American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

August 12, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-6082-NC

Re: Request for Information—Reducing Administrative Burden to Put Patients Over Paperwork

Dear Administrator Verma:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on additional ways to reduce administrative burden through the Centers for Medicare & Medicaid Services' (CMS') "Patients over Paperwork" Initiative.

ACEP supports CMS' commitment to eliminating barriers that impede our ability to provide the best possible care to our patients. We want to especially thank CMS for their recent policy changes that have reduced documentation burden for teaching physicians. First, CMS issued a clarification that allows a teaching physician to rely on medical student documentation. Specifically, the teaching physician can verify medical student documentation for an evaluation and management (E&M) service by providing a signature and date, rather than having to re-document the service.[1] Further, in the CY 2019 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) final rule, CMS finalized a policy that would allow physicians, residents, or nurses to document the presence of a teaching physician during E/M services performed by residents.[2] We appreciate the multiple clarifications CMS provided to this policy through their updates to the CMS Manual System in Transmittal 4283.[3]

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

BOARD OF DIRECTORS
Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS
John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

[1] MLN Matters, "Medical Review of Evaluation and Management (E/M) Documentation," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10627.pdf.

[2] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program—Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program— Accountable Care Organizations— Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Final Rule, 83 Fed. Reg. 59653-59654 (November 23, 2018).

[3] Transmittal 4283 is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4283CP.pdf.

ACEP received some questions from members about what were acceptable versus unacceptable forms of documentation. Given the current active audit environment (including the Targeted Probe and Educate—TPE—process involving emergency medicine), these clarifications provided in Transmittal 4283 helped make our members more comfortable with operationalizing this policy. Overall, these changes around teaching physician documentation requirements provide a significant amount of relief to emergency physicians working in academic medical centers, allowing them to spend more time on patient care. We also recognize that CMS is proposing to provide even more flexibility to teaching physicians in the CY 2020 PFS and QPP proposed rule. Specifically, CMS is proposing to allow the physician, the physician assistant, or the advanced practice registered nurse who delivers and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team.[4]

We also would like to thank CMS for their clarification to the definition of "emergency medical condition" under the Appropriate Use Criteria (AUC) Program. Created by the Protecting Access to Medicare Act of 2014 (PAMA), the AUC program will eventually require physicians ordering advanced imaging for Medicare beneficiaries to first consult appropriate use criteria through approved clinical decision support mechanisms for the furnishing provider to be able to receive payment. PAMA exempts emergency services defined as an "applicable imaging service ordered for an individual with an emergency medical condition" (as defined by the Emergency Medical Treatment & Labor Act, or EMTALA). ACEP appreciated the recognition in PAMA that the federal EMTALA law imposes a duty to provide a medical screening exam to any individual who comes to the emergency department (ED). But Congress, through an inadvertent drafting error, referenced the section of EMTALA Sections 1867(e)(1) of the Social Security Act (SSA) that defines an emergency medical condition, rather than referencing Sec. 1867(a) of the SSA which codifies the requirement to provide a medical screening exam. Aside from cases of obvious trauma or severe visible medical symptoms, in most cases, a medical screening exam is required before definitively establishing that an emergency medical condition exists.

We had asked for years that CMS rectify this drafting error through regulation, and categorically exempt ED encounters from the AUC Program. If CMS did not adopt a categorical exemption, then we asked CMS to at least clarify that the AUC exception also applies in cases where an emergency medical condition is suspected, but not yet confirmed. We believed that this needed change would address the fundamental concern that certain advanced imaging tests may need to be quickly ordered to establish whether an emergency medical condition even exists or not. Requiring an ordering professional in the ED to make a distinction between patients that require AUC and those that have an AUC exemption is an additional burden that would directly impact the provision of timely needed care. In the CY 2019 PFS and QPP final rule, CMS did provide that clarification, stating that this exemption includes cases where an emergency medical condition is suspected, but not yet confirmed. Examples include severe allergic reactions and pain.[5] Additionally, CMS has recently followed up with guidance on July 26, 2019, that instructs clinicians to use modifier "MA" on the same line as the CPT code

[4] Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf; page 214.

