

June 15, 2022

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

CMS-1771-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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) proposed rule. Our comments are limited to those proposals that affect emergency physicians and the patients we serve.

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Quality Reporting/Performance Programs

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 measures under the HVBP Program in FY 2023. CMS instituted a similar policy last year, and hospitals again 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 is disappointed that CMS again has decided to eliminate 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, may count on the facility-based scoring option in order to receive the best possible 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 qualified clinical data registry (QCDR). In addition, there are other circumstances where hospitals are simply not sharing electronic health record (EHR) data elements that are necessary for MIPS reporting with QCDRs. In fact, a substantial number of emergency physicians that use ACEP's QCDR, the Clinical Emergency Data Registry (CEDR), to report quality measures are unable to receive any data from their hospitals. Without these data elements, the quality measures cannot be fully calculated and scored. Hospitals may claim that they cannot share the data for privacy and security purposes, but there are no regulations that impede hospitals from doing so. Thus, these hospital-based clinicians may also need to rely on the facility-based scoring option unless CMS takes more concrete steps going forward to help improve data exchange between hospital EHRs and registries.

Since there will be no HVBP score again in FY 2023, CMS states in the rule that the facility-based scoring option will not be available for the second year in a row. In order to protect hospital-based clinicians that depend on this option, ACEP strongly believes that CMS should reverse that decision and provide hospital-based clinicians a viable opportunity to utilize this option. CMS could consider using an HVBP score from a prior year in order to determine 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.

IPPS Payment Adjustment for N95 Respirators that Are Wholly Domestically Made

ACEP appreciates CMS recognizing the shortage of personal protective equipment (PPE), including N95 respirators, that existed at the beginning of the COVID-19 public health emergency (PHE), as well as CMS' effort to determine how to address this issue for future pandemics. Insufficient PPE and other ancillary medical supplies in the initial stages of the COVID-19 PHE resulted in a notable amount of contention and animosity between different hospital services (e.g., emergency department vs. inpatient ward vs. critical care units), healthcare staff, and hospital administrators, as well as healthcare personnel and the Centers for Disease Control and Prevention (CDC). Multiple incidents occurred in which hospital administrators did not allow healthcare staff to utilize personally acquired PPE to supplant that which the hospital was conserving or could not supply. Therefore, healthcare workers were given the impossible choice of going without sufficient protection or reporting insufficient protection and potentially facing retaliation.

[Current standards](#) established by the Occupational Safety and Health Administration (OSHA) around PPE require employers to implement "PPE programs." These programs should "address the hazards present; the selection, maintenance, and use of PPE; the training of employees; and monitoring of the program to ensure its ongoing effectiveness." Unfortunately, some emergency physicians have found that the PPE programs instituted by hospitals during the pandemic have failed to protect them from the virus. First, many hospitals did not supply their employees with a sufficient level or amount of PPE, requiring healthcare workers to reuse PPE beyond their intended use. While supply chain issues contributed to this practice initially, the reuse of PPE continued even after these supply issues were resolved. Second, as alluded to above, many of these PPE programs made it extremely difficult for healthcare workers to use their own PPE. Although usage of a healthcare worker's own PPE was technically allowed, hospitals would create numerous steps and hurdles before officially approving the practice. Lastly, there were concerns over the PPE properly fitting healthcare workers. Hospitals often changed the brands of PPE that were used, and there has not been sufficient fit testing of supplies to ensure that the PPE have been properly worn.

Given these issues with PPE programs, ACEP does not think that providing an IPPS adjustment to account for the increased cost of domestically made NIOSH-approved surgical N95 respirators would entirely solve the problem. While this policy may help address any PPE supply challenges that may come about in a future pandemic, it would not address the other issues unrelated to the supply chain that health workers have experienced receiving high-quality PPE from hospitals. Therefore, ACEP encourages CMS to work with OSHA to ensure that healthcare workers have the flexibility they need to feel properly protected during future pandemics or COVID-19-driven surges.

Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs—Request for Information

As safety net clinicians, emergency physicians see every day how disparities in healthcare access and affordability affect healthcare outcomes. It is well documented that racial and ethnic minorities represent a disproportionate share of patients in the emergency department (ED) and are more likely to rely on emergency care for both time-sensitive and non-urgent care needs.¹ We also recognize that much more work needs to be done to address these disparities. Thus, we appreciate CMS' ongoing effort to assess how best to measure healthcare disparities and report those results to healthcare providers. We agree with CMS that quality measures and their application to quality improvement initiatives and programs represent a critical opportunity to incentivize healthcare providers and systems to advance health equity.

