

December 28, 2020

Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

Re: Regulatory Relief to Support Economic Recovery; Request for Information (RFI)

Dear Secretary Azar:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on a request for information on the regulatory relief that the U.S. Department of Health and Human Services (HHS) has granted during the novel coronavirus (COVID-19) public health emergency (PHE). As you know, it is critical to ensure that our nation's emergency physicians and other frontline health care workers have the resources and flexibility we need to treat our patients during this global pandemic. Overall, we appreciate the numerous waivers and regulatory flexibilities that HHS has instituted since the PHE began. Some of these have had a direct impact on our members and the patients we serve, providing the appropriate level of flexibility needed to help us safely and effectively do our jobs.

Our comments on these specific waivers are below.

Telehealth Waivers

During the PHE, the Centers for Medicare & Medicaid Services (CMS) instituted numerous temporary changes to existing Medicare and Medicaid telehealth policies that have significantly expanded the use of telehealth services. While we understand that CMS does not have the legal authority to permanently waive some of these policies, ACEP still would like to provide feedback on how they all have affected the way we as emergency physicians have been able to care for our patients during this difficult time.

List of Approved Medicare Telehealth Services

Original Policy: The Medicare-approved list of telehealth services have been mostly cognitive services delivered in the office and outpatient settings. Emergency department (ED) evaluation and management (E/M) codes (CPT codes 99281-99285) were not on the list of approved Medicare telehealth services, up until the PHE began.

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Temporary Flexibilities Provided: During the PHE, CMS has temporarily added all five ED E/M codes, the critical care codes (CPT codes 99291 and 99292), and the observation codes (CPT codes 99217-99220, 99224-99226, and 99234-99236) to the list of approved Medicare telehealth services. Then in the Calendar Year (CY) 2021 Physician Fee Schedule (PFS) final rule, CMS added all five ED E/M codes, the critical care codes, and some observation codes to the list of approved telehealth services under a new “Category 3.” Under this Category 3, codes will remain on the list of approved telehealth services through the end of the calendar year in which the PHE ends.

ACEP Comments:

Types of Services Delivered

During the COVID-19 PHE, Medicare beneficiaries and other patients have been able to safely receive services either from their home, the ED, or an alternative location within the hospital. All in all, emergency physicians have provided telehealth services in the following three different clinical situations, all of which have added clinical value to patients:

1. ***Preventing Medicare Beneficiaries from making unnecessary visits to the ED.*** Medicare beneficiaries who had urgent medical needs, but were unsure if they were having a medical emergency, were able to contact their EDs and have a telehealth visit with an emergency physician to assess whether the patient could stay at home, go to an urgent care clinic, or visit the ED. While previously Medicare beneficiaries had the opportunity to go to the ED in person if needed, this type of telehealth visit has now provided Medicare beneficiaries with a safe way of getting their condition evaluated before needing to make that decision. Emergency physicians are trained in rapid diagnosis and evaluation of patients with acute conditions, so they are the most capable clinicians to provide these type of telehealth services. In many cases, we are able to provide treatment to patients with minor illnesses and injuries completely via telehealth.
2. ***Providing MSEs to Patients who came to the ED.*** As alluded to above, CMS released guidance stating that physicians (or other qualified medical persons) can perform MSEs via telehealth and, where appropriate, meet the MSE requirement without an in-person examination. Hospitals are temporarily allowed to set up alternative locations “on campus” for patients to receive an MSE other than in the ED. For example, patients presenting with possible symptoms of COVID-19 and meeting certain criteria (i.e. vital sign parameters) can be sent to a negative-pressure tent, where they are seen by an in-person nurse and a physician via telehealth (video and audio) who determines if the patient can be discharged from the tent or needs to be seen in the ED. After completing this process, a low percentage of patients need ED evaluation.
3. ***Ensure appropriate follow-up care after ED discharges.*** Emergency physician groups have set up systems and protocols to follow-up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

Impact on Workforce

The use of emergency telehealth services during the PHE has truly helped address unprecedented staffing challenges during the pandemic. Older physicians, or those who are quarantined but asymptomatic, immunocompromised, pregnant, or have underlying medical conditions, have been able to continue to work with minimal to no exposure and also mitigate the impact to staffing issues during this critical time. Physicians and other health care practitioners whose clinics are closed, retired physicians, surgeons with canceled elective surgeries, resident physicians, locums, volunteer physicians, and those physicians from geographic areas that are only mildly affected have all provided services.