[5] 83 Fed. Reg. 59699 (November 23, 2018).

for the advanced diagnostic imaging service in cases where the service is "being rendered to a patient with a suspected or confirmed emergency medical condition."[6]

While we appreciate the actions CMS has taken thus far to reduce burden, we believe that more can be done to help emergency physicians focus their efforts on providing high-quality patient care. Starting with the AUC program, despite the clarification described above (and the fact that the program does not start until 2020), hospitals are starting to force emergency physicians to consult appropriate use criteria before ordering advanced imaging services. From these experiences, we have heard antidotally that the clinical decision support tools are not user-friendly, are burdensome, and do not apply to the cases emergency physicians typically see in the ED. We are attempting to educate our members and hospitals about the exemption for emergency medical conditions, but, as described below, we believe that CMS can also take additional actions to alleviate the burden by postponing the program requirements. We also still have significant concerns about electronic health record (EHR) usability, documentation burden, the Merit-based Incentive Payment System (MIPS), qualified clinical data registries (QCDRs), telehealth services, prior authorization processes, the ability for emergency physicians to participate in alternative payment models (APMs), and the physician self-referral law.

Appropriate Use Criteria Program

ACEP believes that CMS should postpone the AUC Program requirements until at least 2021. Since CMS did not propose this delay in the CY 2020 PFS and QPP proposed rule, CMS should issue an interim final rule announcing the delay. Postponing the AUC program would allow us more time to educate our members and hospitals about when the exemption for emergency medical conditions is applicable and how to appropriately apply the MA modifier to the claim for the advanced diagnostic imaging service. A delay would also provide more time for emergency physicians to continue improving their performance in the Merit-based Incentive Program (MIPS). Created under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, MIPS provides a payment adjustment to clinicians based on their performance on four categories, including Quality, Cost, Improvement Activity, and Promoting Interoperability. In many ways, MIPS, through the Cost Category, achieves the same ultimate goal as the AUC program does—to manage the utilization of services. Thus, in effect, MIPS has replaced the need to have an AUC program in place. From the emergency medicine perspective, it makes much more sense for emergency physicians to spend their time focusing on improving quality and reducing costs through MIPS rather than having to constantly evaluate whether each Medicare beneficiary who needs advance imaging would qualify for this exception (and if the beneficiary does not qualify, having to use a clinical decision support tool and adhere to appropriate use criteria that are not applicable to the ED setting).

EHR Usability

It is extremely challenging for emergency physicians to provide comprehensive care to patients who arrive in our EDs without a medical record that we can easily access. In many cases, we see patients with acute conditions who we have never seen before. With limited information, we deal with life and death situations and must make near-instantaneous critical decisions about how to treat our patients. Therefore, we are particularly anxious to work with hospitals toward the goal of interoperable EHRs that will open the door to more comprehensive

[6] MLN Matters, "Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements," available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf.

patient information sharing across sites of care. Linking disparate EHRs will allow us to make more informed decisions and will significantly enhance timely communication with patients, community physicians, and other caregivers. To that end, we support Medicare policies that promote our ability to receive and exchange information about our patients. A specific initiative that ACEP strongly supports to help manage care for patients is the Collective Medical Technologies' (CMT) EDIE™ (a.k.a. PreManage ED) software. EDIE™ is an information exchange that provides EDs with critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their medication history, other providers who are involved with the patients, and, finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It can also help identify individuals that have gone to the ED frequently. Finally, it lowers health care costs through a reduction in redundant tests and through better case management that reduces hospital readmissions. Washington state, in the first year alone, experienced a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than $32 million.[7]

