Emergency Department EDPMA Practice Management Association

September 2, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-P
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically

Re: RIN 0938-AS82; CMS-1656-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program

Dear Acting 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. We appreciate the Centers for Medicare and Medicaid Services' (CMS') efforts in issuing its proposals to update the Medicare Hospital Outpatient Prospective Payment System (OPPS) for calendar year (CY) 2017, as well as the opportunity to provide comment on these proposals.

Collecting Data on Services Furnished in Off-Campus Provider Based Departments

The Bipartisan Budget Act of 2015 included a provision that applicable items and services furnished by certain off-campus outpatient departments of a provider on or after January 1, 2017, will not be considered outpatient department service under the OPPS. The law states that these services will be paid "under the applicable payment system; under Medicare Part B" (e.g. the Medicare Physician Fee Schedule). However, the law also states that the items and services to which this policy apply are

items and services other than those furnished by a dedicated emergency department. CMS observes in the proposed rule that emergency departments may furnish both emergency and non-emergency services. However, CMS proposes that all services furnished in an emergency department regardless of whether they are emergency services would be exempt from the provisions and will continue to be paid under the OPPS. To implement this, CMS proposes to define *applicable items and services* to include all items and services not furnished by a dedicated emergency department. ***EDPMA supports the CMS proposal***. We believe that Medicare billing mechanisms and processes should not interfere with the delivery of patient care. A proposal to subject otherwise similarly-situated services (e.g., same physicians, same site of service, etc.) to different payment systems based on whether the service was an emergency would have been incredibly disruptive to emergency departments. We believe the CMS has correctly interpreted the statutory provisions and agree with the CMS proposal to exclude all services delivered in an emergency department from the off-campus provider-based department proposals.

Hospital Outpatient Quality Reporting (OQR) Program Updates

New Measures

CMS proposes to add several new measures to the Hospital OQR Program for the CY 2020 payment determination and subsequent years. EDPMA offers comments on three of those proposed measures.

- *OP-35: Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy*

  OP-35 is structured to assess care provided to cancer patients and to reduce the number of unplanned inpatient admissions and emergency department visits among cancer patients receiving chemotherapy in a hospital outpatient setting. The measure cohort includes Medicare fee-for-service (FFS) patients, ages 18 years and older with a diagnosis of any cancer (except leukemia) who received at least one hospital outpatient chemotherapy treatment at a reporting hospital during the performance period. The measure calculates two mutually exclusive outcomes:

  1) One or more inpatient admissions; or
  2) One or more emergency department visits within 30 days of chemotherapy treatment among cancer patients receiving treatment in a hospital outpatient setting for any of the following diagnoses:
     - Anemia
     - Dehydration
     - Diarrhea
     - Emesis
     - Fever
     - Nausea
     - Neutropenia
     - Pain
     - Pneumonia
     - Sepsis

As part of its discussion, CMS highlights that there are no publicly available quality of care reports for providers or hospitals that provide outpatient chemotherapy and proposes the inclusion of this measure to address that gap.

First, ***EDPMA supports the fact that CMS would calculate inpatient admission and ED visit rates separately since the severity and cost of an inpatient admission is different from that of an ED visit***. Calculating a single rate for both outcomes could have created a performance rate that was less clear and actionable. However, we note that while the Measure Applications Partnership (MAP) provided "conditional support" for the measure, it also recommended that the measure be submitted to the NQF for endorsement with a special focus on analyzing the measure at it relates to necessary sociodemographic status (SDS) adjustments and the selection of exclusions. While we do not object to the proposed measure, ***EDPMA requests that CMS wait to finalize the measure for inclusion in the CY 2020 OQR program until the NQF process reviews and adjusts the measure.***

In addition, we would again like to remind CMS to be cautious in how this measure is applied. We recognize that CMS has proposed this measure to address potential unmet needs of outpatient chemotherapy patients. We do request, however, that CMS monitor the use of the measure to ensure that it is not misappropriated to penalize the services delivered in the emergency department. We continue to urge CMS to avoid the inappropriate application of quality and resource use measures to a health care service (specifically, the emergency department) with an entirely unique statutory requirement (in this case, the Emergency Medicine Treatment and Labor Act (EMTALA), or other similar legal requirements that support patient access and frequently require the delivery of care under specifically nuanced standards (in this case, the prudent layperson definition of an emergency medical condition, a/k/a the prudent layperson standard), or, within the setting of an acknowledged health care safety-net (in this case, full access to a provider irrespective of insurance or ability to pay) versus a private practice setting where patient selection is permitted (patient selection), recognizing that an emergency department is a setting that is unlike any other component of the health care system.

- *OP-36: Hospital Visits after Hospital Outpatient Surgery (NQF #2687)*

CMS states that there are no currently publicly available quality of care reports for providers or facilities that conduct same day surgery in the hospital outpatient setting. CMS is concerned that providers (both hospitals and surgeons) are often unaware of their patients' hospital visits after surgery because patients often present to the ED or to different hospitals and believes that reporting this outcome could help providers with quality improvement for cases with which they have had little data to date.

