Emergency Department EDPMA Practice Management Association

September 13, 2022

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1772-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: **Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating (CMS-1772-P)**

Dear Administrator Books-LaSure:

On behalf of the Emergency Department Practice Management Association (EDPMA), I appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS') calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (OPPS) and Rural Emergency Hospitals proposed rule.

EDPMA is the only professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all ownership models and sizes, many of whom serve rural communities, 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 146 million patients that visit U.S. emergency departments each year.

Our comments are focused on the proposed Rural Emergency Hospital (REH) provisions.

REH PAYMENT POLICIES

1. Covered Outpatient Department Services Performed by REHs

Per the statutory provisions related to REHs, CMS proposes to implement payment for services performed by REHs. This includes that "REH services" shall be paid at an amount that would otherwise be paid in the hospital outpatient department (OPD) for covered OPD services increased by 5 percent. In addition, beneficiary cost-sharing will not apply to the 5 percent

increase in payments. CMS proposes to define "REH services" as all covered outpatient department services "that would be paid under the OPPS when provided in a hospital paid under the OPPS for outpatient services."

While CMS seeks input on whether it should define "REH services" more narrowly, ***EDPMA recommends that CMS define "REH services" more broadly in order to implement these regulations more in line with Congressional intent.*** As you know, the REH-designation is limited to those facilities that were already in existence as rural hospitals and Critical Access Hospitals (CAHs) and the intent of the legislation is to ensure basic access to emergency services in the communities where these facilities exist. Further, under the CAH Method II optional reimbursement model, professional services are reimbursed at 115% of the physician fee schedule reimbursement rate.

Throughout the REH proposals (both here and in the REH Conditions of Participation proposed rule), CMS remains silent on reimbursements for professional services under the Medicare Physician Fee Schedule. While this may be due to an assumption that professionals will use standard billing protocols at the Medicare Physician Fee Schedule rates as occurs at rural hospitals and under CAH Method I, ***EDPMA is concerned that allowing the 115% CAH Method II reimbursement to lapse for the facilities that convert to REH status will undermine the intent of the statute that authorizes REHs.*** REHs will not just be buildings. They will be health care providers to their communities that are staffed by health care professionals serving the patients who are treated at those facilities. By limiting the definition of "REH services" to services payable under the OPPS, we are concerned that, certainly for those CAHs currently reimbursed under Method II, the proposal will exacerbate workforce issues in rural settings and critical access hospitals that are eligible to convert to a REH. To ensure that the goals of the statute are met, ***EDPMA recommends that CMS modify its proposal so as to reimburse the professional (and not just the facility) claim for outpatient services at 105% of traditional fee-for-service payment.*** We believe that this will support the goals of the legislation creating the REH designation and provide rural communities with the resources that are needed to ensure the presence of a work force that can meet the community's needs. Regardless, ***EDPMA also recommends that CMS issue explicit guidance about the Medicare Physician Fee Schedule claims submission process for professional services delivered in the REH setting.***

2. <u>Monthly REH Facility Payment</u>

CMS makes several proposals to create the methodology for determining the monthly REH facility fee as directed by statute. According to those statutory provisions, the REH monthly payment is determined by:

- For 2023, Calculating the total amount that was paid to all CAHs in 2019 minus that which would have been paid to CAHs in 2019 if payment were made for inpatient hospital, outpatient hospital, and SNF services
- Dividing that number by the number of CAHs enrolled in Medicare in 2019
- Dividing that number by 12
- For 2024 and subsequent years, the amount of the monthly facility payment from the previous year increased by the hospital market basket percentage increase.

As you know, the current CAH reimbursement currently relies on a cost-based reimbursement methodology. This cost-based framework includes the costs associated with CAH ER Availability Cost (i.e., "amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility."[1]). CMS continues to outline the parameters for including "Emergency Department Physician Availability Services Costs" in its Provider Reimbursement Manual.[2]

In order to effectuate the spirit of the statute and to ensure that the methodology for the Monthly REH Facility Payment does not inadvertently create a disincentive for CAHs to convert to REH status when it would otherwise be in the best interests of the community, ***EDPMA requests that CMS explicitly include these costs as part of its methodology for calculating Monthly REH Facility Payments or, in the alternative, to administer this funding to REHs via a mechanism that will allow REHs to dedicate these resources to staffing their emergency departments.*** As CMS alludes to in the proposed rule, the policies finalized should seek to avoid scenarios where "a CAH converting to a REH would face a substantial reduction in Medicare payment if it converted to a REH."[3] ***EDPMA believes that ensuring access to already-existing CAH support for ED physician availability costs is critical for REH financial sustainability.***