Impact on Patient Health Outcomes

While ACEP is still collecting data to more fully assess the value of being able to bill the ED E/M codes during the PHE, we expect to see improved health outcomes due to the proliferation of emergency telehealth services. For example, telehealth has the potential to improve care coordination and limit avoidable trips to the ED or hospital. Further, it allows for screening examinations that do not need to be done in person, thereby reducing the chance of exposure to COVID-19. Finally, it improves access to care for beneficiaries, a clear clinical benefit, by connecting patients with clinicians from any location in a timely manner.

Some EDs have been able to track data that could be used to evaluate clinical outcomes, such as monitoring whether a patient required an additional medical visit after the telehealth visit, and determining the percentage of patients who avoided an ED or urgent care visit for the illness or injury.

ACEP Recommendations

ACEP strongly urges CMS to add the ED E/M codes levels 1-3 (CPT codes 99281-99283) permanently to the list of approved Medicare telehealth services. CMS should add these services on a Category 2 basis, as we continue to believe that these services add significant clinical value. We also believe that these ED E/M codes best reflect the services that emergency physicians typically render, regardless of whether these services are delivered in-person or remotely via telehealth. Having the ED E/M codes levels 1-3 on the list of approved telehealth services permanently would also allow EDs that have stood up telehealth programs during the COVID-19 PHE to be even more ready to respond to the next disaster.

With respect to ED E/M code levels 4-5 (CPT codes 99284-99285), we note that there are many situations where it is appropriate for emergency physicians to provide telehealth services to patients where they could use a higher-level ED E/M code. Patients in rural EDs can be co-managed by emergency physicians in tertiary care EDs, thus saving expensive patient transports (including by helicopter). Board-certified emergency physicians with extensive critical care and trauma experience can provide medical guidance and collaborative care to patients being treated in rural EDs or at rural hospitals (including critical access hospitals) by a non-specialized ED clinician. Effective telehealth collaboration for high-level cases (which would yield ED E/M codes of level 4 or 5) could facilitate clinical collaboration and decrease unnecessary transfers. In fact, one study found significant cost savings from averted transfers across a cohort of ED telehealth programs in rural areas. Averted transfers saved on average \$2,673 in avoidable transport costs per patient, with 63.6 percent of these cost savings accruing to public insurance.¹

¹ Ward MM, Carter KD, Ullrich F, et al. "Averted Transfers in Rural Emergency Departments Using Telemedicine: Rates and Costs Across Six Network." *Telemed J E Health*. 2020;10.1089/tmj.2020.0080. <https://pubmed.ncbi.nlm.nih.gov/32835620/>.

We therefore support CMS’ decision in the CY 2021 PFS final rule to include the higher level ED E/M codes, the critical care codes, and a subset of the observation codes to the list of approved telehealth services on a Category 3 basis.

In addition, we believe CMS should test the use of ED codes and critical care codes in Centers for Medicare & Medicaid Innovation (CMMI) models, like the Emergency Triage, Treat, and Transport (ET3) Model—where a paramedic or emergency medical services (EMS) technician is onsite with a Medicare beneficiary but can connect with a board-certified emergency physician who is able to treat the beneficiary remotely via telehealth. This kind of approach, if done appropriately, ensures that patients get timely, appropriate care under the supervision of an emergency physician. Under current ET3 rules, physicians providing telehealth services to beneficiaries can only bill codes on the list of approved telehealth services. Therefore, if ED E/M and critical care codes are eventually removed from the list, they could no longer be used in the model from that point forward. Testing the ability to bill for these codes in CMMI models may demonstrate clinical effectiveness and could eventually give CMS the information it needs to add these codes to the list of approved telehealth services on a Category 2 basis.

The Emergency Medical Treatment and Labor Act (EMTALA) Telehealth Waiver

Original Policy: The medical screening exam (MSE), a key component of EMTALA as defined under Section 1867(a) of the Social Security Act (SSA), must be conducted in-person.

Temporary Flexibilities Provided: During the PHE, MSEs can be conducted via telehealth. Qualified health care practitioners providing the telehealth service may be on the hospital’s campus or offsite (due to staffing shortages). The use of telehealth to provide screening of individuals who have not physically presented to the hospital for treatment does not create an EMTALA liability.

