American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

September 14, 2026

CMS-1848-P

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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RE: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of our 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the opportunity to comment on the *Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule*[1], 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 6.

[1] 91 FR 43842

Executive Summary

The Physician Fee Schedule

- **Unsustainable payment rates and inadequate short-term fixes:** In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a physician fee schedule (PFS) conversion factor of $33.1693 for physicians participating in Advanced Alternative Payment Models (APMs), and $32.8409 for all other clinicians, including most emergency physicians. This represents a decrease of 1.19% and 1.68%, respectively, from the CY2026 conversion factor. If such a reduction is finalized, emergency physicians will face this cut despite positive budget neutrality adjustments due to the expiration of the one-time payment increase provided in H.R 1. This cut is further compounded by other payment policies effecting practice expense (PE) payments for the second year. Year after year, physicians are subject to payment cuts that are simply unsustainable and without intervention by federal policymakers will cause access to Medicare-participating physicians to become a significant issue in the long term. We request that CMS do everything within its authority to mitigate the reduction and recognize that the complete resolution of this issue will require action by Congress and therefore urge the agency to work with Congress on a permanent fix to the broken Medicare payment system.

Practice Expense

- **Determination of PE RVUs**: For CY 2027, CMS proposes three correlative changes to PE methodology that would phase out the Indirect Practice Cost Index (IPCI), add clinical labor Relative Value Units (RVUs) to work RVUs for the indirect PE allocation calculation for codes without a 10- or 90- day global period, and capping year-over-year PE RVU changes at ±5%. ACEP supports CMS' goal of simplifying the complex PE formula; however, is concerned by the complexity of each change – individually and intertwined. Additionally, this is the second consecutive year that CMS has proposed significant changes to the indirect PE methodology, and the cumulative impact of these policies cannot be fully understood by examining any single proposal in isolation. Accordingly, ACEP recommends that CMS delay these proposals, release additional specialty-specific impact analyses, and work with stakeholders to evaluate the cumulative effects of recent PE methodology changes before implementing further reforms.

- **Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential**: In the CY 2026 PFS final rule, CMS modified the indirect PE allocation methodology for services furnished in the facility setting to reduce the portion of indirect PE allocated per work RVU to 50% of the amount allocated for non-facility services. This policy had a disproportionate impact on emergency physicians, who mainly perform evaluation and management (E/M) services exclusively in the facility setting. ACEP supports CMS's goal of improving payment accuracy and better aligning indirect PE payment with the entity that actually incurs the underlying overhead costs. However, the policy as implemented is overly broad as it does not adequately account for variation in physician practice structures,

penalizing certain specialists like emergency physicians who exclusively work in the facility setting. ACEP again urges 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 by establishing a claim-level payment modifier for eligible facility-based services furnished by physicians and/or physician groups who are not employed by a hospital.

Global Procedures

- **Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods:** CMS proposes reducing payment by 50% for all lower-cost services, including office/outpatient evaluation and management (E/M) visits or procedures, furnished by the same physician or practice on the same day as a 0-, 10-, or 90-day global procedure, citing overlapping operational efficiencies. ACEP strongly opposes this proposal and any potential expansion, arguing that it ignores distinct, non-duplicative physician work, distorts relative values, and risks driving fragmented care by forcing patients into separate visits. ACEP urges the agency not to finalize the reduction and instead collaborate with specialty stakeholders to accurately identify payment overlaps.

Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC)

- **Current Procedural Terminology (CPT) Request for Information (RFI):** CMS seeks public comments on a potential range of approaches to improve the accuracy of valuing services under the PFS, including the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure codes, as an alternative to CPT-4 codes. Overall, ACEP supports the current balanced American Medical Association (AMA) Relative Value Scale Update Committee (RUC) process and is concerned by changes that could distort the value of codes under the fee schedule and significantly harm emergency medicine. Alternative coding systems such as ICD-10 cannot be assumed to serve as interchangeable substitutes for CPT – especially in the emergency medicine context, as well as others that report cognitive work. ACEP also cautions CMS against utilizing payment methodologies built upon diagnosis codes instead of the work performed which would undermine the prudent layperson standard foundational to the practice of emergency medicine.

Changes to the Regulations Associated with the Ambulance Fee Schedule: ACEP strongly supports CMS's incorporation of temporary extensions for ground ambulance payments to stabilize baseline funding for emergency medical services through the end of 2027. However, temporary add-ons do not fix an outdated payment system that relies on legacy transport tiers and shifts costs onto hospitals. To build a sustainable model, ACEP urges CMS to aggressively modernize the Ambulance Fee Schedule by establishing permanent reimbursement pathways for modern, comprehensive care; including treatment-in-place, alternative care destinations, non-transported emergency care, and physician-directed attendant care.

Medicare Shared Savings Program: ACEP supports CMS's proposed changes to advance the MSSP's long term sustainability and encourage participation from a broader range of providers as we believe that they will help increase participation in Accountable Care Organizations (ACOs). 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 facilitate engagement in the MSSP and other ACO initiatives.

CY2027 Modifications to the Quality Payment Program Reporting and Data Submission:

- **Transforming the Quality Payment Program:**
    - **MVPs**: For 2027, CMS is proposing policies to continue the transition towards Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) and end traditional MIPS in CY2029. ACEP disagrees with CMS's decision to move to mandatory MVPs and believes the transition is premature. There are several substantial barriers for clinicians to participate in MVPs that have limited uptake among emergency physicians. ACEP recommends several incentives to encourage participation in MVPs.

