EM ACTION FUND
Preserving the Future of our Specialty

Vital Viewpoint

Perspectives from Emergency Medicine on Federal Regulatory Activities

Message from the Chair

The cold and snow have finally subsided in our Nation's capitol (for now) and warm temperatures are just around the corner. With spring less than three weeks away, it won't be long before patches of pink adorn the tidal basin and the National Mall is full of enthusiastic tourists!

The change in seasons will also bring significant changes in how emergency physicians are reimbursed under the Medicare program. In April, the Centers for Medicare and Medicaid Services (CMS) is expected to release a proposed rule outlining new physician payment programs – the Merit-Based Incentive Payment System (MIPS) and physician-focused Alternative Payment Models (APMs), as outlined in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

You will recall that Robert Jasak, JD, one of our consultants at Hart Health Strategies, Inc. (HHS), provided a detailed overview of these new pathways toward Medicare payment at our last face-to-face meeting and outlined upcoming pre-rulemaking opportunites to provide input as proposals for the new programs are developed. Toward that end, ACEP's Barbara Tomar and Stacie Jones, MPH, collaborated with HHS consultants Emily L. Graham, RHIA, CCS-P, and Rachel Groman, MPH, to prepare detailed comments on CMS' Request for Information on MIPS and APM development, CMS' Request for Comment on developing episode groups, and CMS' Quality Measure Development Plan.. Comments were recently submitted to CMS and remain under consideration.

On February 12, 2016, our consultants at HHS, Inc. and Health Policy Alternatives (HPA) engaged in a dialogue with several of our EMAF Governors to discuss ways in which EMAF can better support issues facing emergency medicine programs at academic and teaching institutions through regulatory advocacy. Not surprising, the central concern for these groups is graduate medical educaton and funding for emergency medicine residencies. EMAF Governors, HHS, Inc., and HPA, along with staff from ACEP, have formed a workgroup to answer key questions, identify potential regulatory vehicles and new partners, and seek meaningful opportunites to address concerns.

HPA's Marjorie Kanof, MD, MPH and Thomas Walke, PhD, continue efforts to collect qualitative data that would appropriately characterize the importance of emergency medicine visits in Medicaid populations and help us dispel the myth that non-urgent emergency department visits yield little value to the health care system, while the other would demonstrate the critical role of emergency medicine physicians in a value-driven health care model. Their analysis will include a review of the role emergency medicine groups have played in accountable care models, episode-based and bundled payments, and care coordination activities.

I'd like to also welcome Dr. Karen Borman, a new member of the HPA consulting team, to the EMAF family. Dr. Borman brings a wealth of knowledge and expertise to the table and will be a tremendous asset to EMAF. She is a

VITAL SIGNS:
CMS Addresses Program Integrity Concerns through Provider Enrollment Processes

On February 25, 2016, the Centers for Medicare and Medicaid Services (CMS) released the Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process Proposed Rule that requires Medicare, Medicaid, and Children's Health Insurance Program (CHIP) providers and suppliers to disclose certain current and previous affiliations with other providers and suppliers and also provides CMS with additional authority to deny or revoke a provider's or supplier's Medicare enrollment. The purpose of the proposed rule is to implement additional provider enrollment provisions of the Affordable Care Act to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods. The proposed rule was published in the Federal Register on March 1, 2016. Comments will be accepted through April 30, 2016.

general surgeon by training, with a focus on trauma surgery and surgical critical care, spending most of her clinical career in academia. Dr. Borman previously served as Vice Chair of the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel, as a member of CMS' Advisory Panel on Hospital Outpatient Payment, and as a Commissioner on the Medicare Payment Advisory Commission (MedPAC).

Our next face-to-face meeting is set for May 18, 2016, as part of ACEP's Leadership and Advocacy Conference (LAC). I encourage each of you to attend and take advantage of opportunities to network, engage in dialogue and impact change for emergency medicine.

CMS Finalizes 2017 Notice of Benefit and Payment Parameters

CMS published its 2017 Notice of Benefit and Payment Parameters final rule, and its Annual Letter to Issuers. Both documents outline important policy changes and put in place standards for Qualified Health Plans (QHPs) in the Health Insurance Marketplace related to application and certification processes, network adequacy and essential community providers, quality reporting and patient safety, prescription drugs, and discriminatory benefit designs. ACEP expressed concerns about access oversight and urged CMS to apply out of network payments by enrollees to count toward their annual deductible. CMS backed off their access and network adequacy proposals but will allow OON payments to reduce the annual deductible. Further, all plan levels contain large co-pays for ED visits ranging from 50% under a bronze plan to $400 under the lowest cost silver plan.

New Final Rule Addresses Reporting and Returning Medicare Overpayments

CMS issued its long-anticipated final rule on reporting and returning "self-identified" overpayments made to providers by the Medicare program. The new requirements stem from a provision in the Affordable Care Act (ACA), which requires healthcare providers and suppliers to report and return Medicare and Medicaid overpayments no later than 60 days after the overpayment was "identified". The final rule applies to Medicare Parts A and B overpayments; additional rules to address Medicare Parts C and D are forthcoming.

In the rule, CMS finalized that a person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. CMS clarified that the 60-day time period begins when either reasonable diligence is completed or on the day that the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence *and* the person in fact received an overpayment. CMS established a six-year look-back period for overpayments, instead of the 10-year period that was originally proposed. CMS will permit overpayments to be returned via claims adjustment, credit balance, self-reported refund process, or "another reporting process set forth by the applicable Medicare contractor."