ACEP Comments: **Being able to perform the MSE via telehealth has helped preserve PPE and reduce unnecessary exposure to COVID-19.** Emergency physicians are at an increased risk of contracting COVID-19 due to frequent and close physical interactions among patients and other health care workers. Patients also are able to be appropriately screened and evaluated without any fear of being in close proximity to other patients or health care workers who may have the virus. Performing MSEs via telehealth also does not jeopardize the quality of care that patients receive. **Going forward, ACEP hopes that CMS will consider extending or making permanent this waiver to allow MSEs to be performed via telehealth.** However, as described in the EMTALA section below, there are other waivers to EMTALA that CMS granted during the pandemic that we do not think should be extended once the PHE ends.

Geographic and Originating Site Restrictions

Original Policy: Under Section 1834(m) of the SSA, there are specific “originating site” and “geographic” restrictions that limit where telehealth services can be performed under Medicare. Unless otherwise excepted, telehealth must be performed in rural areas of the country. Further, Medicare beneficiaries must travel to certain health care facilities such as a physician’s office, skilled nursing facility, or hospital for the visit. They cannot receive telehealth services from their homes.

Temporary Flexibilities Provided: During the PHE, under section 1135 authority, CMS waived both the originating site and geographic restrictions. Telehealth services can be provided in all areas (not just rural), and any Medicare beneficiaries can receive these services from any location, including their homes. This applies to both new patients and those with whom the furnishing physician has a pre-established relationship.

ACEP Comments: The temporary removal of both these restrictions has truly been a game-changer in terms of expanding the use of telehealth services. Being able to provide telehealth services outside the four walls of the ED has kept both patients and physicians safe during the PHE. It has also allowed patients to receive care in the most appropriate setting, which in some cases, could be the comfort of their own homes. Further, it has enabled physicians to employ technology in innovative ways that have improved the quality of care we deliver to patients.

ACEP understands that CMS does not have the legal authority to permanently eliminate these restrictions once the PHE ends. However, we hope that CMS will join us in support of federal legislation such as the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2741) that would accomplish this goal.

Licensing and Credentialing

Original Policy: Currently there are regulatory barriers that restrict the ability for physicians to get licensed and credentialed in multiple states so that they can provide telehealth services to patients across state lines.

Temporary Flexibilities Provided: CMS has issued a temporary waiver to allow physicians who are licensed in one state to provide services to a patient another state. This applies to Medicare and Medicaid.

For Medicare, this policy only applies if the following conditions are met:

- The physician or non-physician practitioner must be enrolled as such in the Medicare program;
- The physician or non-physician practitioner must possess a valid license to practice in the State which relates to his or her Medicare enrollment;
- The physician or non-physician practitioner is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and
- The physician or non-physician practitioner is not affirmatively excluded from practice in the State or any other State that is part of the emergency area.

In addition, this policy does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government. Those requirements would continue to apply unless waived by the state. In other words, in order for a physician to deliver services in another state, that state would have to waive its licensure requirements for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.

CMS has never fully addressed the issue of credentialing with respect to telehealth and has pointed out that this is within the jurisdiction of the states to address.

ACEP Comments: Many emergency physicians have been able to successfully take advantage of this waiver and perform telehealth services (and in-person services) across state lines. The waiver has been especially useful when COVID “hotspots” have popped up in certain areas of the country and health care practitioners from other locations have been able to either travel or provide telehealth services to patients in these areas.

Going forward, we hope that CMS will, to the extent of its authority, continue to allow physicians to provide telehealth services across state lines. We also note that this is not only a federal issue. States must follow suit and also change their existing laws that hinder the ability for physicians to provide telehealth services.

Supervision Requirements

Original Policy: In order to meet the direct supervision requirement, physicians have had to be physically present during the duration of the service. Teaching physicians also have had to be physically present in order to meet the requirement that they be present for the key portion of the service.

Temporary Flexibilities Provided: CMS has revised the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. This policy will last through the later of the end of the calendar year in which the PHE ends or December 31, 2021.

During the PHE, teaching physicians could use interactive, real-time audio/video to interact with the resident through virtual means in order to meet the supervision requirement. In the 2021 PFS final rule, CMS established this as permanent policy, but limited it to residency training sites of a teaching setting that are outside of a metropolitan statistical area (MSA).