We also spend much too long entering information into EHRs. This is the precious time that we could be spending focused directly on patient care. Seconds matter when it comes to treating patients experiencing life-threatening emergencies, and eliminating duplicative requirements is extremely beneficial to both emergency providers and their patients. EHRs contain vast amounts of data, and we need better tools to be able to utilize that data efficiently and effectively to serve our patients better. The ability to find information quickly is most critical when emergency physicians and other emergency medical service (EMS) providers respond to both man-made and natural disasters. During disasters, we must have access to real-time data regarding all of the available health care resources in the affected region. However, unfortunately, emergency physicians do not always know where or how to find this essential information. ACEP surveyed its members in May 2018 and found that over a quarter of emergency physicians did not have complete access to real-time data when responding to a natural or man-made disaster or mass casualty incident.[8] This is not acceptable, and we strongly encourage the Administration to help improve providers' access to clinical data and information on available health care resources during these devastating events.

The lack of consistency regarding how data are displayed in EHRs also makes it hard for us as emergency physicians to search for what we need and find it promptly. For example, some information can be stored in the EHR as a scanned image rather than as structured data, making it almost impossible at times to find the data we are looking for. Finally, we need to improve the way patient information is collected and entered into EHRs to integrate it into the clinical workflow better. A lot of the data we are forced to collect and screenings we are required to perform are not necessary and do not add clinical value. Also, as referenced above, we believe that a lot of the documentation and provider entry that we currently do is duplicative. We support the use of non-physician aids to put in orders and data and also encourage the use of scribes and dictation to reduce physician burden further. Going forward, we would like to see more advancements in technical innovations that would further automate the collection process of structured data (such as voice recognition technology and connected devices) and make it even easier for providers to enter usable information into EHRs.

[7] Anderson, S. "Emergency Department Information Exchange Can Help Coordinate Care for Highest Utilizers," ACEP*Now,* https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/.

[8] ACEP New Release, "Most Emergency Physicians Report Hospitals Lack Critical Medicines; Not "Fully Prepared" for Disasters, Mass Casualty Incidents," May 22, 2018, http://newsroom.acep.org/2018-05-22-Most-Emergency-Physicians-Report-Hospitals-Lack-Critical-Medicines-Not-Fully-Prepared-for-Disasters-Mass-Casualty-Incidents.

Unfortunately, implementing EHRs or adapting to systems that do not align with clinician workflow or are not intuitive can result in medical errors. Studies have shown that poor EHR usability has led to certain types of medical errors, as physicians, nurses, and other clinicians use these systems to care for patients, and there is increasing evidence showing the association between usability issues and safety. For example, a study in Health Affairs examining 9,000 health information technology and medication safety events in three pediatric hospitals showed that inadequate usability contributed to approximately a third of the errors, many of which resulted in patient harm.[9] **ACEP strongly believes that physicians should never be penalized for reporting medical errors caused by poor EHR usability. Efforts in some states such as Rhode Island to punish doctors for reporting mistakes that are meant to draw attention to risks in their EHR systems are unjustifiable.[10]**

Finally, as emergency physicians working in hospitals, we should have access to all the patient's data from the hospital's EHR. However, in many cases, this does not occur. For example, a large number of emergency physicians and groups that use ACEP's qualified clinical data registry (QCDR), the Clinical Emergency Data Registry (CEDR), to report quality measures for MIPS do not receive any data from their hospitals. Data from hospitals could include critical information such as medications, labs, and other test results for patients. Without these data elements, the measures cannot be fully calculated and scored. Hospitals claim that they cannot share the data for privacy and security purposes, but CMS has indicated that there are no regulations that impede hospitals from doing so. **Since this is a serious issue for hospital-based clinicians, we would like to CMS to require hospitals to share this clinical data with clinical data registries to fulfil MIPS reporting requirements.**

Reducing Documentation Burden

ACEP recognizes the actions CMS took to reduce documentation burden in the CY 2019 PFS and QPP final rule and looks forward to reviewing in more detail the proposals included in the CY 2020 PFS and QPP proposed rule. We strongly support not having to re-document specific data already present in the medical record or information that may have previously been inputted by residents or other members of the medical team. We do note, however, that many of the policies, besides those related to teaching physicians described above, would not affect emergency physicians. These policies apply to Evaluation and Management (E/M) office and outpatient visits, not ED E/M services. We encourage CMS to consider reducing documentation requirements for ED E/M services, and we hope that other payers follow CMS' lead and only require documentation when it truly adds clinical value.