As CMS continues this important work, ACEP offers the following points to consider:

- ***Ensuring Data are Accurate and Meaningful:*** ACEP believes that in order to effectively stratify quality measure results by race and ethnicity, there must first be assurance that such data are accurate and collected in a way that allows for their meaningful use. Granular demographic data as related to race and ethnicity (e.g., specifying discrete categories of Asian Americans like Korean American and Filipino American rather than a monolithic Asian American racial designation) provides the degree of detail necessary to effectively understand differences and set meaningful policy.
- ***Accounting for Social Risk Factors:*** Quality measures should account for risk factors such as lack of access to food, housing, and/or transportation that affect patients' ability to adhere to treatment plans. As emergency physicians, we see patients from all backgrounds who have various social risk factors. Many interventions are being employed in the ED to help identify barriers to health such as transportation and access to food and housing. One such tool that ACEP supports to help manage care for patients with complex needs is the Collective Medical Technologies' (CMT) Edie™ (a.k.a. PreManage ED) software. Edie™ is an information exchange that provides critical information on patients, such as how many ED visits patients have had in the last year, where they presented, their drug history, other providers who are involved with the patients, and finally, whether there is a patient-specific care management plan that could guide treatment. The platform improves patient care by allowing emergency physicians to make more informed clinical decisions and better direct a patient's follow-up care. It also lowers healthcare costs through a reduction in redundant tests and through better case management, which reduces hospital readmissions. Through an alliance with CMT, ACEP has seen this system mature in approximately 17 states. Washington state, in the first year alone, experienced

¹ Richardson LD, Norris M. Access to Health and Health Care: How Race and Ethnicity Matter: ACCESS TO HEALTH AND HEALTH CARE. *Mt Sinai J Med.* 2010;77(2):166-177. doi:10.1002/msj.20174.

a 24 percent decrease in opioid prescriptions written from emergency departments, a 14 percent reduction of super-utilizer visits, and state Medicaid savings of more than \$32 million.²

Some EDs across the country are attempting to create care coordination and case management programs that help improve follow-up appointment scheduling from the ED and target social interventions and primary medical care to high ED utilizers. One such program in Maryland applies mobile technology to use paramedics in a community health worker role to follow up on discharged patients at risk for readmission.³ Many of these patients are Medicare beneficiaries. Another program in the East Bay, California has a help desk for health-related social needs with four integrated medical-legal partnerships, called Health Advocates, to help patients navigate housing and transportation challenges, immigration challenges, and benefit eligibility.⁴ ACEP is continuing to explore other innovative ways our physicians can help coordinate care for high-risk patients, including through participation in alternative payment models.

- ***Accounting for Bias:*** Universal race and ethnicity data collection is a fundamental prerequisite for disparities quality measurement. We believe that patient self-reported race and ethnicity data should be collected through use of standardized surveys and questionnaires. Use of surveys and questionnaires to capture race and ethnicity data should incorporate adequate training to ensure data collection is culturally competent and respectful. Patients should be informed that demographic data will be used exclusively to improve the quality of care and not to limit access to care. If such data are unavailable, ACEP also does not think that estimating an individual's race and ethnicity based on name and geography is appropriate. Women and children often take the names of their husbands and fathers, respectively. Particularly for women, estimating one's race/ethnicity based on surname simply does not make sense. Such estimation would also be insufficient for adopted individuals who take their adoptive family's surname. If CMS plans to use proxies for race and ethnicity data to help identify and address inequities in care delivery and health outcomes, it must incorporate robust mechanisms by which to check conclusions. Routine audits of such processes and conclusions would also be ideal in order to discover and correct errors expeditiously.
- ***Attribution of Quality Measures:*** A critical consideration of quality measure development is measure attribution, or the process of selecting a patient population for which a group or entity will be held accountable for providing appropriate health services and achieving adequate health outcomes. ACEP encourages evaluation at the *clinician group level* in order to ensure that gaps are fairly attributed to entities with adequate agency to be responsible and accountable for outcomes.
- ***Accounting for Under-Resourced Facilities:*** There should be sensitivity, and perhaps an actual formulaic coefficient applied, when evaluating under-resourced facilities to ensure some congruency between their quality performance relative to facilities with more resources. CMS should consider adjusting programmatic requirements to ensure that reporting on quality measures is feasible for all facilities and that under-resourced facilities do not face undue difficulty or burdensome penalties that could affect access to care for vulnerable populations.

