American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

June 28, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD, 21244-1850

CMS-1752-P

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program Proposed Rule

Dear Administrator Brooks-LaSure:

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On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the fiscal year (FY) 2022 Inpatient Prospective Payment System (IPPS) proposed rule. Our comments are limited to those proposals that affect emergency physicians and the patients we serve.

Quality Reporting/Performance Programs

Hospital Inpatient Quality Reporting (IQR) Program

The Centers for Medicare & Medicaid Services (CMS) is proposing a number of changes to the Hospital Inpatient Quality Reporting (IQR) Program, including one that has a significant impact on care that we deliver to patients in the emergency department (ED). Specifically, CMS is proposing to eliminate the electronic clinical quality measure (eCQM) version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure starting in the calendar year (CY) 2024 reporting period.

ACEP STRONGLY OPPOSES this proposal and requests that CMS retain the measure in the Hospital IQR program. ED boarding represents one of the single greatest threats to patient safety in the ED setting. Unlike other clinical areas for which multiple measures may exist, ED-2 is the only measure of this ubiquitous challenge.

In the rule, CMS relies on just a few studies to justify its decision to remove the measure under factor 8 for removing measures from the program--"The costs associated with a measure outweigh the benefit of its continued use in the program."

Specifically, CMS relies heavily on one meta-analysis by Boudi, et al.[1] that looked at 12 studies that did not find a clear association between ED boarding and in-hospital mortality. CMS goes on to state that "Boudi's systematic review is consistent with previous research finding conflicting results related to the association between ED crowding and inpatient mortality," [2] Finally, CMS makes an argument that the costs of maintaining the measure outweigh the benefits.

ACEP disagrees with CMS' assessment of the studies and its ultimate conclusion. Boarding in the ED is a significant issue that must continue to be tracked diligently—especially now as ED volume is beginning to increase again after a large drop in visits at the early stages of the COVID-19 public health emergency. A 2016 report that ACEP conducted found that over 90 percent of EDs routinely reported crowded conditions—which directly leads to boarding.[3] Although CMS believes that there is not a clear linkage between boarding and patient mortality, there is ***indisputable evidence*** showing the opposite to be true. Many of the studies CMS reviewed did, in fact, show an association between ED boarding time and inpatient mortality. In fact, the Boudi, et al. meta-analysis concludes by stating that its "systematic review highlights a clear and shared message delivered by all authors, which is that EDB (ED boarding) may cause harm to patients waiting for an in-hospital bed. The authors emphasize the absolute necessity to implement efficient interventions to minimize EDB."[4]

Further, in Appendix A, we include nearly 70 studies and other resources that demonstrate the linkage between boarding and patient morbidity and mortality. These references show that ED crowding leads to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED and higher overall health care costs. Some of the studies also demonstrate that boarding of psychiatric patients in EDs is particularly prevalent. Unfortunately, many times psychiatric services are not provided to these patients while they are being boarded. Due to its loud and chaotic nature, the ED environment can exacerbate any underlying conditions— and boarded patients tend to have higher rates of psychotic and personality disorders and are more likely to require physical restraints and seclusions.[5]

ACEP would appreciate the opportunity to meet with CMS to walk through the highlights of these studies.

With respect to CMS' argument regarding the administrative costs of maintaining the measure, ACEP notes that hospitals have been reporting the measure for years (and it is a commonly reported-on measure), and since it is purely an electronic measure, the costs of reporting are not high. The data utilized for this measure are all elements of common data feeds and value sets promoted by CMS. ED-2 is a model measure that demonstrates how eCQMs can improve measure validity and reduce measurement burden in comparison to prior, limited chart abstracted versions.

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[1] Boudi Z, Lauque D, Alsabri M, Ostlundh L, Oneyji C, Khalemsky A, et al. (2020) Association between boarding in the emergency department and in-hospital mortality: A systematic review. PLoS ONE 15(4): e0231253. https://doi.org/10.1371/journal.pone.0231253.

[2] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program. 86 Fed. Reg. 25581 (May 10, 2021).

[3] American College of Emergency Physicians. "Emergency Department Crowding." May 2016. https://www.acep.org/globalassets/sites/acep/media/crowding/empc_crowding-ip_092016.pdf.

[4] Boudi, et al.

[5] Nordstrom, K; Berlin, J; Nash, Sara Siris; Shah, Sejal B.; Schmelzer, Naomi, A; Worley, Linda L.M. "Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document." West J Emerg Med. 2019 Sep; 20(5): 690–695. Published online 2019 Jul 22. doi: 10.5811/westjem.2019.6.42422.

While we do not have any quantifiable data that shows what the cost is of reporting the measure, given the clear benefits of tracking and trying to mitigate ED boarding, we think the benefits definitely outweigh any costs.

In all, we believe that ED-2 is an extremely important measure, and its removal could have a detrimental impact on patient care. Again, we strongly urge CMS not to finalize the proposal.

Hospital Value-based Purchasing Program

In the rule, CMS proposes modifications to multiple hospital quality programs, including the Hospital Value-Based Purchasing Program (HVBP), Hospital Readmissions Reduction Program, and Hospital-Acquired Condition Reduction Program. Due to the COVID-19 pandemic, CMS proposes to suppress most measures under the HVBP Program in FY 2022. Therefore, hospitals will not receive a HVBP score and will not be eligible for any positive or negative payment adjustments based on their performance in the program.