Simplifying MIPS Reporting Program Requirements

In the CY 2019 PFS and QPP final rule, CMS took several actions to reduce provider reporting burden under MIPS. We also recognize that there are numerous proposals in the CY 2020 PFS and QPP proposed rule that are meant to streamline MIPS reporting requirements, including the proposed MIPS Values Pathway (MVP) framework that would hopefully provide a more cohesive and meaningful participation experience for clinicians.

---

[9] Ratwani, R. et al. "Identifying Electronic Health Record Usability And Safety Challenges In Pediatric Settings," Health Affairs, Vol. 37, NO.11 (Nov. 2018).

[10] Allen, A. "Rhode Island docs alarmed by subpoenas they link to EHRs," Politico (30 Jan. 2019) https://www.politico.com/story/2019/01/30/medical-misconduct-subpoenas-ehr-1107689.

Most importantly for emergency medicine, in the CY 2019 PFS and QPP final rule, CMS finalized the "facility-based scoring option" effective starting in the performance year 2019. With this new scoring option, clinicians who deliver 75 percent or more of their Medicare Part B services in an inpatient hospital, on-campus outpatient hospital, or emergency room setting will automatically receive the quality and cost performance score for their hospital through the Hospital Value-based Purchasing (HVBP) Program starting in 2019. CMS estimates that most emergency physicians would qualify for this option. Clinicians who qualify for the option can still report quality measures through another submission mechanism (such as a QCDR) and receive a "traditional" MIPS score for quality. If they do so, CMS will automatically take the highest of the HVBP score and the traditional MIPS score. Having this option to fall back significantly reduces the overall burden for emergency physicians, and again, we appreciate CMS establishing this policy.

CMS also finalized a new scoring methodology in the CY 2019 PFS and QPP final rule for the Promoting Interoperability category of MIPS. While ACEP appreciates CMS' effort to reduce complexity and burden, we are concerned that CMS has gone back to an "all or nothing" approach, which existed in the original Meaningful Use program. Under CMS' final policy, clinicians are required to report on all measures within each of the four objectives unless they claim an exclusion for a particular measure. Failure to report on one measure would make the clinician receive a score of zero for the entire category. CMS did not propose any changes to the Promoting Interoperability scoring methodology in the CY 2020 PFS and QPP proposed rule.

However, CMS did consider an alternative approach in the CY 2019 PFS and QPP proposed rule that would have allowed scoring to occur at the objective instead of individual measure level. Under this alternative, if an objective includes two measures and clinicians did not report accurately on one measure (and failed to claim an exclusion) but did report accurately on the other, they would still be able to receive a Promoting Interoperability score. In ACEP's comments on the proposed rule, ACEP had supported this alternative. We believe that in order to realize the full potential of EHRs, requirements of the Promoting Interoperability category need to flexible in order to allow clinicians to incorporate available technology into their unique clinical workflows, to mitigate data access and functionality issues that might be unique to their practice and outside of the individual clinician's direct control, and to use EHRs in a manner that more directly responds to their patients' needs. Requiring that clinicians report every single measure or have to actively claim an exclusion creates an unfair burden and is antithetical to CMS' overall goal to streamline reporting requirements. Another possible change to the scoring methodology for the Promoting Interoperability category of MIPS that would reduce complexity would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The total number of points in the Promoting Interoperability category would, therefore, be 25 (since the Promoting Interoperability category represents 25 percent of the total MIPS score), and clinicians would receive points for the measures that they choose to report. This approach would also eliminate the "all or nothing" scoring methodology that is currently in place and reward clinicians for reporting on those measures that are meaningful to them. Finally, ACEP supports a proposal put forth by the American Medical Association that would set a threshold of points that would dictate whether a clinician has "successfully" reported. Under this proposal, CMS would give full credit for the Promoting Interoperability category to any clinician with a score of over 50 points.

