EM ACTION FUND
Preserving the Future of our Specialty

Vital Viewpoint

Perspectives from Emergency Medicine on Federal Regulatory Activities

Message from the Chair

Washington has finally dug out from "Snowmageddon 2016"!! And, while traces of white continue to cover the Capitol City, EMAF and its consultants continue making strides in our regulatory agenda.

On January 19, 2016, EMAF met with its consultants and EMAF members to discuss the regulatory landscape and have a frank discussion about potential projects that might provide important data to addressing some of our toughest battles with Medicare, Medicaid and private payers. To start the dialogue, our consultants with Health Policy Alternatives (HPA) and Hart Health Strategies (HHS) outlined the year ahead, which largely centered on the move toward value-driven payment and delivery models as described in the recently enacted Medicare Access and CHIP Reauthorization Act (MACRA). They also clarified some sharp comments made by CMS' Acting Administrator Andy Slavitt pertaining to the future of the "meaningful use" program.

The Centers for Medicare and Medicaid Services (CMS) is expected to release a proposed rule in the Spring, which will outline new physician payment programs; the Merit-Based Incentive Payment System (MIPS) and physician-focused alternative payment models (APMs).

To inform the establishment of these program, CMS is seeking feedback on the development episode groups, which will be used to measure resource use, and its Quality Measure Development Plan. Emergency medicine will weigh in on both of these important topics.

Over the course of the next few months, our consultants will collaborate to address two potential projects; one would collect data that would appropriately characterize the importance of emergency medicine visits in Medicaid populations and help us dispel the myth that non-urgent emergency departments visits yield little value to the health care system, while the other would demonstrate the critical role of emergency medicine physician in value-driven health care model, to include how emergency medicine can reduce the impact of emergency department visits on episode-based and bundled payments through thoughtful triage, acute diagnostics, and care coordination.

On January 29, 2016, I joined my colleagues in Dallas for a meeting of ACEP's Task Force on APMs. I presented on current models underway in the State of Maryland, and provided an overview of the work EMAF is doing that will assist with emergency medicine's efforts to engaged in APMs.

Recently, the ACEP Board of Directors met to review its legislative and regulatory priorities and discuss next steps on addressing the ongoing challenge with CMS' Greatest of Three regulations.

VITAL SIGNS: New ACOs Join CMS' Shared Savings Program, Other ACO Programs

Forty-nine states and the District of Columbia now have a Medicare Accountable Care Organization (ACO), according to an announcement from CMS in late January. CMS explained in the notice that 121 new ACOs had joined the agency through the Shared Savings Program, Next Generation ACO Model, Pioneer Model, and the Comprehensive ESRD Care Model.

With this announcement, there are a total of 477 ACOs serving 8.9 million beneficiaries. CMS also notes that at least 64 of the ACOs are in risk-bearing tracks.

Our new EMAF Coordinator, Ms. Orit Sager, is diligently working to prepare EMAF dues statements, so be on the lookout for an invoice in the coming weeks. As a reminder, Orit can be reached by phone at the 703-909-8596 or by email at osager@acep.org.

Innovation Center Launches New Accountable Health Communities Model

The Centers for Medicare & Medicaid Services (CMS) Innovation Center launched a new five-year demonstration project, the Accountable Health Communities (ACH) Model, aimed at aligning clinical and community-based services to address health-related social needs of Medicare and Medicaid beneficiaries. The Innovation Center has set aside up to $157 million to implement and test a three-track model that will see if intensive community service navigation, such as in-depth assessment, planning, and follow-up provided by the bridge organizations, help reduce total health care costs, emergency department visits, and hospital stays, and improve the quality of care.

As explained in a CMS blog post by Drs. Darshak Sanghavi and Patrick Conway, "*Many social needs, such as housing instability, hunger, and interpersonal violence, affect individuals' health…Over time, these unmet needs may increase the risk of developing chronic conditions and reduce one's ability to manage these conditions, resulting in increased health care utilization and costs, such as emergency room visits or hospitalizations.*"

Updated Process to Set Benchmarks Proposed for Medicare ACOs

CMS is proposing to update the methodology used to measure the performance of Medicare Shared Savings Program Accountable Care Organizations (ACOs) by modifying the process for resetting ACO benchmarks. Specifically, CMS is proposing to incorporate factors based on regional fee-for-service expenditures, into establishing and updating the ACO's rebased historical benchmark, including an adjustment to the benchmark based on regional spending that is phased-in over several agreement periods. These changes are in response to feedback from Medicare ACOs and other stakeholders, including the Health Care Payment Learning and Action Network (The "LAN") and Health Care Transformation Task Force (HCTTF). A fact sheet outlining additional details about the proposal can be found on CMS' website. Comments will be accepted through March 28, 2016.