² <https://www.acepnow.com/article/emergency-department-information-exchange-can-help-coordinate-care-highest-utilizers/2/>

³ For more information on the Maryland Mobile Integrated Health Care Programs, please go to

<https://www.miemss.org/home/LinkClick.aspx?fileticket=w-K7gG-8teo%3D&tabid=56&portalid=0&mid=1964>

⁴ For more information on the Health Advocates Program, please go to <http://www.levittcenter.org/ed-social-welfare-in-collabor/>.

- ***Minimizing Variation:*** While CMS states that there should be some discretion to individual facilities to use quality measures in a way that most benefits their populations, there should be clear guidelines, suggestions, and guardrails in place to minimize variation amongst facilities. Providers who treat less-resourced, more diverse patient populations may lag in collecting data compared to providers who treat less diverse patient populations. Particular attention should be paid to support institutions with limited resources that serve a large volume of historically disadvantaged patients in acquiring health information technology that supports adequate data collection for quality improvement. Health systems and provider groups must also be cautious that disparities measurement does not lead to other unintended or adverse consequences such as provider selection or avoidance of certain patient populations.

Medicare Promoting Interoperability Program

CMS is proposing to require the reporting of the Query of Prescription Drug Monitoring Program (PDMP) measure as part of the Medicare Promoting Interoperability Program and to expand the measure to include Schedule II, III, and IV drugs starting in calendar year 2023.

ACEP is concerned with CMS' proposal to mandate and expand this measure simultaneously. We have historically supported CMS' proposals to keep the reporting of this measure optional. While ACEP believes that PDMPs play an important role in identifying high-risk patients and recognizes that PDMPs are becoming more widely available, we still think that CMS should move slowly to allow sufficient time for PDMPs to become fully integrated into clinicians' electronic health records (EHRs) and their workflow. We support effective and interoperable PDMPs that push prescription data to emergency physicians, rather than requiring them to separately sign into and pull the data from the PDMP. Although all states host PDMPs, some states have not made commitments to make their PDMPs state-of-the-art, and as a result, they are cumbersome, may not contain real-time data, and contain potentially unreliable information. In addition, patients may cross state lines for care, and not all states are part of InterConnect, which shares interstate information about dispensed prescriptions.

If CMS goes forward and finalizes this proposal, we believe that CMS and the Office of the National Coordinator (ONC) for Health Information Technology should ensure the following two conditions are met:

- All EHRs must integrate PDMPs into their existing capabilities.
- All PDMPs should be interoperable and include certain standards, such as privacy and security protocols that protect patient sensitive information.

Condition of Participation (CoP) Requirements for Hospitals and CAHs to Report Data Elements to Address Any Future Pandemics and Epidemics as Determined by the Secretary

Currently, there are hospital conditions of participation (CoPs) in place that require hospitals to report certain data around COVID-19 to CMS during the COVID-19 PHE. CMS is proposing to modify the CoPs in order to extend the COVID-19 reporting requirements to April 30, 2024. Further, CMS is proposing to require hospitals to report specific data elements for future pandemics and PHEs to the CDC's National Health Safety Network (NHSN) or other CDC-supported surveillance systems.

In general, ACEP supports efforts from CMS and other federal agencies to incentivize and/or require the reporting of useful data during pandemics and other PHEs that could aid in the nation's response. However, we do note that even with these hospital CoPs in place during the COVID-19 pandemic, there were still significant gaps in the data

available on key COVID-19 indicators. Overall, among the weaknesses exposed by the COVID-19 pandemic has been the lack of a sophisticated, integrated system for biosurveillance capabilities and public health data collection and reporting. Given technology that is currently available (and in many cases already in use at system, local, or state levels), it is incomprehensible that much of this data are still not publicly available in real-time or near-real-time.

ACEP also believes that it is essential to improve the exchange of public health data and reporting to public health data systems. A truly interoperable, seamless exchange of health data should be standard practice in everyday healthcare delivery, not just during public health emergencies.

Lastly, we do request that CMS exercise caution in how it decides to implement additional information sharing requirements in order to ensure that these new requirements do not impose additional burdens on physicians or further hinder clinical workflows, especially during times of crisis.

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,

A handwritten signature in cursive script that reads "Gillian R. Schmitz, MD, FACEP".

Gillian R. Schmitz, MD, FACEP

ACEP President