    - **MVP Scoring RFI**: CMS seeks information on MVP scoring to compare performance of clinicians within the same MVP. ACEP strongly opposes any future proposal to modify MVP scoring so that clinicians are evaluated primarily based on their performance relative to other clinicians participating in the same MVP. ACEP believes that quality programs should reward achievement against objective benchmarks rather than create artificial distinctions among clinicians who are all delivering high-quality care. Accordingly, CMS should not alter the MVP scoring methodology to incorporate peer-relative comparisons and should instead establish a scoring framework that rewards achievement, promotes collaboration, and provides clinicians with stable and predictable performance expectations.

Quality Performance Category

- **Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP**: ACEP appreciates CMS's continued efforts to refine the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. However, ACEP has significant concerns that the core measures chosen are presumed to be universally applicable, despite the diverse nature of emergency medicine practice settings. Additionally, the removal of QCDR measures altogether risks undermining the MVP's ability to accurately reflect emergency medicine practice and emergency physicians' ability to meaningfully participate in MIPS.

- **MIPS Performance Category Measures and Activities: Proposal to Designate MIPS Core Measures**: ACEP supports CMS's intention of simplifying reporting pathways for physicians but maintains significant concerns with the current proposed core measure framework in both traditional MIPS and MVPs – specifically, the reliance on existing topped out MIPS measures and the exclusion of QCDR measures. ACEP recommends that CMS explicitly ensure QCDR measures are eligible for designation as MIPS core measures.

- **Proposal To Remove High-Priority Measure Designation and High-Priority Quality Measure Retention Consideration**: ACEP urges CMS not to finalize the policy to eliminate the high-priority measure designation and remove retention considerations for high-priority and outcome measures. Removing the high-priority designation devalues measures that reflect true patient outcomes and undermines CMS's stated goal of advancing clinically relevant, evidence-based performance assessment. ACEP urges CMS to preserve incentives for high-priority and outcome measures to ensure continued investment in measures that meaningfully improve patient care.

- **Proposal To Implement Data Submission Requirement for MIPS Core Measures**: ACEP remains concerned that imposing mandatory data submission requirements for MIPS core measures will increase administrative burden and exacerbate program volatility. This proposal runs counter to CMS's stated goal of simplifying MIPS and reducing clinician burden. ACEP urges CMS to avoid rigid core measure submission requirements and instead prioritize stability, flexibility, and specialty specific relevance in MIPS reporting.

- **Proposal To Exempt Small Practices from MIPS Core Measure Reporting Requirement**: ACEP strongly supports providing flexibility and protections for small practices. CMS should maintain the exemption for small practices and support those practicing in rural, critical access or resource-limited settings.

Advanced APM Track: CMS is proposing to change how Advanced Alternative Payment Model (APM) Qualifying Participant (QP) determinations are made by applying QP and Partial QP status only at the specific TIN/NPI level. ACEP has significant concerns with this proposal, particularly given the unique practice patterns of emergency physicians who practice across a wide variety of clinical settings. This proposal would weaken APM uptake among emergency medicine and increase administrative burden. ACEP strongly urges CMS to not implement this change.

Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs RFI: ACEP supports the long-term vision of transitioning to Fast Healthcare Interoperability Resources® (FHIR)-based quality measures; however, there are several barriers of cost, timeline, and uncertainty that risk destabilizing the system. We urge CMS to adopt a measured and flexible approach to implementation. ACEP requests that CMS provide additional time and flexibility for legacy measure conversion and ensure that the transition to FHIR-based digital quality measurement proceeds in a manner that is feasible, transparent, and minimally disruptive to clinicians and registries alike.

The Physician Fee Schedule

Physician Fee Schedule (PFS) Conversion Factor

In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes CY 2027 physician fee schedule (PFS) conversion factors (CFs) of $33.1693 for physicians who meet certain participation thresholds in Advanced Alternative Payment Models (APMs), and $32.8409 for other clinicians. These CF amounts represent decreases of 1.19% and 1.68%, respectively, from the CY2026 conversion factor. Most emergency physicians will receive the lower CF since they do not participate in Advanced APMs.

The proposed conversion factor update is based on the following factors:

1. Statutory update in the Medicare Access and CHIP Reauthorization Act (MACRA): 0.25% for non-QPs and 0.75 for QPs.
2. An estimated +0.53% positive budget neutrality adjustment accounting for proposed changes in work RVUs for some services.
3. Expiration of the one-time 2.5% payment increase included in H.R. 1

As indicated above, the majority of the decrease in the CFs for CY 2027 is due to the expiration of the one-time payment increase provided in H.R 1. However, CMS has also continued to advance broader payment policies affecting practice expense payments, including policies related to indirect practice expense methodology for the second year in a row, that are significantly reshaping physician reimbursement. ACEP urges CMS not to adopt these policies, especially absent intervention by federal policymakers to permanently reform the PFS to address the underlying payment challenges of the fee schedule. Without needed statutory reforms, these changes will further destabilize physician reimbursement.

