Emergency Department EDPMA Practice Management Association

September 11, 2023

Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1786-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction (CMS-1786-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' calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) 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.

Hospital Outpatient Quality Reporting Program (OQR)

Removal of OP-22: Left Without Being Seen

CMS proposes to remove the measure, OP-22: Left Without Being Seen, from the Hospital OQR Program beginning with the CY 2024 reporting period/2026 payment determination. This measure, which was first adopted for this program in 2011, assesses the percent of patients who

leave the emergency department (ED) without being evaluated by a physician, advanced practice nurse, or physician's assistant. CMS originally adopted this measure because it felt that left without being seen (LWBS) was an appropriate indicator of ED overcrowding. However, over the last few years, routine measure monitoring has indicated limited evidence linking the measure to improved patient outcomes and that LWBS rates may reflect other factors rather than systemic issues within the ED (e.g., insufficient community resources, poor access to timely clinic-based care, poor staffing, etc.). Although CMS believes that ED performance and care are important topic areas for the Hospital OQR Program, it also believes that the existing OQR Program ED-throughput measure, OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients, is more suitable for measuring ED performance.

EDPMA appreciates CMS' recognition of the fact that LWBS rates may reflect other factors rather than systemic issues within the ED. Nevertheless, it is still critical to monitor the frequency of this event as one piece of a larger puzzle that will help us to better understand its causes and minimize its occurrence. Furthermore, data collection on this practice will help lend transparency to the issue, which might in turn result in greater resources being invested in potential solutions.

According to data presented at EDPMA's recent Solutions Summit conference, emergency encounter volumes have rebounded since the pandemic to new record levels and wait times and crowding have become worse than ever. Findings reported at this Summit include:

- Overall emergency department volumes have rebounded to new record levels, with 155 million visits in 2022 and a projected 160 million visits in 2023. Because of the unavoidable demographic pressures caused by the aging baby boomer generation, visits are expected to reach 180 million visits by 2028. About 80% of these patients arrive as "walk-ins" with about 20% arriving by pre-hospital Emergency Medical Services (EMS). ED patients that then get admitted account for over 65% of hospital inpatient stays across the country.
- The marked decrease in available staff, particularly nurses, has resulted in many inpatient beds being unavailable to emergency patients requiring admission for inpatient care. These patients spend prolonged periods of time "boarding" in the emergency department, which in turn reduces the number of treatment rooms available for new emergency patients. The end result is that patient flow is awful, creating increased stress for both patients and staff.
- The ED Median Boarding Time increased from 121 minutes in 2020 to 192 minutes in 2022 and is trending even higher in 2023. It is not uncommon for high volume EDs to average 50 or more boarding patients in their emergency department. The number of patients that leave emergency departments before treatment is complete has more than doubled in the past 4 years, to the highest level ever at 4.6% in 2022. And again, this metric is trending even higher in 2023.[1]

There is ample evidence that boarding harms patients and leads to worse outcomes, compromises to patient privacy, increases in medical errors, detrimental delays in care, and increased mortality, as noted in a letter aimed at bringing attention to this crisis that was signed

[1] https://www.emopti.com/emopti-blog/ed-care-landscape-2023-data-shows-crowding-problems-are-worse-than-ever

by 30 stakeholders and sent to the President in November.[2] The letter goes on to note that boarding and ED crowding lead 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.[3]

With ED boarding rates trending higher and the repercussions being so serious and far-reaching, EDPMA strongly urges CMS to maintain measure OP-22: Left Without Being Seen in the Hospital OQR. We believe OP-22 captures a distinct data set that is different, but equally as valuable as OP-18. Preserving OP-22 would ensure the ongoing collection of national data on this critical issue, which would help paint a more complete picture of the causes and impact of ED boarding, which in turn could help incentivize investments in more targeted solutions.

Public Display of measure OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-18 was adopted for reporting in the Hospital OQR Program beginning with the CY 2013 payment determination. The measure is calculated in stratified subsections for certain types of patients:

- Median Time for Discharged ED Patients- Reported Measure, which excludes psychiatric/mental health and transferred patients;
- Median Time for Discharged ED Patients- Psychiatric/Mental Health Patients, which includes information only for psychiatric/mental health patients;
- Median Time for Discharged ED Patients- Transfer Patients, which includes information only for patients transferred from the ED; and
- Median Time for Discharged ED Patients- Overall Rate.

Currently, measure data for the Median Time for Discharged ED Patients- Transfer Patients and Median Time for Discharged ED Patients- Overall Rate are not reported publicly on the Care Compare site. Measure data for the Median Time for Discharged ED Patients-Reported Measure is currently publicly displayed on the Care Compare site and in the corresponding downloadable data file for the Hospital OQR Program. CMS also collects and reports Median Time for Discharged ED Patients Psychiatric/Mental Health Patients for public awareness of behavioral health gaps in the transfer of such patients. In the CY 2018 OPPS/ASC final rule, CMS adopted a policy to publicly report these stratified behavioral health data beginning in July 2018 using data from patient encounters during the third quarter of 2017. CMS now believes displaying all strata will highlight and prioritize various issues in the health care system, specifically behavioral health and continuum of care.

[2] https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

[3] https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

As such, beginning with the CY 2024 reporting period, CMS proposes to make data publicly available on its Care Compare website and in downloadable data files found at data.cms.gov for the following chart- abstracted measure strata:

- Median Time for Discharged ED Patients-Transfer Patients and the Median Time for Discharged ED Patients- Overall Rate, which contains data for all patients.

EDPMA supports CMS' proposal to publicly report all strata associated with OP-18. EDPMA agrees with CMS that publicly reporting these measure stratifications can elucidate ED throughput performance gaps for patients requiring higher levels of specialized care above what a facility is able to or provide. This is especially important as the ED is starting to see more mental health and substance abuse patients in relation to overall volume of patients than we have in past. Publicly reporting OP-18 gives visibility to issues in the ED, which in turn helps to funnel resources towards solutions.

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Again, we appreciate the opportunity to provide input on this 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,

Andrea Brault, MD, MMM, FACEP
Chair
Emergency Department Practice Management Association