REH ENROLLMENT POLICIES

CMS makes a series of proposals to guide the enrollment process for eligible CAHs and rural hospitals to convert to REH status. EDPMA wishes to highlight two key components of those enrollment policies. First, CMS proposes to allow facilities to complete the "change of information" enrollment form (rather than the "initial enrollment" form) when converting to a REH. Second, CMS proposes to place REHs in the "limited risk" category with hospitals, CAHs, VA hospitals, and other federally owned hospital facilities, which affects the level of review to which the facility is subjected at enrollment. ***EDPMA applauds CMS on its proposals to allow REH utilization of the "change of information" enrollment form and for REH placement in the "limited risk" screening category.*** We believe these efforts will help aid CAH and rural hospital conversion to REHs where desired, and we commend the Agency on efforts to reduce unnecessary administrative burden for providers.

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON) POLICY FOR REHs

Hospitals and CAHs are subject to statutory requirements mandating the provision of a "written notification and an oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours,"[4] indicating that the patient is an outpatient and

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[1] Noridian Healthcare Solutions, *Critical Access Hospital ER Availability Cost*, https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/cah-er (accessed August 31, 2022).
[2] CMS, *Allowability of Emergency Department Physician Availability Services Costs,* Provider Reimbursement Manual, Chapter, 15-1, Section 2109.3.C.
[3] 87 Fed. Reg. 44,780 (July 26, 2022).
[4] 87 Fed. Reg. 44,789 (July 26, 2022).

not an inpatient and the implications of that patient status. This notice is referred to as the Medicare Outpatient Observation Notice (MOON). Because REHs are not statutorily defined as a "hospital" and because REHs will have no inpatient service from which to distinguish their outpatient care, CMS proposes that REHs will not be required to provide the MOON to patients under observation status. ***EDPMA encourages CMS to finalize its proposal that the MOON will not be required for use in the REH setting***. We commend the Agency on efforts to reduce unnecessary administrative burden for providers.

PHYSICIAN SELF-REFERRAL UPDATES: REH OWNERSHIP/INVESTMENT INTEREST EXCEPTION

CMS makes several proposals to account for the existence of REHs in the already existing physician self-referral regulations (i.e., "the Stark regulations"). CMS proposes to amend the Stark regulations so that the definition of "entity" includes REHs. CMS also proceeds to create a new Stark exception specifically for REHs, the "REH Exception" premised on the "Whole Hospital" exception and the physician-ownership exception for rural hospitals. CMS states its belief that a specific REH exception is necessary because the already existing related exceptions are directed at "hospitals," and an REH is not statutorily categorized as a "hospital." CMS also states that it believes the exception is necessary because, without an applicable exception (with safeguards) for physician ownership interests in an REH, CMS policies could contradict the access policy goals that the creation of the REH designation was designed to achieve.[5] ***EDPMA applauds CMS decision to ensure that physician REH ownership and investment interests are specifically safeguarded through a new exception.*** We agree with CMS' sentiment that without these protections, ownership and investment resources that some physicians provide to rural facilities could inadvertently become prohibited, having a negative effect on the ability of rural facilities to continue to provide services. With workforce shortages of specialty physicians continuing to impact access to care across the country, these investment and ownership opportunities can also become valuable recruitment and retention tools. It would be unfortunate if REHs did not have access to the same physician ownership/investment protections that other facilities have under the Stark regulations, which would place REHs at a competitive recruitment/retention disadvantage and thus impact the community's access to quality health care. We agree with both CMS' policy and approach and request that the Agency continue to explore additional methods to provide facilities with physician recruitment and retention tools while safeguarding beneficiaries and program integrity.

REH QUALITY REPORTING (REHQR) PROGRAM

Under statute, CMS is also required to establish quality measurement reporting requirements for REHs, which may include the use of a small number of claims-based measures or patient experience surveys. An REH must submit quality measure data to CMS, and the agency shall establish procedures to make the data available to the public on a CMS website.

[5] *See,* 87 Fed. Reg. 44,791 (July 26, 2022).