Emergency physicians continue to struggle with year-after-year reductions in payment. An analysis conducted by ACEP found that Medicare payments have decreased by 33 percent when comparing Medicare payments to inflation between 2001 and 2024. In fact, even when accounting for the positive adjustments summarized above, the CY 2027 proposed CF $32.84 for standard/non-qualifying APM clinicians is still 10% less than it was in 1998 ($36.69) when first established as a unified rate, despite the fact that cost inflation has increased by more than 105% over the same period.[2] The 2026 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

[2] From July 1998 to July 2026, the CPI-U has increased from 163.2 to 333.918 (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, 167.408%, from 244.7 to 654.347 during the same timeframe (Consumer Price Index 1998 and CPI- U by Expenditure Category, 2026).

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, compounding financial instability under the PFS through the cumulative impact of other policies reducing physician reimbursement will 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 requires action by Congress, and we therefore urge the agency to collaborate with Congress on a permanent fix to the broken Medicare payment system. 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 upon which millions of Americans rely.

Practice Expense

Determination of PE RVUs

ACEP appreciates CMS's commitment to accurate payment for PE RVUs. For CY 2027, CMS proposes three correlative changes to PE methodology that would phase out the Indirect Practice Cost Index (IPCI), add clinical labor RVUs to work RVUs for the indirect PE allocation calculation for codes without a 010- or 090- day global period, and capping year-over-year PE RVU changes at ±5%.

ACEP supports CMS' goal of simplifying the complex PE formula, however we are concerned by the complexity of each change – individually and intertwined – on specialties based upon the proposed formula and aggregate tables. We ask the agency to consider providing specialty impact analysis data for each distinct proposed change in the practice expense methodology to allow practices to prepare for this phased-in change.

We ask CMS to exercise caution with respect to enacting policies that further reduce resources across the house of medicine. Emergency departments (EDs) serve as the front door for unscheduled acute care, absorbing demand that cannot be accommodated elsewhere, and provide essential backup capacity for primary care and specialty practices when patients require urgent evaluation or hospital-based treatment.

Given the magnitude and complexity of the proposed changes, ACEP urges CMS to delay implementation of these PE revisions and provide additional time for stakeholder evaluation and analysis. This is the second consecutive year that CMS has proposed significant changes to the indirect

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[3] The 2026 Medicare Trustees Report is available at: https://www.cms.gov/files/document/2026-medicare-trustees-report.pdf

PE methodology, and the cumulative impact of these policies cannot be fully understood by examining any single proposal in isolation. Each successive modification compounds the effects of prior changes, resulting in layered reductions that may substantially decrease payment for certain services over time. These compounding adjustments also raise concerns about valuation accuracy, as services affected by previous PE reductions are subsequently revalued on an already diminished valuation basis. Without a more comprehensive assessment of the combined impact of these policies, CMS risks inadvertently distorting the relative valuation of services and further destabilizing reimbursement for clinicians. Accordingly, ACEP recommends that CMS delay these proposals, release additional specialty-specific impact analyses, and work with stakeholders to evaluate the cumulative effects of recent PE methodology changes before implementing further reforms.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

In the CY 2026 PFS final rule, CMS modified the indirect PE allocation methodology for services furnished in the facility setting to better align its payment policy with physician practice patterns and address potential duplicative payments for indirect costs. The agency's decision to reduce the portion of indirect PE allocated per work RVU to 50% of the amount allocated for non-facility services resulted in a seven percent cut to facility-based payment.[4] This policy had a disproportionate impact on emergency physicians, who 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.

In the CY 2027 PFS proposed rule, CMS acknowledges stakeholders who believe that the 2026 policy had a detrimental effect on facility-based physicians who work in independent practices. However, CMS notes that it has heard "no general consensus among interested parties to this effect," and that the agency has "received feedback that this policy supports independent practices." CMS notes, however, that it is open to further refinements to the 2026 policy, particularly in how PE costs vary for physicians who are employed by facilities.

ACEP supports CMS's goal of improving payment accuracy and better aligning indirect PE payment with the entity that actually incurs the underlying overhead costs. However, the policy as implemented is overly broad as it does not adequately account for variation in physician practice structures, penalizing certain specialists like emergency physicians who exclusively work in the facility setting. ACEP again urges 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.

While this approach may support certain independent practices, we do not believe that this policy supports independent emergency physician practices, especially small practices, and note that the vast majority of stakeholders responding to the CY 2026 PFS proposed rule noted their concern about the impact the policy would have on independent practices. Given the concerns we have received from

[4]American Medical Association. What to expect from the 2026 Medicare Physician Fee Schedule. American Medical Association December 11, 2025. https://www.ama-assn.org/practice-management/medicare-medicaid/what-expect-2026-medicare-physician-fee-schedule

emergency physician practices about this policy, we respectfully disagree with the assertion that CMS received "feedback that this policy supports independent practices" – at least as far as it relates to emergency medicine.

Approximately two-thirds of emergency physicians are not employed by hospitals but instead provide services in hospitals as part of a group through contracts for their professional services. These physician groups furnishing services in facility settings remain responsible for substantial professional practice overhead, including billing, coding, scheduling, compliance, administrative infrastructure, and other back-office functions. As implemented, the CMS site of service payment differential fails to distinguish between these arrangements and hospital-employed models in which the hospital bears those costs directly.

