

August 27, 2014

Marilyn Tavenner
Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services
445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1612-P

Re: Medicare Payment Policies under the Physician Fee Schedule Proposed Rule for CY 2015

Dear Ms. Tavenner:

On behalf of more than 33,500 members, the American College of Emergency Physicians' (ACEP) appreciates the opportunity to comment on the proposed rule for physician payment and other Part B policy proposals for 2015 that affect the practice of emergency physicians and the patients we serve.

Yet again, we urge CMS to work closely with Congress on proposals to replace the SGR formula to avoid the next across the board reduction in physician payments of over 20 percent in 2015. We also urge you to provide practical guidance on the costs and benefits of quality measures for purposes of physician payment under legislative proposals. ACEP supports goals of improved care coordination, quality, and safety, but the Medicare program is bordering on an impractical number and variety of measures with methodologies that have become increasingly complex, expensive, and burdensome for providers. Many of these measures lack clear evidence on their effects on patient outcome and some types of measure domains included in the physician payment modifier are not relevant for most hospital-based practitioners – a continuing concern that we will address in detail later in this letter.

Proposal for Implement a Complex Chronic Care Management Code in 2015

In the proposed rule, CMS continues to recognize the importance of care management as a significant component for improving the care of Medicare beneficiaries with chronic diseases. CMS moves forward with its 2014 proposal to pay separately for care management services furnished to Medicare beneficiaries with two or more chronic conditions and proposes a payment rate for complex chronic care management services. To be eligible to bill the new code, physicians and their staffs must provide at least 20 minutes per month of non-face-to-face care coordination to beneficiaries with two or more chronic conditions which are unlikely to resolve easily. In addition to requirements to provide 24-hour coverage, medication review, and ongoing coordination, CMS is also proposing to require use of certified EHR technology. An important benefit from care coordination should be appropriate ED utilization, which includes contacting the ED when referring a patient for evaluation. ACEP believes this important

WASHINGTON, DC OFFICE

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

202-728-0610
800-320-0610
202-728-0617 (FAX)
www.acep.org

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component of care coordination should be considered in CMS proposal of the required components of care coordination. ACEP is also concerned that CMS has not linked care management services with quality metrics, such as ED utilization and hospital re-admissions.

Emergency physicians support CMS' recognition that the care management included in many of the E/M services do not adequately describe the typical non-face-to-face care management involved for treating patients with chronic conditions. Emergency physicians and hospital clinical staff can and do provide a growing amount of care coordination to link beneficiaries with care in the community and with post-acute providers, to help patients avoid return trips to the ED and or hospital for re-admission. As part of CMS' initiative to expand care management, the ACEP believes it is appropriate to consider the development of a care coordination service that would be specific to the services required for providing non-face-to-face follow-up with both the patient and community health care providers for a complex Medicare patient discharged from the ED.

Payment Policy for Substitute Physician Billing

CMS asks for comments on the need for regulations to address perceived operational and program integrity concerns regarding the status of physicians who cover for other physicians. First, ACEP believes that all physicians who care for Medicare beneficiaries should be enrolled in the Program and receive a unique NPI. Second, there appears to be some confusion about the distinction between physicians with the same specialty who cover for each other on a regular basis ("taking call") and what is referred to as "locums tenens" arrangements. Emergency medicine makes broad use of locums tenens where emergency physicians often work under arrangement with a private company or physician organization that provides emergency physicians to hospitals that need additional coverage. This is quite common in rural areas that may be experiencing difficulty recruiting physicians and in places like resort towns that experience a large, temporary influx of population during certain times of the year. The usual arrangement is that the emergency physician contracts with the company at a negotiated payment rate and the company contracts with the hospital and is also responsible for billing.

With regard to some of the questions posed by CMS in the proposed rule, we stress that CMS needs to consider the following:

- There needs to be a clear distinction between "taking call" and locums tenens and this needs to be incorporated into any related proposed CMS policy.
- Restricting billing arrangements to situations between only two physicians would render the locums model unworkable and negatively impact ED coverage in hospitals.
- The 60-day limit for a substitute physician will also not work in some locums situations where vacancies are unfilled; this is more of a market than regulatory issue.

Continuing Education Exclusion under the Sunshine/Open Payments Rule

ACEP supported the language of the Sunshine Act final rule of February, 2013 excluding reporting of monies paid to certified continuing education session speakers. This policy acknowledged the historical safeguards in place for “standards for commercial support” from the ACCME and adopted by the other accrediting organizations (AMA, AOA, AAFP, ADA) listed in that final rule. Education grants given to medical societies for CME preclude the donor from choosing the content, lecturer/presenter, or providing direct payment to the presenter. CME providers are accredited by the organizations listed above as well as others, and the specific content of a program must also be certified. We understand that CMS received numerous complaints from accrediting groups other than those mentioned in the final rule, and appreciate that CMS does not want to exclude other qualified organizations or duplicate the work of accreditation organizations. However, the proposals put forth in this draft regulation; 1) to create a longer list of accrediting organizations or 2) articulate accreditation/certification standards that organizations would have to meet to qualify for the exclusion, are cumbersome and have created significant uncertainty among CME providers and manufacturers that provide support to crucial educational programs for physicians. **We believe the current system is working and strongly recommend that CMS continue to provide the reporting exclusion included in the 2013 final rule and codified by 42 CFR 403.904 (g)(1).**