ACEP Comments: ACEP believes the flexible supervision requirements have been helpful during the PHE and is therefore supportive of CMS' decision to continue these policies past the end of the pandemic. Doing so will extend the reach of board-certified 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 emergency physicians directly supervise all care delivered in EDs, and telehealth represents a viable tool to accomplish this goal.

Technology Requirements

Original Policy: Telehealth services are required to be delivered via a two-way, real-time interactive communication, with only a few exceptions.

Temporary Flexibilities Provided: During the PHE, telehealth services can be delivered through the use of mobile devices that have audio and video capabilities. HHS is waiving penalties for Health Insurance Portability and Accountability Act (HIPAA) violations against health care professionals that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype.

ACEP Comments: ACEP believes that expanding the available technology platforms that can legally be used to provide telehealth services has made it easier for physicians to develop telehealth programs and reach their patients. To the extent HHS is allowed to do so under the law, it should consider permanently eliminating barriers and penalties for using both innovative and every-day technologies to treat patients—while at the same time ensuring that the privacy of patients is always protected.

The EMTALA Limited Waiver

Background

As emergency physicians, we are subject to EMTALA, which guarantees that we provide patients with emergency medical care regardless of their insurance status or ability to pay. ACEP strongly supports the patient protections embedded within the EMTALA requirements. During the PHE, the majority of existing EMTALA requirements have remained in place, including the requirement to provide stabilizing treatment to individuals found to have an emergency medical condition and for hospitals with capacity to accept patients in transfer. Besides the ability to provide the MSE via telehealth (described above), CMS highlights a few other temporary policies, which are found in

the agency's March 30th guidance to hospitals.² In this guidance, CMS provides information for ensuring that workflows and processes implemented by hospitals to address COVID-19 are compliant with EMTALA, including rules around alternative on-campus sites for performing MSEs.

Further, CMS issued a limited waiver to the MSE requirement under Section 1867(a) of the SSA. Specifically, CMS is allowing hospitals, psychiatric hospitals, and critical access hospitals "to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness or pandemic plan."³ The off-campus site must be staffed with qualified personnel capable of medically screening patients who present with flu-like symptoms suggestive of Covid-19 infection.

ACEP Comments

Overall, ACEP has been communicating to our members that despite the limited waiver related to the MSE requirement, it is best to continue to follow all the usual EMTALA requirements, unless they somehow significantly impede patient care and are covered under the waiver. Going forward, once the PHE ends, we believe that there is no more use for this limited waiver. However, as previously described, CMS should consider permanently allowing MSEs to be performed via telehealth.

Free Standing Emergency Department Waiver

Background

Currently, free standing emergency departments (FSEDs) that operate independently from hospitals are not eligible to enroll in Medicare and Medicaid. In April 2020, CMS issued guidance allowing licensed independent FSEDs in Colorado, Delaware, Rhode Island, and Texas to temporarily provide care to Medicare and Medicaid patients.⁴ In order to make this policy change, CMS waived certain Conditions of Participation (CoPs) for hospitals. Under the guidance, independent FSEDs may participate in Medicare and Medicaid in one of three ways:

- Becoming affiliated with a Medicare/Medicaid-certified hospital under the temporary expansion 1135 emergency waiver;
- Participating in Medicaid under the clinic benefit if permitted by the state; or
- Enrolling temporarily as a Medicare/Medicaid-certified hospital to provide hospital services.

Any of these options must be implemented in a manner that is consistent with the state emergency and pandemic plan for patient surges during the COVID-19 PHE. Licensed independent FSEDs choosing to enroll as a hospital during the COVID-19 PHE must initially meet and continue to meet the Medicare hospital COPs, to the extent not waived. The independent FSEDs will receive hospital facility payments from Medicare based on the care provided. They may also provide both inpatient and outpatient care, as needed during the PHE.

² Center for Clinical Standards and Quality/Quality, Safety and Oversight Group. *Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19) (Revised)*. March 3, 2020. <https://www.cms.gov/files/document/qso-20-15-hospital-cah-emptala-revised.pdf>.

³ CMS COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

⁴ Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. *Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid during the COVID-19 Public Health Emergency*. April 21, 2020. <https://www.cms.gov/files/document/qso-20-27-hospital.pdf>.