It is essential that CMS refine the policy in the CY 2027 PFS final rule. Therefore, ACEP urges CMS to establish a claim-level payment modifier for eligible facility-based services furnished by physicians and/or physician groups who are not employed by a hospital. When reported on a qualifying claim, the modifier would trigger a targeted payment adjustment, more accurately reimbursing for these services using the CY 2025 PE RVU calculation methodology. For facility-based services billed without the modifier, indicating those services were rendered by a hospital-employed physician or clinician, the CY 2026 practice expense reduction would remain intact. This refinement aligns directly with the agency's goal of accurate payment for actual resource use by limiting the reduction in indirect PE to circumstances in which the hospital, rather than an independent physician group or practice, is covering the relevant professional overhead expenses. A targeted modifier will avoid unnecessary financial pressure on independent groups that staff EDs and support the long-term stability of the emergency care infrastructure on which patients, hospitals, and community physicians rely.

Global Procedures

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

In the CY 2019 PFS, CMS proposed a 50% payment reduction of the least expensive 0-day global procedure or visit that the same physician furnishes on the same day as a separately identifiable E/M visit, due to its concern that a same-day E/M visit alongside a procedure with a global period duplicates payment. CMS reasserts this concern for CY 2027, proposing to reduce payment when a separately identifiable office/outpatient E/M (O/O E/M) visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure. The most expensive service would be paid at 100%, while all other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 50%.

CMS believes there are efficiencies when services are provided in conjunction during a global period that the agency currently overpays for and seeks comment whether this policy should apply to other E/M visits. **ACEP strongly opposes this proposal and is particularly concerned by CMS's interest in expanding it to additional E/M visits.** CMS ultimately did *not* finalize this proposal for CY 2019 after many stakeholders across the house of medicine raised concerns about duplicative adjustments through the RUC review process and unjustified reductions. It also fails to recognize the full scope of services furnished and would undervalue the physician's work required to appropriately diagnose, manage, and treat the patient. For example, an emergency physician may evaluate a Medicare patient who presents to the emergency department with a traumatic laceration after a fall. The

physician must perform a medically necessary ED E/M service that includes obtaining the history, conducting a physical examination, assessing for potential head injury or other trauma, reviewing diagnostic testing, evaluating comorbidities and anticoagulation status, and determining the appropriate disposition. The physician may also perform a laceration repair during the same encounter. In this scenario, the E/M service represents distinct cognitive work that is separate from and far exceeds the work captured in the laceration procedure.

Further, the policy would cause undue burden and potential medical risk for Medicare beneficiaries by causing physicians to bring patients back for necessary visits on a different day to avoid triggering the payment reduction. Later, in the *Request for Information: Redesigning Primary Care to Make America Healthy Again* portion of the proposed rule, CMS states, "The current O/O E/M code set may still insufficiently reflect differences in the nature and intensity of care provided." We urge CMS not to finalize this policy, and instead engage specialty stakeholders to determine what services, if any, are paid in duplicate instead of reducing payment for appropriate services based upon a percentage instead of national relative values.

Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC)

Current Procedural Terminology (CPT) Request for Information (RFI)

CMS seeks public comments on a potential range of approaches to improve the accuracy of valuing services under the PFS.

CMS asks about the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure codes, as an alternative to CPT-4 codes. CMS requests information on how ICD-10-PCS services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs).

Overall, ACEP supports the current balanced American Medical Association (AMA) Relative Value Scale Update Committee (RUC) process and is concerned by changes that could distort the value of codes under the fee schedule and significantly harm emergency medicine. In addition, while we share CMS's commitment to ensuring that services are transparently described, accurately valued, and appropriately reported, it is important to understand that procedure coding systems are highly specialized and are designed to support distinct clinical, operational, and payment functions. As a result, alternative coding systems such as ICD-10 codes cannot be assumed to serve as interchangeable substitutes for CPT – especially in the emergency medicine context.

The ICD-10-PCS code set is owned by the World Health Organization (WHO) and maintained by the CMS ICD-10 Coordination & Maintenance Committee in the U.S.A. ICD-10-PCS includes procedure codes for surgical, medical, and diagnostic procedures for admitted hospital inpatients ***only***. The code system relies on the diagnosis related group (DRG), a classification system that determines hospital payments based on patient diagnosis for inpatient stays, and includes complex seven-character code sequences, where each character represents a specific aspect of the procedure (body region, approach, device, etc.). Instructing all outpatient practices in the country to switch to ICD-10-PCS would require extensive training for all outpatient procedure coders, practice administrators,

physicians, and advanced practice providers (APPs) – at substantial cost both in terms of dollars and staff time. Similarly, outpatient practice electronic medical records software would need significant changes to allow proper documentation, claim submission, and claim processing.

Perhaps more concerning than this administrative burden, ICD-10-PCS contains no structure to report cognitive work – the bedrock of E/M codes. This coding system would leave many specialties, such as primary care/family medicine and emergency medicine, unable to accurately capture the important medical decision-making and complexity of care provided.

Additionally, DRG payments are determined by the primary diagnosis. This is especially problematic for emergency medicine, as the Emergency Medical Treatment & Active Labor Act (EMTALA) requires EDs to provide stabilizing treatment for all patients presenting with an emergency medical condition.