Proposal to Modify the Process for Code Reviews

We appreciate CMS’ objective of including proposed RVUs for new, revised and potentially mis-valued services in the annual Physician Fee Schedule Proposed Rule (rather than an Interim Final Rule) which would allow full notice and comment before payment rates were established for the subsequent year. We support inclusion of payment rates in the PFS proposed rule but support the AMA-proposed timeline which allows CMS to include the January/February RUC meeting recommendation in the proposed rule. We do not recommend the implementation of CMS’ proposal for the 2016 payment schedule; we **agree with the AMA that any schedule change should be implemented in 2017, not 2016.** The schedule of meetings for the RUC and CPT Editorial Panels have already been set for the next year and the result of CMS finalizing its proposal for a 2016 change would introduce unnecessary burdens for physicians by either delaying code changes for an additional year or introduce additional G codes. **We also support the AMA’s objection to eliminate the Refinement/Appeals Process.** The Refinement panel provides an important opportunity for all physician specialties to have an objective and open appeal process by which they could formally question the proposed values assigned to various codes.

Potentially Mis-valued Services

We support review of potentially mis-valued code RVUs and encourage CMS to make use of the RUC process and other valid resources for refinement.

Moderate Sedation: If there is a need to examine services that currently include moderate sedation as an inherent part of furnishing a procedure, we recommend that codes included in Appendix G be reviewed through the CPT and RUC process. In fact, there is currently a joint CPT/RUC task force looking into this issue. **We strongly urge CMS to consider the recommendation of that workgroup before acting on the moderate sedation valuation issue**

Changing the Global Periods: CMS proposes to transition all 10 and 90- day global surgical codes by 2017 and 2018, respectively. Under this policy, all global surgical codes would be considered 0-day global surgeries and medically reasonable and necessary E/M services would be billed separately. ACEP believes the reconsideration of the global package concept is a significant task that must receive careful evaluation before any changes are implemented. We agree that the evaluation of global surgical codes needs to be based on accurate inputs including the actual number and appropriate level of E/M services. The question of higher practice expense inputs related to the post-operative visits needs to be considered and further evaluated. ACEP recommends that CMS work with the RUC for developing a methodology to ensuring the accuracy of current 10- and 90-day global surgical codes.

Secondary Imaging

Because of the long-standing concern over the question of contemporaneous interpretations in the ED, meaning those on which the diagnosis and treatment of the patient is based, payment of secondary interpretations of images is an important issue to emergency physicians.. Timely diagnostic radiologic testing, including a review of the results, is often critical in the ED setting for providing the highest quality and least costly care. ACEP agrees that when a radiologist provides a complete and written interpretation at the time the patient is diagnosed and treated, the emergency physician should not report a secondary interpretation from the same image. However, if a radiologist does not provide an interpretation at the time the patient is initially evaluated and managed, then we agree with CMS' current policy that another physician , such as the emergency physician, can provide a complete and written interpretation of the radiologic study and be reimbursed for this service, In this scenario, ACEP does not understand how a second interpretation can be obtained in a timely enough fashion to affect follow up radiological services emanating from the ED setting. ACEP does not think that Medicare should routinely pay for a second interpretation of diagnostic tests such as plain films and ultrasounds; payment should be for the physician providing the written interpretation at the time the patient is having the test and treatment in the ED.

Routine payment for secondary interpretations of high cost advanced diagnostic imaging services, such diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine should be approved if there was a medically indicated reason and if this would either avoid repeating the diagnostic study or provide medical necessity for repeating a study The provision of routine secondary interpretations could be determined by applying a modifier such as -77 (repeat procedure by another qualified health care professional) to current codes. CMS should consider a HCPCS modifier for non-contemporaneous interpretations to indicate that those were not performed during the time the diagnosis and treatment decisions for that patient were being made.

Physician Compare

In this rule, CMS reiterates its proposed roadmap for a rapid expansion of publicly reported performance data, including the release of data in *early* 2015 on a select set of PQRS individual-level measures reported in 2013 (rather than in late 2015 based on 2014 data) and the release of *all* individual-level measure data reported in 2015 by late 2016.

Proposed Timeline for Reporting Physician Performance Data: We appreciate CMS' continuing efforts to improve the accuracy and format of the Physician Compare website, including outreach to professional societies to ensure publicly reported data is clinically relevant and accurate and that plans to test consumer understanding of the data are conducted. Nevertheless, we have concerns about the rapid pace at which CMS proposes to release this data. While we support CMS' desire to make consumers more informed decision-makers, releasing too much data too quickly may only confuse the public and result in information that is of little value to healthcare consumers. This past year – 2014 – represents the first year that CMS is releasing physician *performance* data to the public, and only on a very limited basis and for a very selective population (i.e., 5 Diabetes Mellitus and Coronary Artery Disease measures collected via the Web Interface for group practices with a minimum sample size of 25 patients and Shared Savings Program ACOs). This leaves CMS with barely two years to evaluate the accuracy and utility of publicly reported data, based on a very limited sample, before expanding it to all physicians and all measures reported. **We urge CMS to take a more gradual approach to public reporting and to evaluate the public response to the release of more limited data prior to widespread implementation to ensure they are accurate and presented in a format that is easy to understand, meaningful, and actionable for both patients and physicians.**

We also remind CMS of the ongoing work that will be needed to ensure the utility of the Physician Compare website. Current explanations regarding the data, descriptions about calculations and benchmarks, and disclaimers all need to be much more detailed than they are now, and will require continuous evaluation and updates based on physician input and consumer testing. The challenging task will be to find a balance between full transparency and not overwhelming or confusing the public.