ACEP supports this proposal, but requests that CMS, in the CY 2022 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, clarify how this proposal, if finalized, would impact the facility-based scoring option under the Merit-based Incentive Payment System (MIPS). Under MIPS, many hospital-based clinicians, like emergency physicians, are eligible for this option. If they do qualify, they can receive the quality and cost performance score for their hospital through the HVBP Program. Hospital-based clinicians still have the opportunity to report quality measures through a traditional mechanism, such as a qualified clinical data registry (QCDR)—and CMS will automatically take the higher of that quality score and the facility score when determining clinicians' final MIPS performance score.

While many hospital-based clinicians do report traditionally through MIPS and do not solely rely on the facility-based scoring option, some clinicians, especially those in small practices and those located in rural areas, do count on the facility-based scoring option in order to receive a MIPS performance score. In some cases, these clinicians do not have the resources or technological capability to report quality measures through an electronic health record, registry, or QCDR.

Since there will be no HVBP score in FY 2022, it is unclear what will happen with the facility-based scoring option. In order to protect hospital-based clinicians that depend on this option, ACEP believes that CMS should ensure that hospital-based clinicians have a viable opportunity to utilize it even if this means altering existing policies to exclude FY 2022 HVBP scores from being used for determining a MIPS-eligible clinician's facility score. If CMS is not able to use other data to determine a facility score, then CMS should create a hold harmless provision to ensure that hospital-based clinicians are not penalized and do not receive a downward adjustment simply because a facility score is not able to be calculated.

Graduate Medical Education

CMS is implementing provisions of the Consolidated Appropriations Act of 2021 relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs—including distributing 1,000 new Medicare-funded medical residency positions. The agency plans to distribute 200 slots a year over a five-year period starting in 2023. The first round of applications for hospitals to apply for the slots are due on January 31, 2022. CMS proposes to only distribute 1 full time equivalent (FTE) slot to a hospital at a time.

There are no restrictions on what residency programs can be funded—they can be new or existing programs and they can be for any specialty. However, in line with the statute, CMS will prioritize applications from hospitals that fall into specific categories:

- Hospitals that are located in rural areas;
- Hospitals currently training residents above FTE cap;
- Hospitals located in states with new medical schools or campuses; and
- Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs).

ACEP appreciates CMS' attempt to distribute the slots in a fair and equitable way as well as the agency's commitment to improving access to care in rural and underserved areas. Thus, we support CMS' proposal to prioritize applications from hospitals that will use the additional residency positions in residency programs serving underserved populations. We also fully endorse CMS' proposal to target primary care or mental health population HPSAs. While we recognize that the statute does not distinguish between physician specialties for purposes of allocating the additional residency positions, we believe that CMS should fund primary care residency programs and programs for any other specialties for which there is a shortage of physicians.

ACEP also has a technical comment on CMS' distribution methodology. Although we understand that CMS proposed the 1 FTE per hospital per year limit to help ensure that the maximum number of hospitals can receive a slot, we believe that CMS should modify its proposal to ensure that hospitals applying for slots can build and maintain stable residency programs. Specifically, we believe that if CMS accepts an application from a hospital, it should guarantee at least three FTE positions (one FTE per year over three years) without requiring hospitals to reapply for additional FTEs every year. Providing this guarantee would give hospitals a more reliable funding mechanism that they need to grow their residency programs.

Median Payer-specific Negotiated Charge Information

In the proposed rule, CMS is proposing to repeal its policy established in last year's rule to use median payer-specific negotiated charge information collected on Medicare cost reports for the purposes of calculating Medicare Severity Diagnosis Related Group (MS-DRG) relative weights. This new methodology was set to begin in FY 2024. Hospitals will also not have to report the median payer-specific negotiated charge on their Medicare cost reports by MS-DRG that the hospital has negotiated with all of its Medicare Advantage payers.

ACEP supports this proposal, but we still have underlying concerns with the hospital reporting policies that became effective at the start of the year. Although we believe patients deserve meaningful information about the price of their healthcare, CMS' policies are unnecessarily burdensome, detract from the relevant patient cost-sharing information, and have unintended effects on the market as providers and payers are pressured to negotiate basic fee schedules. The requirement to disclose rates could eventually lead to anticompetitive behavior by payors once they are aware of the rates that its competitors have negotiated. Numerous legal complications will likely arise from hospitals attempting to meet the requirements to disclose privately negotiated rates with private payers. CMS does not fully address these factors in its regulations, including the fact that many current provider-payor contracts include non-disclosure agreements regarding the negotiated rate. Even though these policies have already been finalized, we ask that CMS refine its overall price transparency strategy.

Promoting Interoperability Programs

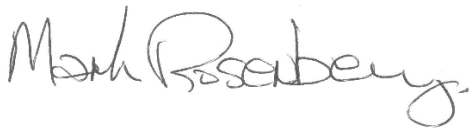
For CY 2023, CMS proposes an electronic health record (EHR) reporting period of a minimum of any continuous 90-day period for new and returning participants (eligible hospitals and critical access hospitals [CAHs]) in the Medicare Promoting Interoperability Program. ACEP supports a 90-day reporting period for hospitals and CAHs

and hopes that CMS will maintain the same reporting period length for other health care providers participating in the Promoting Interoperability (PI) category of the Merit-based Incentive Payment System (MIPS).

However, we do not support CMS' proposal to increase the reporting period to 180 days starting in CY 2024. We believe that a 90-day reporting period is the appropriate length of time needed to ensure that hospitals are meeting all the objectives of the program, while at the same time not posing an undue burden on these facilities. Thus, we strongly urge CMS to retain a 90-day reporting period for the foreseeable future.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,



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ACEP President

Appendix A: References Related to ED Boarding

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