Further, the federal "Prudent Layperson" (PLP) Standard is another essential patient protection, ensuring Medicare patients can seek emergency care without fear of coverage denial. PLP states that any medical condition "manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

> 1) placing the health of the individual (or a pregnant woman or her unborn child) in serious jeopardy;
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> 2) serious impairment to bodily functions, or
>
> 3) serious dysfunction of any bodily organ or part."[5]

First established under the Balanced Budget Act of 1997, the PLP originally applied to all Medicare and Medicaid managed care plans. Patients do not present to the ED with a known diagnosis, only symptoms – it is unlawful to deny or reduce coverage based on the diagnosis. Emergency physicians cannot differentiate based upon presenting symptoms alone if a patient is experiencing an emergent or nonemergent condition. Many conditions, both minor and life-threatening, share very similar symptoms and require a full work-up and exam, including additional diagnostic tools, to determine what the ultimate diagnosis is. Emergency physicians are proud to serve as the safety net to all who need treatment, however, EDs already face very real budget and staffing constraints. A 2025 RAND study, *Strategies for Sustaining Emergency Care in the United States,* brought many of these challenges into sharp relief, finding that:

> "Several studies suggest that Medicare payments to ED physicians are dropping relative to costs, with care intensity having increased over time, making analyses of cost more difficult to interpret. An analysis of ED professional services in 2019 showed that Medicare-insured ED visits cost $5.7 billion annually but generated $5.3 billion in revenue from Medicare payments (Nicola, 2023). Another study examined the 20 most common emergency medicine

[5] Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd

procedures and services, finding that mean Medicare payments for emergency physician services declined by an average of 29 percent over the past two decades (Pollock et al., 2020)."[6]

ACEP cautions CMS against utilizing payment methodologies built upon diagnosis codes instead of the work performed, which would undermine the prudent layperson standard foundational to the practice of emergency medicine and the very nature of the safety net itself.

In addition, the proposed rule states that MedPAC believes that specialty societies have financial stake in the RUC process. ACEP believes that CMS, through the budget neutrality confines of the PFS, has a long history of ensuring that any accepted RUC recommendations are evidence-based and justifiable. Physicians remain the experts who can best articulate the resources required in the provision of the clinical services. CMS should engage with all specialties caring for Medicare patients on evolving the Healthcare Common Procedure Coding System (HCPCS) to best help fulfill the goals of the "Make America Healthy Again" effort.

Changes to the Regulations Associated with the Ambulance Fee Schedule

ACEP strongly supports CMS's self-implementing update described in the proposed rule, which incorporates Section 6203 of the Consolidated Appropriations Act, 2026 (CAA 2026). The proposed update would incorporate CAA 2026 Section 6203, which extends the statutory ground ambulance add-on payments for services rendered on and after January 1, 2023, through December 31, 2027. The 2-percent increase for urban areas, 3-percent increase for rural areas, and 22.6-percent increase for super-rural areas represent a significant extension to baseline funding of rural and urban emergency medical services (EMS) systems and should be incorporated in the proposed rule.

Temporary add-ons, while beneficial for stabilizing the system, do nothing to modernize an ambulance payment system desperately in need of reform. Current reimbursement models are no longer able to keep pace with the growing complexity of out-of-hospital practice, as changing patient needs and provider challenges place growing demands for non-transported advanced care. At the same time, Medicare payment rates for ambulance services are stuck in the past. Medicare reimbursement for emergency ground ambulance services is based on outdated fee schedule tiers (BLS, ALS1 and ALS2), which were never intended to address a system increasingly relying on high-level clinical evaluation and intervention in lieu of simple transportation. These fee schedules, if left unmoderated, create a situation that reflects a tragedy of the healthcare commons: cost shifting to hospitals and other healthcare sectors.

CMS must pivot toward aggressively modernizing the ambulance fee schedule by establishing permanent Medicare payment pathways that would reimburse for comprehensive medical care, not just transportation. ACEP urges CMS to pursue the following changes in CY 2027:

- Treatment in Place: Reimbursement for medical care patients receive while on scene when discharge or transfer to other settings is warranted but not medically indicated.

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[6] Abir, Mahshid, Brian Briscombe, Carl T. Berdahl, Kirstin W. Scott, Sydney Cortner, Daniel Wang, Rose Kerber, and Wilson Nham, Strategies for Sustaining Emergency Care in the United States. Santa Monica, CA: RAND Corporation, 2025. https://www.rand.org/pubs/research_reports/RRA2937-1.html.

- Alternative Destinations: Equitable coverage for emergency care that requires transportation to an alternative healthcare setting (urgent care, behavioral health or infusion therapy or cardiology clinics, etc.) to prevent preventable hospitalizations and reduce fragmentation of care.
- Non-Transported Care: Full funding of response and on-scene stabilization when no patient disposition is possible, or transport to an acute care facility is not medically indicated.
- Physician Direction and Attendant Care: Equitable reimbursement for physicians and other alternative care providers who direct or provide attendant care in lieu of standard emergency medical technicians or paramedics.

EMS physicians stand uniquely positioned as stewards of limited community resources and have the capability and clinical knowledge to thoughtfully work through complex delivery decisions. Realizing their full potential to meet the evolving clinical needs of patients, as well as the broader goals of public health and population-based care, will require a modern, flexible payment framework that encourages behavior that drives toward improved patient health, community wellness and appropriate utilization of healthcare resources over unnecessary transports. ACEP looks forward to working collaboratively with CMS to forge a strong path toward building a sustainable, care-focused ambulance fee schedule model.

Medicare Shared Savings Program

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 to improve overall health outcomes. However, we note that not many emergency physicians directly participate in the MSSP. While some emergency physicians may technically be part of a larger physician group or hospital participating in the program or another ACO, emergency physicians do not play an active role in these initiatives – a missed opportunity to meaningfully improve value-based care delivery. Because emergency physicians routinely make key clinical decisions regarding whether patients should be admitted, kept under observation, or safely discharged, they are prime candidates to drive value over volume and manage post-ED discharge transitions.