CMS Aims to Improve Access to Data Through QEs

The Centers for Medicare & Medicaid Services (CMS) is proposing significant changes to its Qualified Entity (QE) program, as required under Section 105 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS' proposed rule would modify how QEs may use and disclose data, create non-public analyses and provide or sell such analyses to authorized users, as well as how QEs may provide or sell combined data, or provide Medicare claims data alone at no cost, to certain authorized users. Comments on CMS' proposals are due March 29, 2016.

Health Care Workforce Focus of GAO Study

A new Government Accountability Office (GAO) study recommends that the Department of Health and Human Services (HHS) develop a comprehensive and coordinated planning approach that includes performance measures, identifies any gaps between its workforce programs and national needs, and identifies actions to close these gaps, which HHS concurred with. These recommendations come after GAO found that HHS has limited legal authority to target certain existing programs to areas of emerging needs and that its programs do not specifically target areas of workforce need, such as for primary care and rural providers. According to GAO, without a comprehensive and coordinated planning approach, HHS cannot fully identify gaps and actions to address those gaps, including determining whether additional legislative proposals are needed to ensure that its programs fully meet workforce needs.

Future of Meaningful Use Subject of Recent CMS Blog

A new blog post by CMS Acting Administrator Andy Slavitt and National Coordinator Karen DeSalvo, MD, recognizes that the federal government's efforts to encourage the adoption of health information technology through the "Meaningful Use" program may have placed "too much of a burden on physicians" and "[pulled] their time away from caring for patients." Slavitt and DeSalvo explain that their plans to revise meaningful use in future years will be guided by several critical principles: Rewarding providers for the outcomes technology helps them achieve with their patients; Allowing providers the flexibility to customize health IT to their individual practice needs; and, Leveling the technology playing field, prioritizing interoperability and focusing on real-world uses of technology.

The authors also remind providers that current law requires the agency to continue measuring meaningful use under the existing set of standards, and that changes expected via the new Medicare Access and CHIP Reauthorization Act

(MACRA) programs will only address Medicare physician payments.

"The challenge with any change is moving from principles to reality," Slavitt and DeSalvo explain. "The process will be ongoing, not an instant fix and we must all commit to learning and improving and collaborating on the best solutions."

Hardship Exception Application for EHR Program Posted

The Centers for Medicare & Medicaid Services (CMS) posted its long-awaited "streamlined" hardship application, which reduces the amount of information eligible professionals (EPs) must submit to apply for an exception from the Medicare Electronic Health Records Incentive Program 2017 payment adjustment. Importantly, EPs that wish to use the streamlined application must submit their application by March 15, 2016, which was established in the Patient Access and Medicare Protection Act (PAMPA). Applications submitted after March 15, 2016 will be subject to the "case-by-case" review process. Instructions for applying can be found on CMS' EHR Incentive Program web site.

CMS Implements Changes For Medicaid Drug Program

CMS released a final rule with comment that establishes the long-term framework for implementation of the Medicaid drug rebate and reimbursement programs by some of which was outlined in the Affordable Care Act. Among many other changes, the rule establishes a regulatory definition for Average Manufacturer Price (AMP); provides clarification on the definition of what constitutes a manufacturer's "best price" and aligns it, where applicable, to the definition of AMP; creates an exception to the Federal Upper Limit (FUL) calculation, allowing a higher multiplier than 175% to calculate the FUL based on acquisition costs for certain multiple source drugs; and establishes actual acquisition cost (AAC) as the basis by which states should determine their ingredient cost reimbursement. More about the covered outpatient drugs policy can be found in a CMS fact sheet.

PQRS Web-Based Measure Tool Now Available

CMS announced the availability of the new Physician Quality Reporting System (PQRS) Web-Based Measure Search Tool to assist eligible professionals (EPs) and PQRS group practices with easily identifying claims and registry measures that may be applicable, and help find measures that meet satisfactory reporting requirements for the 2016 PQRS program year. Users can click on a measure to view the individual claims and registry measure specifications available for 2016, as well as search measure-related keywords as well as search and filter important measure-related information such as:

- Measure Number
- Reporting Methods
- National Quality Strategy (NQS) Domain
- Cross-Cutting Measures
- Measure Steward

About EMAF

In January 2011, the ACEP Board of Directors voted to create the Emergency Medicine Action Fund to generate additional financial support for our well established advocacy activities in Washington, DC.

This Action Fund will finance activities that complement ongoing work and enhance resources to address the issues that matter most to you.

The Action Fund can help us enhance our regulatory advocacy with policy makers to ensure emergency physicians receive fair payment for our services. It can also fund numerous meetings with regulators to help guarantee our patients receive the best care, and provide funding for studies to demonstrate the value of emergency medicine.

Find out more about the Action Fund's goals, contribution levels, and governance structure by visiting www.acep.org/EMActionFund.