Benchmarks: CMS also proposes to develop and publicly report on benchmarks in 2016 for 2015 PQRS GPRO data (benchmarks calculated based on 2014 data) using a methodology that is similar to that used under the Medicare Shared Savings Program (MSSP). Benchmarks would be established for each percentile. A group practice would earn quality points on a sliding scale based on performance: performance below the 30th percentile for a measure would receive zero points; performance at or above the 90th percentile would earn the maximum points available. CMS proposes to apply a similar process to individual measures in the future, but offers no details.

ACEP supports strategies to make data more easily interpretable for consumers. However, we question whether this proposed benchmarking methodology aligns with that which is used for the Value-Based Payment Modifier and Quality and Resource Use Reports (QRURs). **We urge CMS to use consistent benchmarking across its programs.** It is also unclear as to whether this benchmarking methodology would translate into a 5-star rating system, which CMS currently uses to display performance data for a limited set of group practices and ACOs on Physician Compare. **ACEP strongly opposes the use of any arbitrary thresholds or groupings, such as star**

ratings, which tend to exaggerate minor performance differences on measures, resulting in inappropriate distinctions between physicians whose performance is not statistically different. While benchmarks can play an important role in performance measurement and quality improvement, their accuracy can only be assured with a strong foundation of data. Building that foundation will take time and require data collection on a consistent set of measures (see related comments below regarding the proposed removal of PQRS measures). As CMS works with professional societies to build that foundation, it should focus more on recognition of physician performance improvement over time rather than physician achievement of what are still relatively weak benchmarks.

Preview Period and Appeals Process: CMS proposes to continue its 30-day preview period prior to the publication of quality data on Physician Compare. ACEP supports a lengthier preview period such as 60 days. Physicians should be given a sufficient amount of time to access reports, review their data, identify any potential errors or other misinformation, and gather the evidence needed to refute erroneous data. **In light of the multiple quality reporting mandates that physicians now face, 30 days is too short a time period of time to accomplish all of these tasks.**

It is equally important that CMS give physicians the opportunity to correct and/or appeal any errors found in the performance information before it is posted on the site. Physicians must be given the opportunity to request changes not only to measure data display, but to measure calculation accuracy. In the Value Modifier section of this rule, CMS proposes to expand its informal inquiry process starting with the 2015 payment adjustment period to establish an initial corrections process that would allow for limited corrections to be made to cost measure determinations. However, CMS notes that it is not operationally feasible to evaluate errors with regard to quality measure data by that time. It is not clear if this corrections process would apply simply to VM determinations or also to the public reporting of data. Nevertheless, performance data should not be used for accountability purposes - whether payment penalties or public reporting - until physicians are given the opportunity to review and appeal it and until CMS has the capability to evaluate and correct calculation errors related to both quality and cost measures.

Publicly Reporting Specialty Measures via Physician Compare: We support CMS' proposal to include specialty society measures on Physician Compare and/or to link Physician Compare to specialty society websites that publish non-PQRS measures. The PQRS currently includes only a limited set of measures that are truly relevant to our members and if proposals in this rule are finalized, our members would have even fewer measures to report. ACEP has invested significant resources in the development of emergency care-specific measures, which may be included in PQRS or a QCDR in future years. Nonetheless, our members collect data on a diverse set of locally administered quality measures that are often more relevant to their practice. **ACEP would very much appreciate the opportunity to publicly recognize emergency physicians who may be reporting these alternative and more meaningful measures.**

Public Reporting of Clinician Group (CG) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Data

In this rule, CMS proposes to further incorporate CG-CAHPS survey measures into its federal quality initiatives. In late 2014, CMS will publicly report on CAHPS performance

reported by groups of 100 or more. By 2015, it will report on CAHPS performance for groups of 25 or more and in 2016, it will report on performance for groups of 2 or more. While reporting CAHPS measures would remain optional for groups with 2-99 Eligible Professionals (EPs) for the 2014 and 2015 reporting years, CMS proposes that beginning with the 2016 reporting period (i.e., the 2018 PQRS payment adjustment), group practices with 25+ EPs participating in GPRO would be *required* to report on these measures and would also be responsible for the cost of using a certified vendor to collect the CAHPS survey measures.

ACEP continues to support the value of patient experience measures. **However, we strongly object to attributing the scores from CG-CAHPS to any emergency physician under any circumstance, as this instrument was neither developed with the intention of measuring emergency care nor validated in the emergency department.**

Many physicians already collect patient experience data in formats other than the CAHPS survey. As such, CMS should recognize and provide credit to practices that use alternative formats to collect patient experience data. CMS is in the process of testing an ED-focused patient assessment instrument of mailed surveys. As we noted in our March 28, 2014 memo to CMS, we continue to note that mailed surveys are antiquated, have low response rates reflecting invalid recall weeks or months after an encounter, ceiling effects within the measures, score compression within and across practices, and place a high burden on elderly patients to complete and mail. **ACEP is gravely concerned that implementation of mailed surveys provides invalid data, with no actionable feedback to physicians, and may crowd out more innovative approaches.** In a learning healthcare system, an information feedback loop to clinicians on their activities and outcomes is critical in achieving the best possible care.⁷ Innovative platforms such as [Bivarus](#) drive real improvements in clinical performance of acute care with near real-time feedback. In practice over the last two years, this tool has contributed to improvements in patient experiences and quality care in everyday practice consistent with the National Quality Strategy. ACEP stands ready to demonstrate the effectiveness of this and other relevant tools and to work with CMS to incorporate these instruments into federal quality programs. **ACEP strongly supports alternative reporting mechanisms for more innovative approaches to patient experience and engagement such as via Qualified Clinical Data Registries (QCDRs).**

If CMS does intend to mandate use of CG-CAHPS, ACEP strongly encourages an exemption to the CG-CAHPS requirement for all hospital-based physicians.