To date, ACOs have not effectively engaged specialists to help meet their cost targets and quality metrics. Going forward, we urge CMS to create additional incentives for specialists, like emergency physicians, to facilitate their engagement in the MSSP and other ACO initiatives. Engaging specialists in ACOs will truly help improve quality and reduce costs. We believe that there is significant potential for ACOs to improve performance by better integrating specialists in the care of their assigned patients.

CY 2027 Modifications to the Quality Payment Program Reporting and Data Submission

CMS proposes policies that affect the 2027 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).

Transforming the Quality Payment Program

MVP

For 2027, CMS is proposing policies to continue the transition towards Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) and are proposing to end traditional MIPS in CY2029. The MVP portfolio is being expanded to include 3 new MVPs: diabetic disease, hospitalist, and hypertension. All of the 27 existing MVPs are being modified to include MIPS core measure selections for each MVP, add measures that expand upon a clinical concept or capture additional specialties most applicable to report an MVP, address maintenance requests from the public, and remove measures and activities that would either be finalized for removal from their respective MIPS inventory or replaced by more robust measures. This includes changes to the MIPS Performance categories.

ACEP disagrees with CMS's decision to move to mandatory MVPs and 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, 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, while we see the value of MVPs as a reporting option and acknowledge that broader participation in MVPs supports CMS's long-term goal to transition clinicians to participate in APMs, we have concerns about the ambiguous and uncertain pathways that will transition clinicians from MVP participation to APM participation.

The emergency medicine MVP was based upon the Acute Unscheduled Care Model (AUCM), 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, despite the "Deserves Priority Designation" given to the model by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), the AUCM has not been implemented by the CMS Innovation Center and 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, as well as 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 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 with care 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 specialists, and such a valuable tool must be maintained.

MVP Scoring RFI

CMS seeks information on MVP scoring to compare performance of clinicians within the same MVP. ACEP strongly opposes any future proposal to modify MVP scoring so that clinicians are evaluated primarily based on their performance relative to other clinicians participating in the same MVP. Such an approach would fundamentally change the purpose of quality measurement from assessing whether clinicians meet established standards of high-quality care to ranking them against one another. As a result, physicians could be penalized not because they delivered low-value care, but because they performed slightly below a small group of highly performing peers. ACEP believes that quality programs should reward achievement against objective benchmarks rather than create artificial distinctions among clinicians who are all delivering high-quality care.

This concern is particularly acute for emergency medicine. The emergency medicine MVP has experienced limited participation, meaning that performance comparisons would be based on a relatively small pool of clinicians. In such an environment, small and potentially insignificant differences in performance could have an outsized impact on scores and payment adjustments. A

physician who performs exceptionally well in absolute terms could nonetheless receive a lower score simply because other clinicians within the MVP performed marginally better. This outcome would undermine confidence in the program and fail to accurately reflect the quality of care being provided to patients.

ACEP is also concerned that peer-relative scoring would pit emergency physicians against one another in direct competition for finite performance outcomes. Emergency physicians regularly share best practices, collaborate on quality improvement initiatives, and work collectively to improve patient outcomes across hospitals and health systems. A scoring methodology that effectively requires clinicians to outperform their peers to avoid penalties risks discouraging collaboration and creating incentives that are inconsistent with the goals of value-based care. CMS should continue to foster a culture of continuous improvement rather than establish a framework in which one physician's success depends on another physician within their specialty receiving a lower score.

Additionally, this proposal has significant implications on the incentives for a specialty to participate in MVPs writ large. For example, if a specialty does not fully participate in MVPs, half of those clinicians will receive a positive adjustment. Compare that to another specialty that *fully* participates in MVPs, they too will only see half of their clinicians receive a positive adjustment. This disincentivizes a specialty from investing the time, energy, and funds in improving the performance of a specialty if the outcome is net neutral. If the current framework persists (scored globally across specialties), then a specialty will be incentivized to participate, as no participation could mean negative adjustments for essentially all their clinicians. This is a critical component for MVP uptake and furthering quality improvements.

Furthermore, a peer-comparison methodology may produce unstable and unpredictable scoring results from year to year. Changes in the composition of MVP participants, differences in case mix, or the entrance or exit of a small number of high-performing clinicians could substantially affect scoring outcomes even when an individual physician's performance remains unchanged. Such volatility would make it difficult for clinicians to understand performance expectations, invest in quality improvement activities, and predict future payment adjustments.

ACEP believes that MVP scoring should be based on transparent, objective, and prospectively established performance standards. Accordingly, CMS should not alter the MVP scoring methodology to incorporate peer-relative comparisons and should instead establish a scoring framework that rewards achievement, promotes collaboration, and provides clinicians with stable and predictable performance expectations – consistent with the recommendations highlighted earlier.

Quality Performance Category

Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP

ACEP appreciates CMS's continued efforts to refine the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP. However, ACEP has significant concerns regarding the scope and impact of the proposed changes.

Proposed Core Measures

CMS proposes to include the following measures as core measures within the Emergency Medicine MVP:

- Q116: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Q331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
- Q416: Emergency Medicine: ED Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2–17

ACEP supports efforts to reduce unnecessary imaging and inappropriate antibiotic use. However, ACEP is concerned that several of these measures are not universally applicable across emergency medicine practice settings. Emergency physicians frequently treat undifferentiated, high-acuity patients, and many practice environments – particularly rural, critical access, and high-volume EDs – may not encounter sufficient eligible cases to reliably report these measures. ACEP urges CMS to ensure that core measures within the MVP are broadly applicable and reflective of the full spectrum of emergency medicine.

