PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

RESOLUTION: 33(20)

SUBMITTED BY: Aimee Moulin, MD, FACEP
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SUBJECT: Metrics, Measures, and Pay-for-Performance Programs

PURPOSE: Seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.

FISCAL IMPACT: Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay for performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of up to 15 ACEP staff.

WHEREAS, Scientific management by metrics, first described by Frederick Taylor, has been widely adopted and implemented in emergency medicine; and

WHEREAS, Metrics are often the basis for reimbursement through pay-for-performance programs; and

WHEREAS, Metrics often become goals, therefore violating Goodhart's law and no longer serve as useful measures; and

WHEREAS, Pay-for-performance programs often lead to perverse behaviors and gaming; and

WHEREAS, Don Berwick, a previous CMS Director, and others, have called for the end of pay-for-performance programs; and

WHEREAS, Many measures, such as the sepsis quality measures, are often at odds with current science; and

WHEREAS, The American Medical Informatics Association has called for the discontinuation of using clinical documentation for billing and administrative purposes; and

WHEREAS, Many emergency physicians cite these programs and expectations as oppressive and rob them of the joy of practicing emergency medicine; therefore be it

RESOLVED, That the College seek the decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements; and be it further

RESOLVED, That the College seek the end of pay-for-performance programs in emergency medicine; and be it further

RESOLVED, That the College encourage the Emergency Medicine Foundation Board of Trustees to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians.

Background

This resolution requests ACEP to seek decoupling of clinical documentation from billing, regulatory, and administrative compliance requirements, seek to end pay-for-performance programs in emergency medicine, and encourage EMF to offer funding for research into the effects of scientific management and pay-for-performance programs on patient care and emergency physicians. The intent of the resolution is to address programs that have become too complex, burdensome, potentially detrimental, and unjustly used to punish physicians and expresses concern that the metrics have become the goals and thereby are no longer useful measures.

The American Medical Informatics Association (AMIA)[1] proposes to substitute clinical documentation by creating an authoritative body from professional and specialty societies to: (1) assess clinical documentation requirements; (2) evaluate technological capabilities available today to extract then report data; and (3) define a financial mechanism to remunerate clinicians, hospitals, and healthcare systems for their work.

Decoupling clinical documentation from the functions of billing, regulatory, and compliance functions is a revolutionary idea. There is long precedent that the medical record is the best source of data to determine the level of service provided, support that service using diagnosis and management options considered, and justify the medical necessity of those choices to the payer community for payment and review under audit. A viable alternative would need to be provided in place of the medical record for this to occur. The clinical medical record is currently the most reliable vehicle for the physician themselves to document what care was provided and why to inform the selection of codes reported for payment, to provide a record of the medical care for future interactions and to justify the services provided under audit for internal review, productivity based compensations, and external payer compliance audits.

Such a move could hurt ACEP's advocacy efforts in the American Medical Association CPT Editorial Panel to define clinical services and the Relative Value Update Committee (AMA RUC) process to accurately value ED-related services.

Eliminating pay for performance programs for emergency medicine would require a change to the 2015 MACRA law that was passed with high bi-partisan support. The resolution invokes former CMS Director Don Berwick and the book *The Tyranny of Metrics* describing how pay-for-performance programs have been detrimental to other industries. Additionally, the resolution warns that although quality measures as a basis for improving performance is admirable, using them for payment purposes may be misguided.

A large percentage of ACEP's Clinical Emergency Data Registry (CEDR) participant groups have scored very well in their Merit-based Incentive Payment System (MIPS) scores to qualify for the "exceptional" bonus. In 2018, 40% of CEDR participants received the exceptional bonus. In 2019, the percentage is likely to be much higher. Exceptional bonus provides a significant return on investment for CEDR participation and a good pay-for-performance bonus on Medicare Part-B reimbursement. For a perfect score of 100 the bonus is 1.79 percent on all Medicare payments for the year under review. If the pay-for-performance program was eliminated, this bonus will likely end. Currently, 70-80% of the participants in CEDR join for the pay-for-performance bonus opportunity. If this program is ended; CEDR will not be sustainable as a data registry. ACEP may have to bring additional funding for it to remain self-sustaining as a tool for quality improvement and gaining data insights. Eliminating CEDR altogether would cause a revenue loss of $3.6 million with a net profit of $335,526. The larger loss would be non-financial to the membership/success of emergency medicine and staff. ACEP would lose its data leadership, quality measures would become non-operational, and the industry would lose methods for emergency physician performance/quality measurement. Additionally, approximately 15 ACEP staff positions would be eliminated if CEDR is not sustainable.

The Emergency Medicine Foundation (EMF) is an independent organization and does consider directed research funds for targeted research.

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[1] "AMIA Calls on HHS to Decouple Clinical Documentation and Administrative Requirements." *American Medical Informatics Association* 29 January 2019: https://www.amia.org/news-and-publications/press-release/amia-calls-hhs-decouple-clinical-documentation-and-administrative

ACEP Strategic Plan Reference

Goal 1: Promote/advocate for efficient, sustainable, and fulfilling clinical practice environments.
Objective D: Promote quality and patient safety, including continued development and refinement of quality measures and resources.

Fiscal Impact

Budgeted staff resources for advocacy initiatives. Potential significant losses in revenue if removing pay-for-performance programs eliminated the need for CEDR and eliminated the opportunity for members to achieve the MIPS bonus payments currently available. Potential elimination of approximately 15 ACEP staff members.

Prior Council Action

Amended Resolution 18(16) Opposition to CMS Mandating Treatment Expectations adopted. Directed ACEP to: 1) work with CMS regarding mandated reporting standards that require potential harm to patients without the recognition of evidence-based care of individual patients; and 2) communicate to members and hospitals the dangers that quality indicators could present to potential patients and the importance of physician autonomy in treatment.

Resolution 12(16) Collaboration with Non-Medical Entities on Quality and Standards referred to the Board. Called for ACEP to collaborate and build coalitions with non-medical organizations involved in developing quality standards and engage with regulatory entities such as CMS, Joint Commission, and the National Quality Forum.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted. Directed ACEP to pursue reimbursement strategies to promote coordination of care and effective ED information sharing systems to incentivize EDs to perform intensive case management for high utilizers

Amended Resolution 17(10) CMS payment Model Pilot Projects adopted. Directed ACEP to continue to develop models for appropriate payment for patient care services provided by emergency physicians and when appropriate, engage CMS.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted. Directed ACEP to closely monitor Medicare contractor behavior regarding interpretation of guidelines and addressing inconsistent and unreasonable policy.

Prior Board Action

June 2017, approved the Quality & Patient Safety Committee's recommendation to support new and existing partnerships with non-medical organizations involved in developing quality standards including: 1) renewing membership in the National Quality Forum; 2) continue participation in Technical Expert Panels (TEP) that developing quality measures for CMS; and 3) conduct outreach and communications with international associations for emergency physicians, such as the Canadian Association of Emergency Physicians (CAEP) and other organizations within the International Federation of Emergency Medicine (IFEM), for international visibility and collaboration for ACEP.

Reviewed and approved an information paper "The Role and Value of Emergency Medicine in Accountable Care Organizations" in November 2015 which discussed metrics and quality measures for emergency medicine.

Amended Resolution18(16) Opposition to CMS Mandating Treatment Expectations adopted.

Resolution 23(15) Integrating Emergency Care into the Greater Health Care System adopted.

Amended Resolution 17(10) CMS payment Model Pilot Projects adopted.

Amended Resolution 39(07) CMS: Arbitrary Regional Interpretations adopted.

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