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Partnership for Quality Measurement

Submitted electronically via: <https://p4qm.org/2025-MSR-Cycle-Proposed-Measure-Comments>

RE: Proposed Measures for the 2025 Measure Set Review (MSR) Cycle

Dear Members of the 2025 MSR Recommendation Group:

On behalf of the Emergency Department Practice Management Association (EDPMA), we appreciate the opportunity to share feedback on specific measures being considered under the 2025 Measure Set Review Cycle for continued use in Centers for Medicare & Medicaid Services (CMS) quality programs.

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) healthcare for over half of the 146 million patients that visit U.S. emergency departments each year.

Our comments below focus on two specific measures relevant to emergency medicine practices:

- **OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients**
- **MIPS 187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy**

OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-18, which is currently used under the Hospital Outpatient Quality Reporting Program (OQR) Program, measures the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department and includes important stratifications for certain types of patients, including psychiatric/mental health patients and transfer patients.

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. 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.¹

Emergency encounter volumes have rebounded since the pandemic to new record levels and wait times and crowding have become worse than ever. The marked decrease in available staff, particularly nurses, has resulted in many inpatient beds being unavailable to emergency patients requiring admission for inpatient care. At the same time, a higher level of acuity and complexity among patients is overcrowding emergency departments, with a larger number of older adults, patients with mental illness, survivors of violence, veterans, unhoused individuals and undocumented immigrants receiving care in the emergency department.² 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 and negatively impacts patient flow, creating increased stress for both patients and staff. It is not uncommon for high volume EDs to average 50 or more boarding patients in their emergency department.³ This problem will only get worse if not addressed, as the aging baby boomer generation is expected to cause emergency department visits to reach 180 million visits by 2028.⁴

There are also serious financial ramifications associated with boarding. A recent study found that daily emergency departments boarding costs were nearly two times higher than daily inpatient costs for stroke patients. The daily total cost for medical/surgical boarding was \$1,856, compared to \$993 for medical/surgical inpatient care.⁵

With ED boarding rates trending higher and the repercussions being so serious and far-reaching, EDPMA strongly urges the PQM to not prioritize OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients for review under the MSR and for CMS to maintain this measure in the Hospital OQR. The Hospital OQR only includes two measures that focus on emergency department care. It is imperative that CMS preserve OP-18 to ensure the delivery of high quality care in emergency departments, to bring more transparency to the issue of boarding through ongoing data collection, and to help us identify more targeted solutions to this critical ongoing problem. In fact, a January 2025 Agency for Healthcare Research and Quality (AHRQ) concluded that “measurement, standards, and public reporting efforts could increase hospital and health system accountability for ED boarding.”⁶

¹ <https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf>

² https://www.rand.org/pubs/research_reports/RRA2937-1.html

³ <https://www.emopti.com/emopti-blog/ed-care-landscape-2023-data-shows-crowding-problems-are-worse-than-ever>

⁴ <https://www.emopti.com/emopti-blog/ed-care-landscape-2023-data-shows-crowding-problems-are-worse-than-ever>

⁵ <https://pubmed.ncbi.nlm.nih.gov/38795079/>

⁶ <https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf>



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MIPS 187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy

MIPS 187 evaluates the percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within 3.5 hours of time last known well and for whom IV thrombolytic therapy was initiated within 4.5 hours of time last known well.

EDPMA believes this is an important measure since it focus on timely administration of thrombolytics to eligible patients, aiming to limit stroke damage and disability. In fact, EDPMA recently urged CMS to add this measure to the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MIPS Value Pathway (MVP). In addition to serving as an important predictor of patient outcomes, MIPS 187 is also one of very few MIPS clinical quality measures applicable to emergency medicine that focuses on an acute diagnosis. Although it is topped out due to high performance, it is unclear if the current benchmark is reflective of the entire population eligible for this measure.

EDPMA urges the PQM to not prioritize this measure under the 2025 MSR cycle. Instead, we believe that CMS should maintain this measure in MIPS and make it available through the Emergency Care MVP to ensure a diverse measure inventory and help to incentivize broader adoption of the measure, which might reveal additional performance gaps.

Again, EDPMA appreciates the opportunity to provide input on the 2025 Measure Set Review (MSR) Cycle. If you have any questions or we can provide any additional information, please do not hesitate to contact Matthew Clark at matt@edpma.org or +202 204 8400.

Sincerely,

A handwritten signature in blue ink that reads "William Freudenthal MD FACEP".

William Freudenthal, MD, FACEP
Chair, Board of Directors
Emergency Department Practice Management Association