To make the MVP more robust, ACEP recommends including two new cost measures in the Emergency Medicine MVP: Medicare Spend Per Beneficiary (MSPB) and Total Per Capita Cost (TPCC). These are currently available to EM physicians as general cost measures in the absence of EM-specific cost measures. We request that CMS add them to the MVP so emergency physicians can continue to use them.

Removal of Existing Measures

CMS proposes removing:

- Q415: ED Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18+
- ACEP52: Appropriate ED Utilization of Lumbar Spine Imaging for Acute Atraumatic Low Back Pain (due to low adoption and lack of benchmark)
- ECPR46: Avoidance of Opiates for Low Back Pain or Migraines (high performing)

ACEP is particularly concerned about the removal of ACEP52 and ECPR46, both of which are part of ACEP's Qualified Clinical Data Registry (QCDR), the Clinical Emergency Data Registry (CEDR). With these removals, only one CEDR measure would remain available within the MVP, significantly limiting emergency physicians' ability to report measures tailored to emergency medicine practice. QCDR measures are essential for capturing specialty specific quality and safety priorities that are not reflected in general MIPS measures.

Potential Modification of ACEP52

CMS indicates that if ACEP52 is not removed, it may be modified to exclude patients aged 65 and older due to higher rates of vertebral fractures and malignancy in this population. ACEP appreciates CMS's recognition of the clinical differences in older adults and agrees that denominator refinement may improve measure accuracy. However, ACEP reiterates that removal of the measure would be premature, particularly given ongoing efforts to improve adoption and benchmarking.

Overall Concerns

Overall, ACEP has significant concerns about the number and magnitude of changes proposed for the Emergency Medicine MVP. The removal of multiple QCDR measures, combined with the addition of core measures that are not universally applicable, risks undermining the MVP's ability to accurately reflect emergency medicine practice. Again, QCDR measures are a critical component of specialty-specific quality reporting, and their removal would significantly limit emergency physicians' ability to meaningfully participate in MIPS.

Therefore, we request that CMS:

1. Retain existing emergency medicine's QCDR measures, particularly ACEP52 and ECPR46, or provide a clear pathway for their continued use within the MVP.
2. Ensure that core measures included in the MVP are broadly applicable across emergency medicine practice settings.
3. Avoid reducing the number of emergency medicine specific measures, as doing so diminishes the value and accuracy of the MVP.
4. Engage with ACEP and other specialty societies to ensure that future MVP refinements support clinically meaningful, specialty specific quality measurement.

ACEP remains committed to working with CMS to strengthen the Emergency Medicine MVP and ensure that it continues to reflect best practices, promote patient safety, and support high-quality emergency care.

Measures included in MVP: Proposal to Designate MIPS Core Measures

ACEP supports CMS's intention of simplifying reporting pathways for physicians but maintains significant concerns with the current proposed core measure framework in both traditional MIPS and MVPs. As currently constructed, the reliance on existing "topped out" MIPS measures provides little incentive for high-quality reporting and effectively discourages the pursuit of meaningful performance improvement. Furthermore, the exclusion of QCDR measures severely restricts the ability of emergency physicians to utilize specialty-specific metrics that reflect the actual complexity of clinical care. Registries serve as critical infrastructure in the development of clinically relevant quality measurement by offering data that remains inaccessible in general administrative or claims-based reporting. Registry-based measures provide substantial value by capturing actual patient outcomes across diverse populations, which moves quality assessments beyond theoretical best practices and into the realm of real-world evidence. By focusing on specific clinical domains, these registries supply granular data elements that generic billing claims data routinely miss, allowing for a more precise assessment of specialty performance. Furthermore, registry data enables developers to pilot-test new measure concepts, ensuring that metrics are reliable, clinically valid, and feasible before wide deployment. Registries also facilitate the identification of performance gaps and help avoid the stagnation inherent in "topped out" measures where standard clinical performance is already uniformly high. Finally, unique registry measures offer a pathway for conversion into digital quality measures (DQMs) and electronic clinical quality measures (eCQMs), which are essential for reducing clinician reporting burdens.

Given these considerations, ACEP explicitly recommends that CMS ensure QCDR measures are eligible for designation as MIPS core measures. Specifically, we urge CMS to include ACEP50 within

the core measure set. This measure directly addresses national public health priorities – specifically the reduction of ED boarding and crowding – while meeting CMS's own criteria for feasibility, computability, and reliable data collection. Integrating ACEP50 would better align the MVP structure with specialty-specific clinical priorities and foster a more meaningful, data-driven reporting environment.

Proposal to Remove High-Priority Measure Designation and High-Priority Quality Measure Retention Consideration

ACEP urges CMS not to finalize the policy to eliminate the high-priority measure designation and remove retention considerations for high-priority and outcome measures. ACEP has consistently emphasized that CMS should reward measures that drive clinically meaningful care, encourage the development of specialty-specific outcome measures, and maintain incentives that promote innovation in quality measurement. Removing the high-priority designation devalues measures that reflect true patient outcomes and undermines CMS's stated goal of advancing clinically relevant, evidence-based performance assessment. ACEP urges CMS to preserve incentives for high-priority and outcome measures to ensure continued investment in measures that meaningfully improve patient care.