Once the PHE ends, an independent FSED would lose its hospital billing privileges. If a licensed independent FSED wishes to become a certified hospital after the PHE has ended, it must begin the process of enrollment and initial certification as a certified hospital under the regular processes. In other words, it must meet all the hospital COPs—which is likely impossible since independent FSEDs are not affiliated with hospitals and only provide emergency services.

ACEP Recommendation

ACEP believes that independent FSEDs that meet certain conditions and criteria should continue to receive reimbursement under Medicare and Medicaid once the PHE ends. These conditions and criteria include:

- Being available to the public 24 hours a day, seven days a week, 365 days per year.
- Being staffed by appropriately qualified emergency physicians.
- Having adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.
- Being staffed at all times by an RN with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support.
- Having policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed.
- Having protocols in place to follow the EMTALA statute. All individuals arriving at a FSED should be provided an appropriate MSE by qualified medical personnel including ancillary services to determine whether or not an emergency exists.
- Having the ability to provide stabilizing treatment within the capability of the facility and having a mechanism in place to arrange an appropriate transfer to the definitive care facility, if appropriate, for the patient to receive necessary stabilizing treatment regardless of the patient’s ability to pay or method of payment.
- Having the same standards in place as hospital-based EDs for quality improvement, medical leadership, medical directors, credentialing, and appropriate policies for referrals to primary and specialty physicians for aftercare. Value based payments should consider the intrinsic differences between FSEDs and hospital-based EDs.

ACEP notes that CMMI’s Community Health Access and Rural Transformation (CHART) Model includes a waiver of “Medicare hospital conditions of participation to allow a rural outpatient department and emergency room to be paid as if they were classified as a hospital.”⁵ We are still waiting to see more details about this waiver and whether it is similar to the independent FSED COVID-19 waiver. We hope that CMS will use the CHART model as an opportunity to continue exploring how independent FSEDs can serve rural communities.

Merit-based Incentive Payment System (MIPS) Reporting Requirements

Background

CMS has announced some needed relief to Merit-based Incentive Payment System (MIPS) reporting requirements. For the 2020 performance period, eligible MIPS providers can submit an application to have their MIPS Quality, Cost, Improvement Activities, and/or Promoting Interoperability performance categories reweighted to 0 percent

⁵ The Center for Medicare & Medicaid Innovation. The Community Health Access and Rural Transformation (CHART) Model. <https://innovation.cms.gov/innovation-models/chart-model>.

due to COVID-19. Specifically, if the COVID-19 pandemic prevents providers or their groups from collecting 2020 MIPS performance period data for an extended period of time, or could impact their performance on cost measures, they can submit an extreme and uncontrollable circumstances application through February 1, 2021. In the CY 2021 PFS final rule, CMS stated that it will be applying this same hardship exemption process to the 2021 performance period as well.

ACEP Comments

ACEP strongly supports the creation of this COVID-19 hardship exemption. We also appreciate the flexibility that CMS has shown in granting hardship exemption application requests. As long as eligible MIPS providers or groups include as part of their rationale that they are claiming the hardship exemption because of their inability to report due to “COVID-19” or the “coronavirus,” CMS will most likely grant the exemption request. We also thank CMS for CMS not requiring providers or groups to submit documentation to support the hardship exemption request and for approving individual hardship exemptions within 24 to 48 hours after the request is submitted.

In addition, we thank CMS for extending the hardship exemption process into 2021. However, we ask that CMS also consider extending it into 2022 depending on when the PHE ends and all health care systems can return to normal operations.

Services Performed or Supervised by Non-Physician Practitioners

Background

During the COVID-19 PHE, CMS instituted a number of temporary policies that expanded the ability for non-physician practitioners to perform or supervise the delivery of services. For example, CMS waived the requirement at that physician visits must be made by the physician personally. CMS is temporarily permitting physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant (PA), or clinical nurse specialist (CNS) who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state’s scope of practice laws.

Further, CMS is allowing NPs, PAs, CNSs, and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians. In the CY 2021 PFS final rule, CMS decided to make this specific policy permanent once the PHE ends.

ACEP Comments

While these policies may be necessary during the PHE when resources are stretched out and physicians are focusing all their time on the most critical cases, ACEP strongly opposes making them permanent. We are therefore disappointed that CMS already decided to make permanent the temporary policy to allow NPs, PAs, CNSs, and CNMs to supervise the performance of diagnostic tests.