ACEP also believes that it is critical that clinicians not be limited by existing technology barriers and penalized for factors outside of their control. CMS must resolve fundamental cornerstones necessary for data exchange (e.g., patient matching, provider directories, standards, and privacy and security) and focus on increasing the

functional interoperability between vendors and among vendors and registries to ensure this aspect of MIPS is achievable, meaningful, and not another unnecessary regulatory burden on clinicians. The Promoting Interoperability metrics themselves should focus only on what the individual clinician has direct influence over and not on the actions of other individuals—whether patients or other clinicians—or technology. Finally, it takes time for physicians to update their current systems with the latest technology. Therefore, CMS should consider providing six months or even a year for physicians to implement upgrades to 2015 certified EHR technology (CEHRT). CMS could also revisit the current certification structure more generally since it significantly stifles innovation for EHR developers and disincentivizes the development of user interfaces that more closely match how physicians practice.

There are other actions the Administration can take to reduce the reporting burden in MIPS. ACEP has long supported the concept of allowing clinicians to report on one set of measures and receive credit in multiple categories of MIPS, as it will help reduce the burden of reporting for physicians and also link elements of the program together into one cohesive function. Therefore, we are encouraged by the proposed introduction of the MVP framework in the CY 2020 PFS and QPP proposed rule and look forward to understanding more about how emergency physicians could potentially participate in MVPs. We also believe that clinicians who use certified EHRs to participate in a clinician-led QCDR should be qualified as fully achieving all points for the Promoting Interoperability category. This would align with CMS's Patients Over Paperwork Initiative, as providing full Promoting Interoperability credit to these clinicians would significantly reduce unnecessary burden for providers.

Finally, specific to emergency physicians and other hospital-based clinicians, ACEP has been extremely concerned with how CMS defines "hospital-based" to approve hardship exemptions for Promoting Interoperability category of MIPS. Currently, clinicians who are deemed "hospital-based" as individuals are exempt from the Promoting Interoperability category of MIPS. However, if individual clinicians decide to report as a group, they lose the exemption status if one of them does not meet the definition of "hospital-based." We have repeatedly argued that this "all or nothing rule" is unfair and penalizes hospital-based clinicians who work in multi-specialty groups. We are therefore extremely appreciative that CMS is proposing to modify this policy in CY 2020 PFS and QPP proposed rule by exempting groups from the Promoting Interoperability category of MIPS if 75 percent of the individuals in the group meet the definition of hospital-based. We strongly urge CMS to finalize this proposal.

Qualified Clinical Data Registries

ACEP believes that CMS should do more to promote the use of clinical data registries. One major ongoing issue for specialists is not able to report on measures that are meaningful to them. Emergency physicians have experienced this problem in the past, and that is specifically why ACEP developed its QCDR, CEDR. Through CEDR, ACEP reduces the burden for our members and makes MIPS reporting a meaningful experience for them. We strive to make reporting as integrated with our members' clinical work flow as possible and constantly work on improving their experiences and refining and updating our measures so that they find value in reporting them. We have found that if our members can report on measures that are truly clinically relevant, they become more engaged in the process of quality improvement. For each measure we develop, a Technical Expert Panel comprised of clinical, measurement, and informatics experts in the field of emergency medicine is assembled, and several criteria are considered when designing a measure, including each measure's impact on emergency medicine, as well as whether the measures are scientifically acceptable, actionable at the specified level of

measurement, feasible, reliable, and valid. Through our work and partnership with CMS, we are proud to have been a certified QCDR for four years and have helped tens of thousands of emergency physicians participate successfully in MIPS.