2017 Advance Notice and Draft Call Letter Released

CMS announced proposed payment and policy changes for Medicare Advantage (MA) and Part D plans as part of its 2017 Advance Notice and Draft Call letter. As outlined in a fact sheet, CMS is proposing a 1.35% payment update for MA plans. CMS is also proposing to adopt a new risk adjustment methodology to better account dual eligible beneficiaries, which would improve the precision of the payments made to plans, and provide increased payments for plans serving full benefit dually eligible beneficiaries. In addition, CMS is proposing to implement a new analytical adjustment for a subset of Star Rating measures that is meant to adjust for plans serving dually eligible enrollees and/or enrollees receiving the low income subsidy, as well as enrollees with disabilities.

Other proposed changes would address drug utilization and opioid use. Regarding drug utilization, CMS is proposing to allow Part D plans to designate specific drugs for which a beneficiary's initial fill could be limited to a 1 month supply, regardless of whether the drug is otherwise available as an extended days' supply. Regarding opioid use, CMS is proposing expectations for Part D plans to implement edits to prevent opioid overutilization at point of sale.

MedPAC, MACPAC Release Data book on Dual-Eligible Beneficiaries

The Medicare Payment Advisory Commission (MedPAC) and the Medicaid Payment and Access Commission (MACPAC) jointly released a data book, *Beneficiaries Dually Eligible for Medicare and Medicaid.* Policymakers have expressed particular interest in dual-eligible beneficiaries because of the relatively large expenditures by both programs for this relatively small group of individuals. This third annual data book promotes a common understanding of the characteristics of dually eligible beneficiaries and their use of services, including information on demographic characteristics, expenditures, and use of health care services.

AHRQ Study: EHR Use Lowers Odds of In-Hospital Adverse Events

A new study funded by the Agency for Healthcare Research and Quality (AHRQ) found that cardiovascular, pneumonia and surgery patients exposed to fully electronic health records were less likely to experience in-hospital adverse events. Specifically, patients exposed to fully electronic health records had 17–30 percent lower odds of any adverse event. Among the patients in the study sample, 347,281 exposures to adverse events occurred. Of these exposures, 7,820 adverse events actually took place, resulting in a 2.25 percent occurrence rate of events for which patients were at risk. Thirteen percent, or 5,876 patients, received care that was captured by a fully electronic EHR. The study, Electronic Health Records Adoption and Rates of In-Hospital Adverse Events, appeared in the February issue of the *Journal of Patient Safety*. Read more in the AHRQ Views blog.

CMS' Transparency Efforts Target Medicare Provider Enrollment Data

CMS made a subset of Provider Enrollment, Chain, and Ownership System (PECOS) data available to the public in an effort to increase awareness about enrollment information on file with CMS. According to CMS' press announcement, "These files will provide a clear and transparent way for providers, suppliers, state Medicaid programs, private payers, and other interested individuals or organizations to leverage Medicare Provider Enrollment data."

A CMS fact sheet explains that the initial data set consists of individual and organization provider and supplier enrollment information directly from PECOS and includes the following elements:

- Enrollment ID and PECOS Unique IDs
- Provider or Supplier Enrollment Type and State
- Provider's or Supplier's First and Last Name/ Legal Business Name
- Gender
- NPI
- Provider or Supplier Specialty,
- Limited address information. (City, State, ZIP code)

Additional data elements will be added in future releases, which will occur on a quarterly basis. Eventually, CMS will consolidate this data with other public lists, such as the Ordering and Referring File, Part D Prescribing File, and Revalidation Lists. "We appreciate industry feedback on what enrollment data will provide value and align with other CMS projects, such as physician utilization data," CMS explains.

Acting Administrator Slavitt Remains "Deadly Serious" About Interoperability

Recently, during the National Rural Health Association meeting in Washington, DC, CMS' Acting Administrator, Andy Slavitt, discussed the agency's 2016 agenda and strategic priorities for rural health care. As part of his remarks, Slavitt reiterated the agency's commitment toward rewarding providers for the outcome they achieve with their patients rather than simply using technology. Identical to his comments at a recent JP Morgan Health Care Conference, Slavitt stated that CMS is "deadly serious about interoperability" and would begin initiatives in collaboration with physicians and consumers toward pointing technology to fill critical use cases like closing referral loops and engaging a patient in their care. Also, while programs established under the Medicare Access and CHIP Reauthorization Act (MACRA) apply to physician office care, Slavitt said that CMS will be exploring vehicles to align hospital measurements with these principals, as well.

"Meaningful Use" FAQs Address Public Health Reporting Requirements

New frequently asked questions (FAQs) were released late last week that address longstanding provider concerns about public health reporting measures and associated requirements. The questions, with links to their answers, are as follows:

- Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date?
- What should a provider do in 2016 if they did not previously intend to report to a public health reporting measure that was previously a menu measure in Stage 2 and they do not have the necessary software in CEHRT or the interface the registry requires available in their health IT systems? What if the software is potentially available but there is a significant cost to connect to the interface?
- For 2016, what alternate exclusions are available for the public health reporting objective? Is there an alternate exclusion available to accommodate the changes to how the measures are counted?
- What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion?
- What can count as a specialized registry?

CMS Extends "Streamlined" Hardship Exemption Deadline

CMS announced that it would extend the application deadline for the Medicare EHR Incentive Program "streamlined" hardship exception process to July 1, 2016. The streamlined application process is the result of the Patient Access and Medicare Protection Act (PAMPA), which allows the Secretary to consider hardship exceptions for "categories" of eligible professionals and eligible hospitals. Prior to this law, CMS was required to review all applications on a "case-by-case" basis. According to the notice, CMS extended the deadline so providers have sufficient time to submit their applications to avoid adjustments to their Medicare payments in 2017. The applications and instructions for providers seeking a hardship exception are available here.

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.