American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

FACT SHEET

ACEP Responses to Major Medicare Payment Rule for CY 2019

Each year, CMS releases several proposed regulations that, once finalized, directly impact how emergency physicians are paid under Medicare. This year, CMS combined the Physician Fee Schedule and the Quality Payment Program (MACRA) proposals into a single rule.

Key provisions of the rule and ACEP's responses to them are below—note that these are all only *proposed* by CMS. We expect final regulations setting CY 2019 payment policy to be released by CMS in early November.

To see ACEP's full response to this rule, please click here.

Medicare Physician Fee Schedule Proposals

- Restructuring Evaluation and Management (E/M) Codes and Streamlining Documentation Requirements —in an effort to reduce physician administrative burden, CMS is proposing to streamline documentation requirements, but at the same time create a blended payment rate for office/outpatient E/M level 2 through 5 visits. **The proposals do NOT initially impact the emergency medicine E/M code set**, but CMS does seek comment on potential such changes to these codes in the future.

  ACEP Response:

  - Disagree that CMS' proposal related to streamlining documentation requirements would reduce burden overall, since clinicians would still need to document for other purposes such as clinical, legal, operational, and quality reporting.
  - Strongly oppose CMS' proposal to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or physician within the same group) furnishes on the same day as a separately identifiable E/M visit (as coded with Modifier-25)
  - Agree with CMS' decision to initially exempt the ED visit code set. It is currently at review at the AMA RUC, which needs to provide recommended values to CMS first. We also urge CMS to consider the unique and unpredictable environment of EDs and the complexity of patients seen as it begins to think about proposing any changes to the ED E/M code set in the future.
    - If CMS were to ever apply this blended payment policy to the ED E/M code set, we support additional add-on codes for complexity.
  - Do not support CMS' implementation date of January 1, 2019 and we urge CMS to delay the start date to January 1, 2020 or even later.

- Teaching Physician Documentation Requirements for E/M Services—in line with the E/M burden reduction proposal, CMS is proposing to remove current requirement that teaching physicians document extent of their participation in the review and direction of the services furnished to each beneficiary, and instead just require documentation that the teaching physician was present at time of service.

  ACEP Response:

  - Concerned that proposal did not mention requirements around medical students. Including medical student documentation in the revised policy would extend the intended relief from the regulatory burden of duplicate documentation on the same patient.

- AUC program for advanced imaging details—created in legislation in 2014, this program will require physicians ordering advanced imaging to first consult appropriate use criteria through approved clinical decision support mechanisms in order for the furnishing provider/radiologist to be able to receive payment.

  ACEP Response:

  - Call on CMS again to correct its misinterpretation of Congress' exemption for emergency medical conditions.
  - If CMS does not make this correction, ask CMS to at least create an additional exemption in cases where clinicians believe that their patients may be experiencing an emergency at the time of ordering.

- Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services—CMS proposes to pay separately for two newly defined physicians' services furnished remotely using communication technology (virtual check-ins and evaluating patient-submitted images and videos).

  ACEP Response:

  - Urge CMS to consider allowing emergency physicians practicing in the ED to bill for these new remote physician services. ACEP could work with CMS on ensuring appropriate reimbursement, that all EMTALA obligations are fulfilled, and that patients are still able and encouraged to come to the ED with full coverage without any hesitation when there is a chance they might need immediate emergency care.

- Bundled Episode Payment for Substance Use Disorder (SUD) Treatment—as part of CMS' effort to combat the opioid epidemic, CMS is seeking comment on creating a bundled payment for components of Medication Assisted Treatment (MAT) such as management and counseling services to help expand access to treatment for SUDs. This new payment would be part of the Medicare physician fee schedule.

  ACEP Response:

  - Strongly encourage CMS to ensure that a bundled payment adequately funds ED-initiated MAT along with the other necessary wrap-around features of it such as treatment management and counseling.
  - Given importance of MAT as a tool to address the opioid crisis, we urge CMS to go beyond scope of their proposal and make a significant investment in MAT, either through a broader model or grant funded by the Center for Medicare & Medicaid Innovation (CMMI).

Quality Payment Program Proposals

- More flexibility for participation—CMS is allowing clinicians to opt-in to MIPS if they exceed one or two, but not all three, of the low-volume threshold criteria (less than $90,000 Medicare Part B charges; fewer than 200 beneficiaries; or less than 200 covered professional services).

  ACEP Response:

  - Support this additional flexibility, but note that the more clinicians exempted from MIPS, the lower the bonus range, given the program's budget neutrality construct.
    - Ask CMS to be mindful of how low positive adjustments could affect participation going forward.

- Use your facility's score—Starting in 2019, hospital-based physicians can have their quality and cost performance for MIPS be based on that of their facility. For those eligible, CMS will automatically take the higher of the hospital quality/cost score and traditional MIPS score.

  ACEP Response:

  - Support this option but stress need for individual clinicians and groups to know before the start of performance period whether they meet eligibility criteria for this to ensure time to make decisions about whether to still report quality measures traditionally or simply rely on their facility score.
    - Believe that if CMS does not notify clinicians ahead of time on eligibility, this new option meant to reduce burden will instead add complexity that will make it difficult for them to succeed.

- Increasing Performance Threshold—CMS is proposing to increase the performance threshold needed for a MIPS bonus payment from 15 to 30 points, and the threshold to get an exceptional performance bonus from 70 to 80 points.

  ACEP Response:

  - Do not support these increases. The proposed performance threshold increase of 50 percent is a large jump for CMS to make in one year. Encourage CMS to establish a more reasonable performance threshold of 25 points.
    - Urge CMS to keep the exceptional performance threshold at 70 points, since raising it to 80 points will adversely affect those specialties that do not have many reportable measures.

- Qualified Clinical Data Registries—CMS includes a number of proposals that would affect ACEP's QCDR, the Clinical Emergency Data Registry (CEDR).

  ACEP Response:

  - Vehemently oppose CMS' proposal to force QCDR measures approved for MIPS reporting to be generally available for other QCDRs' use without a fee. This proposal would prevent the measure owning-entity from recouping any financial investment it put into developing and maintaining it since they would no longer be allowed to charge a licensing fee.
  - Strongly oppose the proposal to revise the start of the self-nomination period from September 1 to July 1 of the calendar year.
  - Generally support the concept of allowing QCDRs to submit data to CMS that would allow them to create benchmarks for QCDR measures; CMS is seeking comments this issue.
  - Do not support CMS proposal to exclude QCDR measures from the topped out 4-year timeline that is available for other measures.

Requests for Information

- Price Transparency—CMS is including requests for information (RFIs) on price transparency in multiple proposed rules. This RFI seeks comment on what role providers should play in making prices available to their patients.

  ACEP Response:

  - Discuss the unique nature of emergency care, our obligations under EMTALA, and the importance of enforcing the Prudent Layperson Standard (PLP). We believe that it is the responsibility of insurers to clearly provide information to consumers prior to the emergency about the potential costs of seeking emergency care under their particular coverage.