EDPMA appreciates that CMS seeks to adopt a concise set of impactful, reliable, accurate, and clinically relevant measures for REHs, and we support CMS' goal of selecting measures that will inform consumer decision-making regarding care and further quality improvement efforts in the REH setting. ***However, we are concerned about the list of potential measures under consideration for this program, which largely consists of current or past Hospital Outpatient Quality Reporting (OQR) Program measures and does not accurately reflect care in REH settings***. Attempting to retrofit existing measures to apply to this setting is like trying to apply the same standards of care to a war time unit and an urban hospital. REHs are simply not the same as other hospitals, or even other emergency departments, in terms of patient populations, resource availability and accessibility, staffing, and clinical and financial priorities. For example, CMS proposed through its separate REH Conditions of Participation (CoP) rule that an REH would not be required to have a doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant physically present at REHs at all times. If finalized, this policy could set REHs up for failure on measures such as OP-22: Left Without Being Seen, which measures the percentage of patients who left the ED before being evaluated by a physician, advanced practice nurse, or physician assistant, and OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional, which measures the mean time between patient presentation to the ED and the first moment the patient is seen by a qualified medical person for patient evaluation and management. Measures of time, including OP-20, but also OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival, OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention, and OP-18: Median Time from ED Arrival to ED departure for Discharged ED Patients, are similarly inappropriate for a setting that is expected to face significant resource constraints at multiple levels. If these and other Hospital OQR measures are applied using the same standards that are used for other hospitals, REHs will inevitably appear as poor performers, which does nothing to address one of CMS' top priorities, which is to promote more equitable care.

EDPMA strongly urges CMS to rethink its approach to measuring quality in REHs. To date, the Hospital OQR Program measures have imposed a heavy administrative burden on Emergency Departments relative to their impact on quality and this dynamic is only expected to worsen in the REH setting. ***We recommend that CMS look beyond the OQR measures and instead work with clinical and patient stakeholders to develop a new, custom set of measures that better reflects the unique challenges associated with providing care in the REH setting***. These measures should focus on principles such as access and more feasible outcomes, such as whether the patient visited another ED within 24-48 hours, rather than throughput. ***EDPMA also requests that CMS not finalize a set of quality measures for REHs until it has a better sense of the number of hospitals that actually convert to an REH and their characteristics.***

When thinking through a novel approach to quality measurement in this setting, CMS might need to abandon traditional methodologies and norms in order to account for factors that are unique to REHs. We encourage CMS to keep the following considerations in mind:

- Burden: REHs will be smaller hospitals that have limited resources compared with larger hospitals in metropolitan areas. As such, certain measures, particularly those that are chart abstracted, may be more burdensome than other measures to report. CMS must keep front and center the fact that REHs are intended to fill gaps in environments where hospitals have been unable to sustain themselves. CMS should proceed cautiously when

applying measures to this setting and ensure that the very action of measurement does not, in and of itself, result in a diversion of resources that negatively impacts patient quality and experience of care.

- Case numbers: Most REHs will lack sufficient case volume to ensure that performance rates on individual measures are reliable. Achieving case numbers with clinical significance is currently extremely challenging in CAHs and is expected to impose an even greater challenge in REHs. CMS must consider more flexible approaches for this setting and potentially discard the whole concept of requiring facilities to report on a minimum number of cases to get credit for a measure. CMS should instead encourage REHs to report whatever data they have, relying on a pay-for-reporting (P4R) approach rather than a pay-for-performance approach (P4P), which will help to eventually generate a more complete picture of the quality of care being provided in this setting.
- Performance standards: As noted above, we believe a P4R approach is more appropriate for this setting than a P4P approach. Not only will REHs face unique circumstances that make it more challenging to accurately measure and compare performance, but they also are a brand-new provider type with no historical data on which to compare them to. CMS cannot expect normative performance where there is not already an existing provider type.

Congress authorized REHs to ensure that patients can maintain access to essential health care services and to help reduce disparities in rural communities. CMS has similarly expressed its support for REHs in fulfilling its commitment to advancing health equity and access to high-quality, person-centered care. Unfortunately, the set of quality measures under consideration for the REHQR Program does not align with the stated goals of Congress and CMS. ***EDPMA urges CMS to reconsider its approach to measurement in this setting and to carefully consider the unique circumstances facing REHs.***

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Again, we appreciate the opportunity to provide input the CY 2023 OPPS/REH proposed rule. If you have any questions or we can provide any additional information, please do not hesitate to contact EDPMA Executive Director, Cathey Wise at cathey.wise@edpma.org.

Sincerely,

Don Powell, DO, FACEP
EDPMA
Chair of the Board