Proposal to Implement Data Submission Requirement for MIPS Core Measures

ACEP remains concerned that imposing mandatory data submission requirements for MIPS core measures will increase administrative burden and exacerbate program volatility. Emergency physicians already face substantial reporting challenges due to the unpredictable nature of emergency care and the limited applicability of many MIPS measures. Frequent structural changes, such as shifting measure designations or adding new mandatory reporting requirements, force practices to reconfigure data capture workflows, update reporting systems, and absorb additional implementation costs. These disruptions run counter to CMS's stated goal of simplifying MIPS and reducing clinician burden. ACEP urges CMS to avoid rigid core measure submission requirements and instead prioritize stability, flexibility, and specialty specific relevance in MIPS reporting.

Proposal to Exempt Small Practices from MIPS Core Measure Reporting Requirement

ACEP strongly supports providing flexibility and protections for small practices and reiterates that rigid reporting mandates disproportionately harm clinicians who lack access to specialty-relevant measures or robust reporting infrastructure. Emergency physicians—particularly those practicing in rural, critical access, or resource-limited settings often face reporting challenges outside their control, including limited eligible cases, insufficient EHR capabilities, and lack of applicable measures. ACEP urges CMS to maintain exemptions for small practices and avoid imposing data completeness thresholds or mandatory core measure reporting requirements that could unfairly penalize clinicians for circumstances unrelated to care quality.

Advanced APM Track

CMS proposes to change how Advanced Alternative Payment Model (APM) Qualifying Participant (QP) determinations are made. Under current policy, if any of an eligible clinician's TIN/NPI relationships qualifies for QP status, that status is applied across all the clinician's TIN/NPI relationships for purposes of both exclusion from MIPS and eligibility for QP payment incentives. CMS is now proposing to apply QP and Partial QP status only at the specific TIN/NPI level, citing concerns that QP incentives may be flowing to entities that are not participants in an Advanced APM.

ACEP has significant concerns with this proposal, particularly given the unique practice patterns of emergency physicians. Many emergency physicians furnish services under multiple TINs and practice across a variety of clinical settings. This diversified practice model allows emergency physicians to maintain financial viability in an environment of stagnant or declining fee-for-service reimbursement while ensuring access to emergency care in a wide range of communities. This proposal would create a disincentive for physicians who work in safety-net hospitals, rural facilities, and other settings that are not aligned with Advanced APMs to try to participate in an Advanced APM separately. By limiting QP status to individual TIN/NPI combinations, physicians will receive extremely limited "credit" for participating in an Advanced APM. In effect, the proposal will weaken the already-limited incentives that currently encourage emergency physicians to engage in value-based care arrangements, while failing to provide a realistic pathway for broader participation by emergency medicine. Rather than promoting value-based care, the policy could further discourage participation by clinicians who already face structural barriers to entering Advanced APMs.

The proposal would also create substantial administrative challenges. Emergency medicine groups frequently contract with multiple hospitals, health systems, and independent facilities, resulting in a complex network of TINs and billing relationships. Applying QP status at the TIN/NPI level would create a fragmented payment structure in which the same clinician may qualify for different payment rates depending on where a particular service was furnished. Billing and revenue cycle teams would be required to track which services qualify for the QP conversion factor and which are subject to the standard conversion factor based on each facility's APM participation status.

This added complexity would increase administrative costs, create opportunities for billing errors, and introduce unnecessary revenue uncertainty for emergency physician groups. At a time when CMS is seeking to reduce administrative burden and encourage participation in value-based care, ACEP believes this proposal would have the opposite effect by making participation more complicated while reducing the benefits available to clinicians who choose to engage in Advanced APMs.

Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs — Request for Information

ACEP appreciates CMS's continued efforts to advance digital quality measurement and improve interoperability across federal quality programs. While ACEP supports the long-term vision of transitioning to Fast Healthcare Interoperability Resources® (FHIR)-based quality measures, we urge CMS to adopt a measured and flexible approach to implementation.

As stated earlier, ACEP owns and operates a QCDR called CEDR. Registry vendors and measure stewards face significant financial and operational burdens in converting existing measures to FHIR specifications. It costs approximately $150,000 per measure to secure the necessary technical expertise and complete the conversion. These unfunded costs are prohibitive and risk destabilizing the quality measurement infrastructure clinicians rely on.

We are also concerned that the proposed CMS transition timeline does not provide sufficient time for registries, measure owners, and vendors to redesign, test, and implement FHIR-based measures. ACEP urges CMS to extend the timeline and offer explicit flexibility for legacy measures to ensure continuity of reporting and prevent disruption to clinician participation in the QPP.

In addition, CMS has not clearly defined which measures will be subject to FHIR conversion. It remains unclear whether the requirements will apply universally to all QPP measures or primarily to QCDR measures. This uncertainty makes it difficult for registries and measure stewards to plan and allocate resources appropriately. ACEP requests that CMS publish a detailed roadmap outlining the scope, timelines, and expectations for measure conversion.

Overall, ACEP respectfully requests that CMS provide additional time and flexibility for legacy measure conversion and ensure that the transition to FHIR-based digital quality measurement proceeds in a manner that is feasible, transparent, and minimally disruptive to clinicians and registries.

Once again, we appreciate the opportunity to provide comments on the proposed rule. If you have any questions, please contact ACEP's Manager of Regulatory and External Affairs, Annalane Miller, at amiller1@acep.org.

Sincerely,

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