Physician Quality Reporting System (PQRS)

ACEP appreciates the Agency's efforts to further align quality measure reporting across its performance programs and improve the number of measures available. Since the inception of the PQRS, emergency physicians have successfully participated in the PQRS more than any other specialty. However, proposed changes to the PQRS program in this rule would seriously threaten the ability of our members to participate in the program. Our concerns are outlined below:

PQRS Penalties: Under statute, starting in 2015, the PQRS will transition to an all penalty program. Physicians who fail to satisfy PQRS reporting requirements in 2015 will face a -2% PQRS penalty in 2017. In this rule, CMS proposes to maintain the

requirement that physicians report on at least nine measures covering three National Quality Strategy (NQS) domains for at least 50% of applicable Medicare Part B patients. However, CMS proposes that two of those measures will now have to come from a list of 18 “cross-cutting” measures.

Given that 2015 is the first year that the PQRS will essentially become mandatory due to the imposition of penalties and lack of incentive payments, we urge CMS to consider easing the reporting requirements for 2015. Although emergency physicians have historically demonstrated a relatively high rate of PQRS measure reporting, we do not yet know how our members will perform in 2014, under the new nine measure requirement. In fact, CMS will not know for certain how any physician fared under this dramatically expanded reporting requirement until well into the 2015 reporting year, if not later. While ACEP is actively engaged in expanding the measure portfolio for emergency physicians, we fear that many emergency physicians may face challenges satisfying the nine measure requirement this and next year.

The proposed changes in this rule, including a doubling of penalties associated with the Value Modifier and the removal of an unprecedented number of measures from the PQRS (both discussed below) will put exceptional pressure on physicians and make it increasingly difficult for emergency physicians to identify nine measures that are truly and universally relevant to their practice. Holding physicians to such a high reporting standard during the very first year that the PQRS program is no longer voluntary, without an initial evaluation of 2014 PQRS reporting rates, and in a year when the VM will put *all* physicians at risk for an unprecedentedly high penalty is simply unreasonable. It is also inconsistent with previously adopted CMS policies that offered less rigorous reporting requirements for those seeking to avoid penalties versus those seeking to earn incentive payments.

Proposed Removal of Measures: CMS’ decision to maintain the nine measures across three NQS domains requirement is particularly concerning given CMS’ simultaneous proposal to remove an unprecedented number of measures from the PQRS. For the 2015 reporting period, CMS proposes to remove over 70 current measures from the PQRS, including the following 4 out of the 7 measures from the 2014 emergency care cluster:

- #28: Aspirin for AMI
- #55: 12-Lead ECG for Syncope
- #56: Community Acquired Pneumonia (CAP): Vital Signs
- #59: CAP: Empiric Antibiotic

ACEP strongly recommends that CMS retain these measures for the 2015 PQRS and that it adopt a standard policy whereby it places measures proposed for removal in “reserve status” or otherwise institutes a strategy that provides *at least an additional year before measures are actually removed from the program.* If the proposal to remove measures in this rule is finalized, it would not be announced until late 2014, leaving physicians with very little time to prepare for alternative reporting mechanisms for 2015. A grace period would allow for the gradual phase out of measures rather than an immediate removal, giving physicians more time to identify alternative reporting mechanisms and providing specialty societies with the opportunity to develop additional measures or consider alternative reporting mechanisms, such as the Qualified Clinical Data Registry (QCDR) option. A grace period is critical given the rapid expansion of penalties under both the PQRS and VM.

CMS’ rationale for proposing to remove many PQRS measures is due to the fact that they have supposedly “topped out” in terms of performance and no longer provide meaningful information to distinguish quality among physicians. **We request that CMS be more transparent in terms of the methodology used to make this determination and regularly and transparently post information about a measure’s average performance score, as well as any other measure statistics such as performance scores at the 10th, 25th, 50th, 75th, and 90th percentiles, which provide meaningful information regarding performance gaps. ACEP strongly encourages CMS to publish this information annually, preferably in an appendix of each year’s PQRS Experience Report, so that specialty societies are not caught off guard when CMS claims that a measure is “topped out”.** We also encourage CMS to more carefully weigh the risks versus benefits of discontinuing the collection of “topped out” measures data. Showcasing the fact that performance is high across the board is not necessarily negative, if it offers consumers the confidence to select from among an equally high quality set of physicians. **Also, with only 32 percent of all doctors (MDs and DOs) reporting, it is difficult to state that performance on the measures is truly topped out, when it is well known that early adopters frequently perform better than their peers.** Further, removal of “topped out” measures puts CMS at risk for missing situations where performance declines subsequent to a measure’s removal. Changes in measure performance can only be tracked if this information is being collected. Finally, if changes are made to the PQRS measure set too frequently, it will be hard for CMS and specialty societies to build the foundation of data needed to set accurate benchmarks.