The measure outcome is any of the following hospital visits:

1) An inpatient admission directly after the surgery; or
2) An unplanned hospital visit (ED visits, observation stays, or unplanned inpatient admissions) occurring after discharge and within 7 days of the surgery.

The measure score is a ratio of the predicted to expected number of post-surgical hospital visits. Same-day surgeries are surgeries and procedures listed on Medicare's list of covered ASC procedures the only exclusion is surgeries for patients without continuous enrollment in fee-for-service Medicare Part A and Part B in the 1 month after the surgery. CMS plans to risk-adjust the measure with 25 risk-adjustment variables that are associated with risk of hospital visits within 7 days following outpatient surgery.

While the NQF endorsed and the MAP supported the measure, some members of the MAP cautioned that the measure was endorsed by NQF before the start of the SDS trial period, the measure should be reexamined during maintenance to determine whether SDS adjustments are necessary as part of future measure updates. ***EDPMA agrees that the measure should be reviewed to determine whether additional SDS adjustments are necessary and, at the very least, should not be finalized until issues related to SDS adjustments are addressed in full.***

In addition, ***EDPMA opposes the use of ED visits as a part of this quality metric.*** EDPMA is concerned with metrics that assume that receiving care in the emergency department should be avoided. In 2013, the RAND Corporation released a study entitled "The Evolving Role of Emergency Departments in the United States," that, among other things, 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 (i.e., EMTALA). 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. 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 believe that the calculation of the "expected number of post-surgical hospital visits" will not provide sufficient assurance, particularly given issues related to risk-adjustment, that the current structure of the measure will avoid creating a disincentive for seeking appropriate care in the emergency department. We believe it will be methodologically difficult to come up with that expected number of visits, and further we believe that applying a measure such as this for patient-initiated services is a tremendous misstep in policy. Therefore, in order to ensure the appropriate implementation of this measure, ***EDPMA urges CMS to remove the ED visits and observation services metric from the measure to focus only on inpatient admissions.*** In the alternative, ***EDPMA requests that CMS wait to finalize the measure for inclusion in the CY 2020 OQR until NQF measure maintenance has concluded so these issues can be further addressed.***

OP-37(a-e): Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey Measures

CMS proposes to adopt five survey-based measures derived from the OAS CAHPS Survey for the CY 2020 payment determination and subsequent years:

- OP-37a: OAS CAHPS – About Facilities and Staff
- OP-37b: OAS CAHPS – Communication About Procedure
- OP-37c: OAS CAHPS – Preparation for Discharge and Recovery
- OP-37d: OAS CAHPS – Overall Rating of Facility
- OP-37e: OAS CAHPS – Recommendation of Facility

While CMS is proposing to remove the current pain dimension from the HCAHPS survey for purposes of calculating performance under the Hospital Value Based Purchasing (VBP) program, the OAS CAHPS Survey would still contain two questions regarding pain management. We support CMS' rationale for this decision since the OAS CAHPS measures focus on pain communication rather than management and would not be tied to performance-based payments, which could influence prescribing behaviors.

The measures have not yet been endorsed by the NQF, however CMS states that it will submit them to the NQF under an applicable call for measures.

While the OAS CAHPS is a step in the right direction, we urge CMS to make its work of testing and revising the Emergency Department Patient Experiences with Care (EDPEC) Survey a priority since patient experiences in the ED setting require unique questions that are not necessarily reflected in the OAS CAHPS. We also urge CMS to make modifications to the pain questions in the EDPEC so that they are similar in focus to the OAS CAHPS survey questions and better account for public health concern over the ongoing prescription opioid overdose epidemic.

Hospital Value-Based Purchasing (VBP) Program

For purposes of hospital Inpatient Prospective Payment System (IPPS) payment updates, CMS assesses performance on measures under the Hospital VBP Program. As part of the Hospital VBP Program, CMS requires data submission for the HCAHPS survey. One of the dimensions that CMS has adopted for the Hospital VBP Program in the survey is Pain Management for which there are three questions:

- *During this hospital stay, did you need medicine for pain?*
- *During this hospital stay, how often was your pain well controlled?*
- *During this hospital stay, how often did the hospital staff do everything they could to help you with your pain*

Because of its ongoing work to better identify better measures related to pain management that take into consideration the impact measures could have on opioid use, CMS proposes to remove the pain management questions from the HCAHPS score under the Hospital VBP. ***EDPMA strongly supports the proposal to remove the pain management dimension from the HCAHPS score under the Hospital VBP.*** We agree that the HCAHPS data should not be disaggregated by hospitals to assess the individual performance of a physician or a nurse. In addition, while never the intended setting, the

application of the HCAHPS survey to the emergency department setting is inappropriate. ***EDPMA shares CMS' desire to develop meaningful measures that encourage appropriate pain management, particularly in the emergency department setting, while taking into consideration the potential for opioid misuse. As mentioned earlier, we urge CMS to refine the pain measures included in the Emergency Department Patient Experience of Care (EDPEC) Survey that is currently under development and to make implementation of that survey a priority.***

The EDPMA appreciates the opportunity to provide input on the proposed rule. If 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