QCDRs have proven to be an excellent way to collect data and report quality measures. QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(l) of the Social Security Act, as added by Section 101 of MACRA, requires HHS to encourage the use of QCDRs to report quality measures under MIPS. This is why we strongly believe, in line with this statutory requirement, that CMS should continue to refine the QCDR option under MIPS to streamline the self-nomination process, and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. While ACEP is still reviewing the proposed QCDR policies in the CY 2020 PFS and QPP proposed rule, we are concerned that some of them may, in fact, make it more difficult and burdensome for QCDRs to participate in MIPS successfully. In fact, CMS estimates in the Collection of Information Requirements section of the rule that the total number of hours and the cost for QCDRs to go through the Self-Nomination and measure submission process will increase by 21 to 35 percent if the policies in the rule are finalized.[11]

Telehealth Services

ACEP strongly supports the delivery of telehealth services by board-certified emergency physicians. There are established examples of high quality, cost-effective telehealth programs in the ED setting that allow greater access to an emergency physician in inner-city or rural EDs that would not usually be able to economically support that level of provider on a 24/7 basis, if at all. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment, and the time these patients remain in the ED waiting for a psychiatric bed to become available (i.e., ED "boarding").

As more and more small and rural hospitals close, their EDs close too, leaving a gap in emergency care in a region. To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital to provide telehealth services to patients and providers in smaller rural or community hospitals that are staffed by registered nurses and advance practice nurses. These valuable services provide clinical expertise in real-time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the teaching hospital before a decision is made to transfer, admit locally, or release the patients.

Section 1834(m) of the Social Security Act (SSA) establishes the specific telehealth services that may be reimbursed by Medicare. Emergency medicine services currently are not included in this list of eligible services. CMS has the discretion through rulemaking to add new codes to the list of approved telehealth services. However, CMS has instituted stringent criteria for adding new codes. To add new codes to the list, the codes must fall under two categories. The first category includes services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. The second

[11] CY 2020 PFS and QPP Proposed Rule, available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf; Table 68, page 1113.

category includes services that are not similar to those on the current list of telehealth services. CMS' review of these requests includes an "assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient."[12] This second category has proven to be an extremely high bar to meet since there must be proven evidence that the service provided through the use of a telecommunications system has clinical benefit. We perceive telehealth as a tool that physicians and other health care providers can rely upon to deliver the same high-quality care they would otherwise provide in-person. Thus, it does not seem appropriate to evaluate whether a service should be added to the list of approved telehealth services if it adds clinical value when it is delivered through the use of a telecommunications system. The service itself adds clinical value, and the telecommunication system only represents how the service is furnished.

Over the years, we have asked CMS on several occasions to add ED services (CPT codes 99281-99285), and observation services (CPT codes 99217-99220; 99224-99236; and, 99234-99236) to this list. CMS has declined each time because of the stringent category 2 requirement CMS has in place. **ACEP continues to support Medicare coverage of emergency telehealth services that would benefit patient care, and strongly encourages CMS to revise their criteria for adding new codes to the list of approved telehealth services to make it easier to add codes to this list.**

To maximize the impact that the provision of emergency telehealth services can have on patients across the country, we also need to eliminate the current statutory restrictions that limit telehealth services to specific sites (the originating site requirement) and geographic locations. Currently, entities that want to circumvent these restrictions must apply for waivers, most of which are granted by the Center for Medicare & Medicaid Innovation (CMMI); however, these waivers must be sought on an individual basis and are granted only in limited circumstances. **ACEP strongly encourages CMS to continue waiving the originating site and geographic location requirements for telehealth services through CMMI authority.**