Newly Proposed Measures: CMS proposes two new measures relevant to emergency care:

NQF-PQRS	NQS Domain	Measure Title and Description	Measure Steward
N/A- N/A	Efficiency and Cost Reduction	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain: Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain.	ACEP

ACEP recommends that CMS not include *Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain* in the final rule. ACEP does not have adequate specifications to implement this measure, nor has this measure had the benefit of a public review or public comment period. We have noted that this measure may not be relevant to the Medicare population at all due to certain “red-flags” in ACR appropriateness criteria which would indicate appropriate imaging. These red-flags include osteoporosis or history of fractures in patients aged 50 and older, as well as all patients who present with back pain aged 70 or older. **Therefore, ACEP urges CMS to withdraw this measure from consideration for the Medicare population.**

NQF-PQRS	NQS Domain	Measure Title and Description	Measure Steward
662- N/A	Communication and Care Coordination	Median Time to Pain Management for Long Bone Fracture: Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	CMS/ OFMQ

ACEP appreciates that CMS has included *Median Time to Pain Management for Long Bone Fracture* in the proposed rule. Emergency physicians worked with the CMS

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contractor - Oklahoma Foundation for Medical Quality - to develop this measure for the Outpatient Quality Reporting (OQR) program. ACEP has reached out to the measure steward to contemplate “retooling” of this measure as a physician level measure for the PQRS program. At this time, it is unclear if or how this measure has been re-tooled.

Cross-Cutting Measures

CMS also proposes that both individuals and group practices who report PQRS be required to report on two out of a potential 18 “cross-cutting” measures, which include:

PQRS#	Measure Title and Description
N/A	Tobacco Use and Help with Quitting Among Adolescents
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
240	Childhood Immunization Status
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
130	Documentation of Current Medications in the Medical Record
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
374	Closing the Referral Loop: Receipt of Specialist Report
46	Medication Reconciliation
110	Preventive Care and Screening: Influenza Immunization
111	Pneumonia Vaccination Status for Older Adults
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
318	Falls: Screening for Fall Risk
047	Care Plan
131	Pain Assessment and Follow-Up
182	Functional Outcome Assessment
321	CAHPS for PQRS Clinician/Group Survey
236	Controlling High Blood Pressure
N/A	Screening for Hepatitis C Virus (HCV) for Patients at High Risk

We note that the majority of these measures are focused on primary screening and prevention services that could be applicable to all Medicare beneficiaries. Most of these services are appropriately delivered in an outpatient office setting. These measures are not an appropriate assessment of the quality of care for unscheduled acute care delivered in the emergency department. **We object again to imposing yet another new reporting burden during the very first year that the PQRS program is no longer voluntary, and in a year when the VM will put all physicians at risk for significant penalties.**

If CMS does intend to mandate such an additional burden, ACEP would strongly encourage CMS to include the following measures, which could be considered “cross-cutting” in acute care:

PQRS#	Measure Title and Description
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

Measures for Future Consideration: We also would like to remind CMS that ACEP’s *Quality Measures Technical Expert Panel* has submitted the following measures for the **2016** PQRS reporting period. These topics have also been proposed for the CMS

measures under consideration for the 2016 PQRS reporting period. ACEP expects draft specifications for these measures to be available for public comment from September-October of 2014 at <http://www.acep.org/quality/qmtep/>. We hope to see these more meaningful measures proposed for inclusion in the PQRS for the 2016 reporting period.

2016	Efficiency	Imaging in adult ED patients with minor head injury
2016	Efficiency	Imaging in peds ED ages 2-17 y/o with minor head injury
2016	Efficiency	Pulmonary CT imaging for patients at low risk for PE
2016	Efficiency	Coagulation studies in patients with chest pain no coagulopathy or bleeding

Claims-Based Reporting under PQRS

Table 25 of the proposed rule lists 56 PQRS measures for which CMS is proposing to change the way in which the measures will be reported in 2015. In many cases, the option of submitting measure data via claims is being eliminated in favor of registry reporting only. ACEP understands that CMS wants to move to more robust reporting mechanisms, but the reality is that claims-based reporting still represents the most widely used reporting option for physicians. **ACEP strongly recommends that CMS allow an adequate number of claims-based reportable measures to remain in the program in order to maintain integrity of that reporting mechanism.** It is inappropriate to limit reporting options for physicians given the steep penalties they will now face as a result of the PQRS and VM. Instead, CMS should be giving physicians a broader choice of reporting options to encourage participation. Additionally, there are numerous quality topics of high impact that lend themselves more easily to claims specifications and reporting.

Traditional Qualified Registries

ACEP looks forward to providing our members with a traditional qualified registry reporting option later this year. As we evaluate options for offering members alternative reporting tools, including applying to become a “qualified PQRS registry,” we have identified specific requirements that may pose a challenge for us. **In regard to PQRS qualified registries, we oppose CMS’ proposal to require the entity to have the ability to collect and transmit to CMS data on all 18 of the proposed cross-cutting measures when physicians are only required to report on 2 of these measures.** CMS claims this will give registry participants the flexibility to choose among the full set of cross-cutting measures. However, we believe that this will only cause confusion from our members over which measures they have to report. Specialty societies are best equipped to determine which of these 18 measures are most relevant to their registry participants. For many specialties, such as ACEP, the majority of these 18 measures are not relevant and therefore, traditional qualified data registries should not be required to have the capability to report these data elements.

Qualified Clinical Data Registries (QCDRs)

Given the continuing paucity of PQRS measures specifically relevant to our membership, we do appreciate the flexibility that the statutorily authorized QCDR reporting

mechanism provides in terms of recognizing more meaningful measures and allowing them to make use of data they may already be collecting for other purposes. ACEP is contemplating applying to become a QCDR in the near future. As such, we have taken a hard look at the current and proposed requirements and take this opportunity to point out elements of this program that may pose a significant challenge for ACEP members. We are pleased that CMS proposes to allow an increase in the number of non-PQRS measures that a QCDR has available for reporting. Having 20 measures available for QCDR participants may allow only a subset of emergency physicians to benefit from using a QCDR with the requirement for reporting 9 measures. Therefore we support CMS' proposal to allow QCDRs to report on up to 30 non-PQRS measures.

