Emergency Department EDPMA Practice Management Association

June 16, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1632–P
P.O. Box 8013
Baltimore, MD 21244–1850

Re: RIN–0938–AS41; CMS–1632–P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program

Dear Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, **EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year.** We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

EDPMA has a number of concerns about the proposal to establish two new inpatient quality measures in 2018 that would measure excess acute care provided to Medicare patients who recently suffered heart failure or myocardial infarction. **We are concerned that the proposal puts patients' healthcare at risk and discourages an efficient and appropriate use of the overall health care system, including the emergency department.**

The current proposal would effectively punish the hospital when a patient who was recently treated for heart failure or myocardial infarction subsequently visits the emergency department. This incentive is in conflict with the Prudent Layperson Standard which establishes the emergency department as a reimbursable venue for care when a prudent layperson reasonably believes there is a health emergency. In 2013, the RAND Corporation released a study entitled "The Evolving Role of Emergency Departments in the United States," where it noted that the patients' "prudence may be justified. The three most common symptoms of Medicare patients who are ultimately *discharged* from EDs—abdominal pain, chest pain, and shortness of breath—can represent benign conditions or life-threatening disorders, such as acute myocardial infarction, bowel perforation, or a pulmonary embolus." It makes little sense to disincentivize emergency care for patients who were recently treated for heart failure and myocardial infarction when they are concerned.

The 2013 RAND study further explains why the emergency department is often the most appropriate venue for many patients. It found that emergency department physicians are the major decision makers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay. Primary care physicians increasingly rely on the emergency department to evaluate complex patients with potentially serious problems, conduct workups, and provide overflow and after-hours primary care. Increasingly, the emergency department is seen not as a health care resource to be avoided, but a key stabilization and decision point for patient disposition, which increasingly involves finding alternatives to hospital admission or observation stays for high-focus patient populations such as heart failure and myocardial infarction.

In order to appropriately care for patients who recently suffered heart failure or myocardial infarction, providers often need access to diagnostic and monitoring equipment, and staff to monitor the patient over a period of time. They also need ready access to specialists. This equipment and staff are often only available in a hospital setting. Patients cannot save the healthcare system money by scheduling an appointment with their primary care provider (or specialist for that matter) and waiting a day or two for that appointment if they are concerned about their heart. In many cases, the patients' practical and timely options are either readmission or evaluation, stabilization, and discharge from the emergency department. And the emergency department is the less expensive option of the two.

The RAND report found that "**an average inpatient admission costs ten times more than an ED visit."** In many cases, a visit to the emergency department is not only appropriate – but the least costly alternative. And increasingly, emergency department providers are finding alternatives to hospitalization (either inpatient or observation stays).

We are also concerned that the proposed measures inappropriately lump time in inpatient, emergency department, and observation care together. In doing so, the proposal implies that care provided in each setting is equally undesirable. Yet, emergency department care is an appropriate venue for patients with serious heart conditions and is an inexpensive alternative to inpatient care.

Moreover, many visits to the emergency department do not lead to a long stay in observation. It makes little sense to compare a relatively inexpensive treat-and-release visit to the emergency department with inpatient care.

Even if you ultimately decide to lump inpatient hours with emergency department visits, the proposal to consider each treat-and-release visit to the emergency department as equal to 12 hours of inpatient care makes little sense. Most treat and release visits are significantly less than 12 hours. That said, we could more readily support measuring visits to the emergency department when those visits lead to an extended stay in observation.

We understand the desire to measure the quality of care provided by a hospital and that readmission measures do not capture patients who are in observation for an extended period of time. However, it's important to note that a visit to the emergency department often reflects other realities, including the absence of primary care resources, difficulty with timely access to primary care, or the use of the emergency department as an advanced center of care (more resources than a doctor's office, but less costly than an admission or extended observation stay). In other words, not all emergency department visits are a sign that the hospital provided a low quality of inpatient care.

Moreover, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to evaluate and stabilize all who visit the emergency department – without regard to the ability to pay. It makes little sense to turn around and punish the hospital for fulfilling this obligation.

We are very frustrated with proposals like this that perpetuate the misconception that a visit to the emergency department is somehow a sign of failure in the health system, and that these patients are better treated in some other venue, left without treatment at all, or that penalties or adverse quality scores are assigned for utilization of the emergency department. We are also concerned about the misconception that emergency care is relatively expensive compared to the alternatives. These misconceptions are due in part to the fact that policy makers often focus on the cost of the emergency department care instead of the cost <u>savings</u> the system enjoyed by avoiding further complications or an unnecessary hospital admission.

We also wanted to recommend that the proposed measures only evaluate acute care related to the quality of care provided in the original inpatient admission. By contrast, the proposal recommends measuring acute care from "all causes" because it would be difficult to determine the underlying cause of each episode of care. We understand the difficulty of determining the underlying cause of a visit. On the other hand, it makes little sense to measure time spent in the emergency department for a twisted ankle when measuring the quality of care the hospital recently provided to a patient with heart failure or myocardial infarction.

In summary, EDPMA is concerned that the proposed measures of excess acute care may discourage patients from seeking appropriate care in the emergency department and will discourage hospitals from providing care in the most appropriate and least expensive venue. Moreover, the proposed measures may not provide the insight into the quality of care that is intended.

Thank you for the opportunity to provide our thoughts on the proposed 2018 measures. Please feel free to contact Elizabeth Mundinger, EDPMA's Executive Director, at 703 610-9033, if we can be of any assistance on this topic or in any other area.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors