Emergency Department EDPMA Practice Management Association

March 1, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Submitted electronically via: episodegroups@cms.hhs.gov

Re: Request for Comment on Medicare Episode Groups

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 appreciates CMS' efforts to respond to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requirements and timelines regarding episodes and the application of those episode groups to the Resource Use performance category as part of the Merit-based Incentive Payment System (MIPS).

In addition, we continue to believe that as CMS transitions to MIPS, it must abandon its reliance on the broad cost measures currently used under the Value-Based Payment Modifier (VM). Broad cost measures assess the total amount billed per patient and not the treatment of the individual provider. While tracking costs (and quality) across the care continuum is important for developing policies to improve our care delivery system, these general assessments are not appropriate for individual physician or group practice accountability since they incorrectly assume that physicians have control over the entire care plan and treatment decisions of other providers, often in other settings, who also treat the patient over the reporting period. In addition, valid resource use comparisons will involve comparing practices that are similarly situated, which means ensuring that professionals in emergency medicine practice groups attributed costs are compared with those providing care in a similar practice group or emergency department setting.

We believe that investing in episode group development is a promising approach for moving away from overly broad resource use measures, and we look forward to providing input to CMS as it develops more appropriate resource use measures that take into account longitudinal assessments of acute episodic care often delivered with rotating groups of providers as typically arises in an emergency department group practice arrangement.

We continue to believe it is important for CMS to remember that the delivery of emergency medical care is unique to the health care system and, in some instances, warrants special considerations for the implementation of programs under MACRA and, in particular, MIPS. We urge CMS to be mindful of this as it develops a proposed rule related to these provisions and as it seeks to meet the MACRA deadlines related to episode groups, patient condition codes, and patient relationship codes.

Patient Condition Groups

As part of meeting the requirements under MACRA, CMS is soliciting input on questions regarding the establishment and utilization of Patient Condition Groups. As it establishes the Patient Condition Groups, CMS is required to consider the patient's clinical history at the time of a medical visit (e.g. the patient's combination of chronic conditions, current health status, and recent significant history such as a hospitalization or major surgery). MACRA requires that the Patient Condition Groups account for a target of one-half of expenditures under Parts A and B, and as such, CMS is requesting input on which conditions should be selected. In addition to today's comments, we look forward to the opportunity to comment on CMS' future proposals as well related to the implementation of the Patient Condition Groups.

However, EDPMA again urges CMS to acknowledge that the provision of emergency medical services and care is unique to the health care delivery system and request that CMS consider potentially unintended consequences in labeling a patient under a particular Patient Condition Group without regard to the setting in which the patient presented for care.

As professionals in the delivery of emergency medical services and care, we are routinely tasked with meeting the unanticipated, unscheduled needs of patients which may include performing a diagnostic assessment, particularly for patients with undifferentiated and non-specific complaints such as pain and shortness of breath. This is exacerbated by instances where community based physicians routinely refer patients to the emergency department as a rapid diagnostic center. In those situations, it is not unusual for an emergency department physician or provider to possess clinical assessment capabilities sufficient to identify a specific patient diagnosis, as the precise diagnosis code (at least under the ICD-9 and now, ICD-10 diagnostic coding classification system) may be beyond reach given the relatively brief time frame in which patients are under our care; as such, knowing which Patient Condition Group a patient fits in or whether an episode has been triggered may prove to be challenging, if not clinically impossible.

In addition, we ask that CMS pay particular attention to the MACRA direction to consider a patient's recent significant history in the concept of the Patient Condition Group. EDPMA believes that CMS must not only take into account the services patients have recently received but must also take into account the needed services that the patient did *not* receive prior to presenting in the emergency department. A patient with a particular condition seen in the emergency department who failed to receive appropriate care prior to arrival in the emergency department may require more intense care

particularly as a result of exacerbated conditions previously left unchecked. This is compounded by the obligations placed on the emergency department coming from the unique statutory requirements mandated by the Emergency Medical Treatment and Labor Act (EMTALA). As CMS is fully aware, emergency departments are required under EMTALA to provide any patient who comes to the emergency department with a medical screening examination and to stabilize that presenting patient, regardless of that patient's insurance status or ability to pay for such stabilizing care. Consequently, the provisions of EMTALA limit an ED physician's ability to effectively influence costs. Given the potential implications of these policies on the Resource Use performance category under MIPS, EDPMA believes it is important that emergency medicine not be placed at an unfair disadvantage and reminds CMS that the emergency department serves as the frontline to many patients who may not be receiving care as needed from other community based settings.

Regarding the CMS request for Episode Groups and Patient Condition Groups with which the Agency should begin, we ask that CMS refrain from creating a specific list of episode or patient condition groups that are specifically assignable to the emergency setting given that resource use and outcomes associated with care delivered in the emergency department are directly correlated to the care that patients have received (or not received) before and after treatment in the ED. Instead, we believe CMS should focus on how to incorporate emergency medicine professionals into the proposed Episode Groups and Patient Conditions Groups, by focusing on policies related to the establishment of Patient Relationship Codes. We provide comments on emergency medicine and Patient Relationship Codes below.