Overall, the requirements for QCDRs are still too stringent for entities that are in their initial year of seeking qualification. They also fail to recognize the unique value of QCDRs over other reporting options and the fact that all registries are not the same and have different goals that may require different procedures. **ACEP recommends that CMS adopt a more scaled approach to QCDR implementation that allows specialties in various stages of registry development to take advantage of this worthy opportunity in a meaningful manner.** We also remind CMS of the importance of working closely with specialty societies and other relevant and informed stakeholders, such as the National Quality Registry Network (NQRN) as it develops standards and certifying criteria for QCDRs.

Public Reporting

ACEP supports efforts to increase transparency around the quality of care provided by physicians, and information on provider performance is critical to enabling the public to make informed decisions about their healthcare. However, CMS' proposal to require QCDRs to make public 2015 performance data at the individual provider or group level on Physician Compare or a specialty society website in 2016, may damage start up efforts for new registries.

In establishing QCDRs in 2014, CMS enabled them to develop and report on non-PQRS measures. Many physicians will be reporting on these new non-PQRS measures developed by QCDRs for the first time in 2015. First year data will not depict an accurate view of performance because there will not be accurate benchmarks for the initial year, and it will take additional time to implement consistent data collection and calculations across many different EHR systems. In the VBM section of the proposed rule, CMS states that it will not include new measures, including new QCDR measures, in the quality composite for the VBM because CMS would not be able to calculate benchmarks for them, and we ask CMS to take the same approach to public reporting. Physicians and other eligible professionals need sufficient time to gain familiarity with the measures, evaluate their performance on new measures and make improvements prior to publicly reporting their performance data.

Requiring public reporting too early in the process before providers have had the opportunity to evaluate their performance and make improvements may discourage eligible professionals from participating in QCDRs, stunting the growth of these promising innovation mechanisms and confusing, rather than enlightening the public. **We strongly urge CMS to delay the public reporting of QCDR data until accurate benchmarking data can be developed, and until providers have the opportunity to analyze their performance and make improvements.**

In situations when public reporting is appropriate, we do support CMS' proposal to only require QCDRs to publicly report on data related to measures reported for purposes of PQRS (and not necessarily all data collected in a registry). We also appreciate that CMS would defer to the QCDR in terms of the method used to publicly report its data (such as via Physician Compare). We encourage CMS to continue to apply this same flexible approach to benchmarking, risk-adjustment, and other methodologies employed by the QCDR. **We also recommend that QCDR measure data be reported at the aggregate group practice level, as a team-based approach is the ED model for delivery of acute unscheduled care.**

Reporting Three Outcome Measures: CMS is now proposing to require that QCDR participants report for successful PQRS participation on at least three outcome measures, or, if three outcome measures are not available, at least two outcome measures and at least one resource use, patient experience of care, or efficiency/appropriate use measure. Although ACEP is developing our own set of appropriateness measures for 2016, and is supportive of innovative approaches to patient experience of care measures, the proposed increase from one to three outcome measures in 2015 does not provide QCDRs sufficient time to develop and implement additional new outcome measures. **While we agree that outcome measures are an important indicator of quality of care, we are concerned that this proposal will be unattainable for broad range of eligible professionals that do not have three, or even two, outcome measures available for QCDR reporting.** The value of QCDRs lies within their data, yet because so many eligible professionals may not have even two outcome measures available for reporting, this proposal could result in lower participation rates and less robust data sets for QCDRs. **ACEP supports CMS proposal that a QCDR include various types of measures, but recommends that CMS phase-in over several years such a requirement, so as to allow new QCDRs to incrementally add measures.**

Reporting on 50 Percent of All Applicable Patients: Individual physicians participating in a QCDR in 2015 would have to report on at least nine measures covering at least three of the NQS domains for 50 percent of *all* applicable patients in order to satisfy PQRS requirements and avoid the 2017 penalty. **ACEP has serious concerns about the existing requirement that participants report on measures for 50 percent of *all applicable* patients both Medicare and non-Medicare.** This exceeds current and proposed requirements for traditional PQRS reporting, and places a disproportionately large reporting burden on QCDR participants, discouraging physicians from taking advantage of what may be the most meaningful PQRS reporting mechanism. This policy also places an unusually higher burden on a high volume physician versus a lower volume one. Further, this high reporting standard may discourage QCDRs from adding data elements to measures to make them more accurate or meaningful since this would further add to the data collection burden. **To address these concerns, we strongly urge CMS to provide more flexibility by recognizing QCDRs that demonstrate a mechanism by which they can provide CMS with data on a statistically valid sample of patients, rather than 50 percent of all their patients.**

Group Reporting: We do not understand why the QCDR reporting option is not available to group practices under the GPRO, or for the reporting of measures groups. **We understand that CMS sees the value in allowing GPROs to use a QCDR and has made efforts to encourage Congress to include in new legislation authority to allow such use. ACEP strongly supports this effort.** The restriction on these two reporting mechanisms will significantly limit the number of measures that a specialty-specific

group practice can report. For many measures, performance rates may be more statistically accurate at the group reporting level due to increasing denominator size.