Prior Authorization Processes

In most cases, emergency services are exempt from prior authorization. Every second counts when it comes to treating patients with potentially life-threatening conditions, and therefore, both public and private payers recognize how it unsafe and impracticable it would be to require patients in the ED to receive prior authorization before being able to receive critical services. However, as emergency physicians, we still see how prior authorization can affect the ability of our patients to receive the most appropriate treatment in the most appropriate care setting. We have experienced numerous occasions where patients who are unable to receive services in other care locations because of a prior authorization denial come to the ED to receive those services (sometimes at the direction of their provider). The patient comes to the ED because he/she and/or his/her provider recognize that the patient can receive the service without undergoing prior authorization. This clearly is not an appropriate reason for a patient to receive treatment in the ED, but it reflects a fundamental flaw in the health care system resulting from extremely stringent prior authorization protocols. Therefore, ACEP recommends that CMS address this issue as quickly as possible and do more to streamline and automate the prior authorization process under Medicare Advantage.

[12] 83 Fed. Reg. 59870 (November 23, 2018).

Participation in Alternative Payment Models (APMs)

CMS must make more APMs available for specialists. Many emergency physicians are ready to participate in APMs, but they have few, if any, opportunities to fully participate in them. ACEP developed a physician-focused payment model (PFPM) called the Acute Unscheduled Care Model (AUCM). The AUCM, if implemented, would fill a very important gap in terms of models currently available to emergency physicians. Structured as a bundled payment model, it would improve quality and reduce costs by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. It would enhance the ability of emergency physicians to reduce inpatient admissions, and observation stays when appropriate through processes that support care coordination. Emergency physicians would become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits or inpatient admissions.

ACEP submitted the AUCM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for consideration. We presented the AUCM proposal before the PTAC on September 6, 2018. The PTAC, established by MACRA, is a federal advisory committee with the primary responsibility for evaluating physician-focused payment models and providing recommendations to the Secretary. **The PTAC recommended the AUCM to the HHS Secretary for full implementation**. The AUCM met all ten of the established criteria, and the PTAC gave one of the criteria ("Scope") a "Deserves Priority Consideration" designation since the PTAC felt that the model filled an enormous gap in terms of available APMs to emergency physicians and groups. The PTAC submitted its report to the Secretary in October 2018. As of the date of this letter, we are still waiting on the HHS Secretary to respond to the PTAC's recommendation—nearly a year after the PTAC submitted its report. We urge CMS and the HHS Secretary to seriously consider the PTAC's recommendation, and we look forward to continuing to work with CMS and HHS to improve emergency patient care through the implementation of the model.

Physician Self-Referral Law

It is often unclear whether many of the new value-based arrangements are legally permissible. With all the consolidation in health care, especially with health systems purchasing provider practices, it is difficult for the average physician to know for sure whether some of the care coordination they are providing is permissible. In order for emergency physicians to actively participate in value-based models and coordinate care for patients that come to the ED, we need to be assured that we are in compliance with all federal laws and regulations, especially those regarding referral patterns of care. For all current and future APMs, CMS should allow a wide range of referrals from physicians based in external locations, such as skilled nursing facilities (SNFs) to the ED. Likewise, CMS should allow all referrals of care to take place from the ED to observation and inpatient hospitalists as wells as referrals from the ED or inpatient setting to post-acute physicians and facilities like SNFs and home health agencies.

ACEP believes that there is a lot of potential for new APMs that allow emergency physicians to coordinate a patient's care with other providers in other healthcare settings. The goal of these APMs would be to potentially keep a patient out of the ED in the first place or to ensure that the patient receives the appropriate follow-up treatment after an ED visit and avoids having to go back to the ED. Restricting the ability for emergency physicians and other providers to refer patients to the most appropriate healthcare providers or facilities would

significantly limit the potential for these APMs to be successful. ACEP is eager to work with CMS going forward on specific ways to modify the Physician Self-Referral law that would facilitate the development and implementation of APMs focused on emergency care.

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,

Vidor E. Friedman, MD, FACEP
ACEP President