In general, ACEP believes that NPs and PAs should not provide unsupervised ED care. Each supervising physician should retain the right to determine his/her degree of involvement in the care of patients provided by PAs in accordance with the defined PA scope of practice, state laws and regulations, and supervisory or collaborative agreement.

We are also concerned about CMS' overall position regarding care delivered by non-physician practitioners. When making any policy choices, CMS should rely on fact-based resources, including a thorough review of the education and training of nonphysician health care professionals and the impact on the overall cost and quality of care. CMS should review the true impact of state scope of practice laws on access to care across the country.

As the most highly educated and trained health care professionals, we believe that physicians should lead the health care team. There is a vast difference in the education and training of physicians and other health care professionals, including Advanced Practice Registered Nurses (APRNs) and PAs. The well-proven pathways of education and training for physicians include medical school and residency, and years of caring for patients under the expert guidance of medical faculty. Physicians complete 10,000-16,000 hours of clinical education and training during their four years of medical school and three-to-seven years of residency training. By comparison nurse practitioners, the largest category of APRNs, must complete only 500-720 hours of clinical training after two-three years of graduate-level education. Physician assistant programs are two years in length and require 2,000 hours of clinical care. Neither nurse practitioner nor PA programs include a residency requirement. The difference does not stop there as physicians are required to pass a series of comprehensive examinations prior to licensure as well as further examinations for specialty board certification. By contrast nurse practitioners must pass a single test consisting of 150-200 multiple choice questions. Similarly, physician assistants must pass a single 300-question multiple choice exam. We encourage CMS to take a close look at the stark differences in education and training as outlined above, which clearly demonstrates the education and training of nurse practitioners and PAs are not commensurate with physicians.

Medicare patients are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs. As such they deserve care led by physicians - the most highly educated, trained and skilled health care professionals. We cannot and should not allow anything less. Patients agree and overwhelmingly want physicians leading their health care team. In fact, four out of five patients prefer a physician to lead their health care team and 86 percent of patients say patients with one or more chronic conditions benefit when a physician leads their health care team.

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of, or collaboration with, physician assistants. Most states require physician supervision of or collaboration with nurse anesthetists, one type of APRN, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in the last five years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

A common argument for expanding the scope of practice of nonphysician professionals is it will increase access to care. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. This occurs regardless of the level of autonomy granted to nurse practitioners at the state level.

Finally, we caution against positioning scope of practice as an administrative burden. Doing so obfuscates the very real administrative burdens facing physicians and other health care professionals every day, where every hour they spend providing clinical care to their patients requires two hours of administrative tasks. **While all health care professionals play a critical role in providing care to patients, their skillsets are not interchangeable with that of fully trained physicians.** The scope of practice of health care professionals should be commensurate with their level of education and training, not based on politics. Patients – and in this case Medicare patients – deserve nothing less.

Targeted Probe and Educate Program

Background

In March 2020, CMS suspended most Medicare Fee-For-Service (FFS) medical review. This included pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate (TPE) program, and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC).

Under the TPE program, the MAC looks for providers and suppliers who have high claim error rate or unusual billing practices and for items and services that have a high national error rate and are a financial risk to Medicare. Common claim errors identified are (a) missing provider signatures; (b) encounter notes that do not support all elements of eligibility, and (c) Documentation that does not meet medical necessity; and (d) Missing or incomplete initial certifications or recertification. If chosen, providers receive a letter from their MAC. The MAC will review 20-40 provider claims and supporting medical records. If compliant, the provider will not be reviewed again for at least one year for the selected audit topic. If some claims are denied, the provider will be invited to a one-on-one education session and give a 45-day period to make changes and improve.

ACEP Comments

ACEP has significant concerns with the TPE audits, and thanks CMS for temporarily suspending them during the COVID-19 PHE. Many of our members who are audited under this program do not have a full understanding of why they are identified as outliers. The MACs do not publicize their methodology for making this determination and it is not always clear if providers are being appropriately compared to their peers. Given our concerns, we recommend that CMS refine and then publicize the TPE program methodology for identifying outliers, including making the comparison peer group criteria transparent, during this suspension and not start up the program again until it has taken these important steps.

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

Sincerely,



Mark S. Rosenberg, DO, MBA, FACEP
ACEP President