Disqualified QCDRs: As previously finalized, if a QCDR is disqualified for any reason, its participating physicians would automatically fail to satisfy reporting requirements and be subject to PQRS and associated VM penalties. CMS does not propose any changes to this policy in the draft rule. Therefore, we continue to urge CMS to offer a grace period for physicians who find themselves in this predicament, since this action would be outside their control. **We request that CMS either exempt them from penalties or give them an extended opportunity to resubmit measure data via an alternative mechanism.**

PQRS Transparency: As CMS phases into an all-penalty stage of the PQRS and continues to add to the reporting burden, it is absolutely critical that the agency work, in consultation with specialty societies, to provide educational tools and other resources to assist the physician community with navigating the various PQRS reporting mechanisms, requirements, and its implications for the VM.

Value-Based Payment Modifier (VBM)

While ACEP understands that the ACA requires CMS to phase the value modifier (VM) in over a three-year period beginning in 2015 and that it apply to all physicians by 2017, we believe implementing this program at such a rapid pace leaves CMS and the public with inadequate opportunity to evaluate the results of earlier years of implementation and make changes to the program based on lessons learned. The VM is yet another regulatory requirement that will only compound the burden that practicing physicians already face and further erode the physician-patient relationship if carried out too aggressively.

As noted in the table below, CMS proposes to not only apply the VM to all physicians in 2017, but to double the amount at risk from 2 to 4%.and to double the penalty from -2% to -4% to all physicians that do not meet the criteria for satisfactorily reporting PQRS data. Although group practices with 2-10 EPs and solo practitioners would be held harmless from downward *performance-based* payment adjustments in 2017, they are still at risk for a *non-participation* penalty that is two times as large as the penalty applied to larger practices (10-99 EPs) and four times as large as the penalties applied to the largest of practices (100+ EPs) during their initial year in the program. In 2017, combining the PQRS penalty of -2% and the VM penalty of -4% results in a total penalty of -6% for failing to report PQRS data. The magnitude of the penalties is extremely concerning considering the distinct lack of PQRS measures relevant to our specialty that may prevent our members from satisfying the reporting requirements.

Proposed CY 2017 Value-Based Payment Modifier Amounts

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

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*Note: * Groups and solo practitioners eligible for an additional 1.0x if reporting Physician Quality Reporting System quality measure and average beneficiary risk score is in the 25 percent of all beneficiary risk scores.*

Smaller group practices and individuals need time to gain experience with the program. It is neither fair nor fruitful to add an even higher VM penalty to the mix when many physicians are already struggling to keep up both financially and mentally with the vast array of other new burdens such as new ICD-10 diagnosis codes, resource-intensive new EHR systems, and escalating quality measurement activities that have been imposed in recent years. A more gradual roll out of the penalties is also critical in terms of giving CMS more time to evaluate and make improvements to the program. **Therefore, we urge CMS to use its existing authority to ease new participants into the program by either holding them completely harmless from penalties, reducing the initial payment penalty, or requiring less stringent reporting requirements during the initial year.** CMS and the public still have much to learn about the validity of cost measures, the accuracy of patient attribution and risk adjustment methodologies, the reliability of composite scores, the significance of benchmarks, and the overall value of performance data to both physicians and patients.

Quality Measures: ACEP supports CMS' proposal to continue to base the VM largely on PQRS quality measure data. **However, CMS' proposal to remove multiple PQRS measures currently reported by our members gives us great concern.** In regard to patient experience measures, ACEP appreciates that CMS proposes to make the reporting of CG-CAHPS measures in 2015 for purposes of the 2017 VM *optional* for groups with two or more EPs. However, other aspects of the rule seem to indicate the agency's desire to make CAHPS reporting a required component of federal quality initiatives in the future, including the VM and Physician Compare. **Again, we strongly urge CMS to look beyond the CG-CAHPS measure set and to consider other more innovative approaches to patient experience and patient engagement, which may be more relevant to emergency care providers and other specialists.**

Cost Measures: We continue to urge CMS to focus on weighting the existing PQRS measures within the efficiency domain for those clinicians and group practices who successfully report for PQRS. ACEP recognizes the statutory requirements for CMS to measure and evaluate the quality of care as well as the costs of care provided to Medicare beneficiaries. However, efficiency methodologies need to establish a clear link between resource use and quality to facilitate value-based decision-making by patients, clinicians and providers. The cost measures that CMS has included to date in the value modifier program are not linked with the quality measures used for the program. Value is a function of both quality and cost, but physicians cannot be accurately evaluated on value if the cost and quality measures are not aligned.

Attribution methodology: This is a continuing problem for our members as the current cost measures continue to be a concern since social determinants of health for many patients continues to drive patients to emergency departments. Physicians who provide services in acute care facilities will naturally have higher costs than their office based counterparts due to facility fees. Currently, emergency physicians only constitute four percent of all physicians, yet they provide 28 percent of all acute care visits. With the influx of many new patients into the health care system expected next year, this trend is expected to increase. While we appreciate CMS decision last year to adjust cost data to account for differences in specialty mix, there needs to be additional ways, such as site of

service documentation proposed in this year's OPDS, to recognize legitimate variation in practice costs even within the same specialty.

Finally, we oppose CMS' decision to not apply socioeconomic status adjustments to cost measures under the VM. A large body of evidence demonstrates that socio-demographic factors such as income and insurance status affect many patient outcomes, including readmissions and costs. Failing to adjust measures for these factors can lead to substantial unintended consequences, including harm to patients and heightened health care disparities by diverting resources away from providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poorer outcomes.