Finally, as CMS contemplates the utilization of Patient Condition Groups, EDPMA strongly urges CMS to consider automated mechanisms for capturing information and making Patient Condition Group assignments rather than adding an additional data element as part of the claims filing process. The information already required as part of the claims submission process, including the increased refinement of information available regarding diagnoses and history with the use of ICD-10, should offer CMS the information it needs to administer these new concepts mandated by MACRA. We believe that any utility derived from the use of Episode Groups and Patient Condition Codes will be dependent on CMS implementing these concepts with little to no increased administrative burden on providers and their billing agents.

Measure Alignment

EDPMA has previously submitted comments encouraging CMS to align resource measures with clinical quality measures. CMS is now requesting input on how episodes can be designed to achieve this goal. First, we believe this goal is critical to establishing a system that is truly patient-centric. A system that measures resource use on one set of services, yet measures quality on a different set of services, runs the risk of inappropriately classifying practices and failing to protect patients from being denied necessary and appropriate care. EDPMA believes one potential solution is for CMS to leverage the current Measures Group concept utilized in the Physician Quality Reporting System (PQRS) but incorporate resource use mechanisms or measures. Under this model, CMS would be able to ensure that it is measuring cost and quality on the same denominator set of services. This will give the public more confidence that the MIPS performance scores received by physicians and practices are not masking reductions in access or quality that resulted in better resource use scores. If quality and cost measures focus on different elements of care, they cannot be used to draw accurate conclusions about overall value.

Patient Relationship Codes

As CMS outlines, MACRA requires CMS to distinguish the relationship and responsibility of physicians and practitioners to allow the resources used in furnishing care to be attributed (in whole or in part) to physicians serving in a variety of care delivery roles. We look forward to responding to future proposals and the published list of draft Patient Relationship Codes. In the meantime, however, we ask CMS to consider the unique role of emergency medicine in the delivery of health care. CMS has listed the potential categories for Patient Relationship Codes, such as a physician (or applicable practitioner) who:

- *Considers themself to have primary responsibility for the general and ongoing care for the patient over extended periods of time;*
- *Considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;*
- *Furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;*
- *Furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or*
- *Furnishes items and services only as ordered by another physician or practitioner.*

It is clear that none of these categories is generally applicable to the services provided by emergency medicine professionals. However, we believe it is imperative for CMS to develop a Patient Relationship Code that captures care delivered in the emergency department. In emergency medicine, we are the acute diagnostician and manager of severe illness and injury. In addition, we are called on to be the corrector of acute changes in chronic diseases. Because of this, we understand that the services in emergency medicine are not easily categorized. A significant amount of the resources is often attributable to services received in the emergency department and those resources are often well utilized in preventing further unnecessary health care spending and improving patient quality of care and outcomes. We believe that the value that accrues to the system because of care delivered by emergency medicine should be captured in episode group methodology and resource use measurement, and a key to being able to do that is developing an appropriate Patient Relationship Code for emergency medicine.

We also believe that CMS efforts to establish Patient Relationship Codes provide a unique opportunity to address the variation in resources available in a particular community setting. Depending on location, emergency departments are often called upon to provide additional services and marshal greater resources for patients seen in the emergency department due to limited availability of primary care physicians and specialists in the surrounding area (e.g. in the case of a Health Professional Shortage Areas (HPSA)). The relationship between the emergency medicine professionals and patients in those areas is almost certain to be different than in an area able to provide greater access to physicians and community resources. In fact, a recent study showed that there was a decrease in ED visits for all-cause, non-emergency care that was "primary care treatable" when paired with access to a primary care appointment within one day.[1] This helps demonstrate the increased pressure placed on

[1] Yoon, Jean, Kristina M. Cardasco, Adam Chow, and Lisa V. Rubenstein. "The Relationship between Same-Day Access and Continuity in Primary Care and Emergency Department Visits." *PLOS ONE* (2015): Web. 11 Feb. 2016. <10.1371/journal.pone.0135274>.

emergency departments when adequate access to primary care services is lacking. In addition, the resources expended by emergency departments in treating patients can also vary significantly based on the hospital's academic status, whether it offers trauma services and at what level, and whether it is in a rural setting. If CMS declines to create and implement a Patient Relationship Code to reflect the availability of community resources, we urge CMS to ensure that, at the very least, it makes resource use comparisons only between those practices that are similarly-situated, including whether there is similarity in the availability of physicians and community resources, factors which can greatly affect the care that must be delivered in the emergency department.

Again, we thank CMS for the opportunity to provide input and look forward to providing continued support for CMS' efforts to implement a new physician payment system designed to encourage value. Please let us know if you have any questions or if we can provider more detail about our recommendations. Should you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

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