February 23, 2022

Re: Emergency Medicine Cost Measure, Winter 2022 Field Testing.

Dear Emergency Medicine Cost Measure Workgroup,

MarsdenAdvisors (MA) is submitting our comments on the draft Emergency Medicine Cost Measure. MA is an EHR consulting and software company that helps small to medium sized specialty practices implement and manage EHR technology and comply with quality reporting requirements, such as those in the Merit-based Incentive Payment System (MIPS). We support over 1,000 clinicians in quality compliance and reporting nationwide.

We appreciate the thought that went into developing this measure, however we are concerned that it is being attributed inappropriately to clinicians who do not coordinate or control emergency care. In addition, we have suggestions on risk adjustment and service exclusions.

In our comments, we will first answer survey questions for this measure, and then add additional comments on issues not covered by the survey questions.

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Survey Questions:

4. **Besides the variables in the current risk adjustment model, are there other factors outside of the reasonable influence of the clinician that should be accounted for in estimating the expected spending for ED episodes?**

MA recommends adding a separate sub-group for those admitted from the ED vs discharged from the ED. We cannot guarantee that every attributed clinician will have an equal mix of patients whose conditions are appropriate for admission vs discharge – the mix of condition severity that clinicians receive is largely based on chance.

Although we understand CMS's stated concerns about inappropriate admissions, we do not believe that this is the appropriate, or most effective, lever to use to address these concerns. Rather, we recommend using something similar to CMS's Targeted Probe and Educate (TPE) program. This will allow CMS to ensure that admissions are appropriate rather than penalize clinicians who have a high volume of medically necessary admissions or disincentivize medically appropriate admissions.

Given the significant cost difference between a stay that includes inpatient care compared to a case that is resolved in the ED or only has outpatient follow-up, this is an important sub-group to add for each visit type.

5. **Should other types of services be excluded from the measure? If so, please indicate the type of service.**

    a. **Shorten the Post-Trigger Window**

Given the acuity of the care intended to be furnished in an Emergency Department, we strongly recommend lowering the post-trigger window from 30 days to 7 days. ED care is not meant to cure a patient. In fact, if a patient has a severe and acute issue, it will likely require long-term follow-up, regardless of the care provided in the ED. To more appropriately measure the costs influenced by ED providers, a shorter post-trigger window is more appropriate.

We specifically recommend shortening the post-trigger window to 7 days given a thorough review of ED revisits estimates that nearly 97% of ED visits related to the index visit would occur within 7 days.[1]

[1] Rising, Kristin L., et al. "Patient Returns to the Emergency Department: The Time-to-Return Curve." *Academic Emergency Medicine*, vol. 21, no. 8, 2014, pp. 864–871., https://doi.org/10.1111/acem.12442.

b. Remove Care for Chronic Conditions

Similarly, we ask the workgroup to develop a method to ensure that visits that are more appropriate for chronic, outpatient care are not included in this measure as it may skew costs for providers who receive a mix of patients who are frequently lost to follow-up.

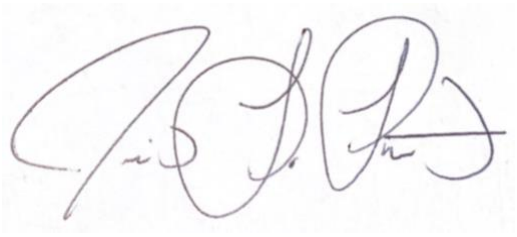
Recommendation on Clinician Attribution:

MA strongly recommends that this measure only be attributed to clinicians who provide emergency medical services (emergency medicine physicians and other non-physician emergency medical workers). The measure's stated intent is to evaluate ED clinicians. As emergency medicine providers are the intended population for this measure, and as they are the clinicians who coordinate emergency care, other clinician types – ophthalmologists, dermatologists, orthopedics, etc. – should be explicitly excluded from EM Cost Measure attribution.

Conclusion

We appreciate the opportunity to work with CMS and Acumen to improve clinician cost measurement in the Merit-based Incentive Payment System. If you have questions or need any additional information regarding any portion of these comments, please contact Dr. Jessica Peterson, VP of Health Policy at MarsdenAdvisors at jessica@marsdenadvisors.com.

Sincerely,



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