Treatment of Hospital-Based Physicians under the Value-Modifier: Based on input from a number of commenters in previous rule-making, CMS is considering including or allowing groups that include hospital-based physicians or solo practitioners who are "hospital-based" to elect the inclusion of the Hospital Value-Based Purchasing (VBP) program performance in their VM calculation. CMS noted that there are limited measures that apply to certain specialties and that those specialties may exercise wide influence over the quality of care provided in a hospital. CMS proposes that groups could elect to include hospital performance in their VM for a payment adjustment period based on a hospital's historic VBP program performance, which would be known to the group (by TIN) at the time of election. CMS notes any change would be through future notice and comment rulemaking.

As noted in previous years, ACEP continues to strenuously object to the concept of emergency physicians being assessed under the value modifier based on the total performance score of the hospital in which they practice. Emergency physicians and groups may be able to influence some ED specific strategies and policies, but ultimately have little actionable impact as far as the implementation or lack thereof of inpatient initiatives. We do note that in the case of the Outpatient Quality Reporting Program, there may be some instances where harmonization for clinician and hospital level measures can occur. However, emergency physicians should be assessed on clinician or group practice performance only. ACEP will continue to carefully review the OQR measures for potential re-tooling in our continued efforts to expand the measure portfolio for emergency physicians.

ACEP reminds CMS that the measures used in the hospital Outpatient Quality Reporting (OQR) program are not included in the hospital's Value-Based Purchasing (VBP) score; therefore VBP would be an even less accurate score for emergency physicians. **However, ACEP would be supportive of efforts to re-tool a certain subset of OQR measures to be reported via PQRS or QCDR on a case-by-case basis.** Further, we would also appreciate hospitals collecting a subset of OQR measures with National Provider Identifier (NPI) as a required field (rather than as an optional field), and to share these data as actionable feedback to individual physicians or physician groups for quality improvement purposes. Individual providers, groups, or specialties could then report that data to a QCDR, or propose a subset of OQR measures for future PQRS performance years, on a measure by measure basis, if they so choose. Offering this as an option, rather than a requirement, would allow for both flexibility and further alignment between hospital and physician reporting programs. It would also eliminate the need for determining which hospital's score should be used and for which measures. As most emergency physicians will have a number of measures available in the PQRS program,

and an even greater number with the addition of the QCDR option, emergency physicians will always prefer to know and report their actual performance score, rather than have a hospital score attributed to them. We welcome working with CMS and volunteer emergency medicine groups to better understand how this approach could work for PQRS.

Informal Inquiry Process: We appreciate CMS' proposal to expand its informal inquiry process in regard to performance calculations. Under current policy, a group of physicians is simply given the option to contact CMS after receiving its annual Physician Feedback report to inquire about the report and the calculation of the VM. In this rule, CMS proposes a more formal process for groups to request a correction of a perceived error. CMS should give groups until at least February 2015 to request a correction for the 2015 payment adjustment. Not only is CMS' proposal of January deadline too short, the February deadline aligns with the PQRS informal review process. CMS would re-compute the group's cost composite and readjust its tier accordingly if the Agency determines it made an error in the cost calculation for 2015. However, CMS claims it is not technically feasible to do the same for quality composite errors in 2015 and would instead classify a TIN as "average quality" in those cases. It is not fair to hold practices accountable for performance without a mechanism in place to ensure corrections to that data. It seems inappropriate to deem a group "average quality" simply because CMS does not have the capacity to correct its own errors, especially if an "average quality" rating could potentially lead to penalties. **We strongly urge CMS to give physicians and groups an opportunity to recalculate their quality composite as well, and if that is not available in time, physicians and groups in question should be held harmless from any penalties.**

Physician Feedback Program

It has never been more important for CMS to continue to evaluate and refine the annual Quality and Resource Use Reports (QRURs) in an iterative, ongoing manner, working closely with specialty societies. The accuracy, format, and usability of these reports will be increasingly important going forward since they will include critical information about how physician payments will be affected under the VM and how quality and cost determinations are translated into such payment adjustments. ACEP notes that the QRUR changes that CMS has made to date based on healthcare provider input have substantially improved the content and usefulness of the reports. ACEP remains concerned, however, about the timing of the release of the QRUR reports. Providing QRUR reports based on 2013 data in late summer of 2014 is too late to provide feedback for physicians to adjust their 2014 performance. CMS needs to continue to explore options to provide physicians with feedback information, even if it is preliminary, earlier in the performance year.

CMS also describes its ongoing work related to the development of episode groupers for purposes of evaluating resource use. The 2012 Supplemental QRURs include 26 condition and procedural episode types. Given our aforementioned concerns about the inappropriateness of Total Per Capita cost measures and the MSPB measure, we appreciate that CMS is aiming to develop more targeted cost measures, which should minimize attribution issues and concerns about physicians being held accountable for care outside of their control. However, it is critical that CMS continue to consult relevant specialties to further refine these episodes, especially now that physicians have access to this data through QRURs. As noted earlier, is important that CMS not use episodes for

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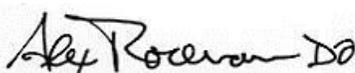
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accountability purposes until it can integrate these resource use measures with relevant quality measures.

We appreciate the opportunity to share our comments and continue to look forward to working with you and your staff. If you have any questions, please contact Barbara Tomar, ACEP's Federal Affairs Director btomar@acep.org or Stacie S. Jones, ACEP's Quality and HIT Director, sjones@acep.org.

Sincerely,



Alex Rosenau, DO, CPE, FACEP
President

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