November 12, 2013

Via First Class Mail and E-mail:
sgrcomments@finance.senate.gov
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The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways & Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Sander M. Levin
Ranking Member
Committee on Ways & Means
1102 Longworth House Office Building
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The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
1102 Longworth House Office Building
Washington, D.C. 20515

Re: SGR Repeal and Medicare Physician Payment Reform Discussion Draft

Dear Chairmen and Ranking Members:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused exclusively on the delivery of emergency medical services, with an emphasis on the provision of high-quality, cost-effective care in the emergency department to all Americans. Together, EDPMA's members deliver (or directly support) health care for over half of the 130 million patients that visit U.S. emergency departments each year. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist health care providers in our nation's emergency departments. We work collectively and collaboratively to deliver essential health care services often unmet elsewhere to an underserved patient population who often has nowhere else to turn.

The American College of Osteopathic Emergency Physicians (ACOEP) represents over 3,000 Emergency Physicians and provides oversight to 45 Emergency Medicine Residency Programs. ACOEP, founded in 1975, exists to support high quality emergency care, promote and protect the interests of Osteopathic emergency physicians, ensure the highest standards of postgraduate education, and provide leadership in research through the Foundation for Osteopathic Emergency Medicine, in a distinct unified profession.

On behalf of EDPMA and ACOEP, we appreciate the opportunity to provide comments on the Discussion Draft for SGR Repeal and Medicare Physician Payment Reform prepared by the House Ways & Means Committee and Senate Finance Committee Staff and distributed October 30, 2013 (the "proposal" or "Discussion Draft").

In summary, EDPMA and ACOEP urge the Committees to:

- Repeal the SGR formula which mandates a 24.4% cut to physician reimbursement on January 1, 2014,
- Modify the proposed performance assessment provisions to ensure that the composite value score does not prejudice emergency physician groups and others who are not eligible for heavily-weighted programs (such as EHR) and measurements (such as the current methodology used for quality tiering),
- Include legislative language retaining claims-based reporting,
- Ensure that emergency physician groups are eligible for incentives for complex chronic care management, primary care, transitional care and other important incentives where emergency physician groups can and do provide such care,
- Ensure that emergency physician groups can qualify for clinical practice improvement activities such as care coordination,
- Encourage the development of an APM for emergency physician groups,
- Ensure that emergency physician groups are at the table when APMs are developed that impact primary care or hospital admissions, and
- Work with EDPMA when drafting provisions that allow groups to opt into using value scores of an affiliated group or hospital.

Important Role of Emergency Physicians

Emergency physician groups are particularly well situated to play an important role in improving care. Emergency physicians are often the first point of access for individuals in need of acute care, handling 28 percent of first-contact care in the United States, utilizing only 5 percent of the physician workforce.[1] Emergency Department (ED) patients include millions of indigent individuals and Medicaid recipients with little or no access to timely primary care. This "first-contact care" constitutes a critical interface for patients with the health care delivery system and often serves as a critical point of transition of care for longitudinal services. The ongoing

[1] Pitts, S., Carrier, E., Rich, E., & Kellermann, A. (2010). Where Americans get acute care: Increasingly, it's not at their doctor's office. Health Affairs, 29(9), 1620-1629. doi: 10.1377/hlthaff.2009.1026.

availability of quality emergency services not only ensures an important safety net for Medicare beneficiaries but as an important critical access point for care for all patients. The emergency department additionally serves the health care delivery system as the interface between inpatient and outpatient services. Consequently, emergency department providers possess a unique but perhaps underutilized perspective on how proposed changes will affect the care of Medicare beneficiaries not just in the emergency department, but how beneficiaries will interface with elements of the entire delivery system beyond the emergency department.

A 2013 Report by the Rand Corporation entitled "The Evolving Role of Emergency Departments in the United States," (the "Rand Study") finds that emergency physicians are important partners of both primary care physicians and hospitals. Primary care physicians are increasingly relying on the ED to evaluate complex patients with potentially serious problems, conduct workups, and provide overflow, weekend, and after-hours primary care. ED physicians are also the major decisionmakers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay.

I. Support for SGR Repeal

EDPMA and ACOEP agree that the SGR formula is fundamentally broken. We also believe that the Medicare program should reward quality, efficiency, and innovation.

While many of the proposed elements of the SGR Payment Reform take important steps forward to improve quality, efficiency, and innovation; we believe that there are other steps which should also be taken to advance the goals of focusing on value over volume.

We therefore respectfully request that you incorporate the ideas put forth in the Rand Study by recognizing the role of the emergency department and the reliance placed on it by both the acute and chronic care provider communities. The various alternative payment models that readily exist today in the primary care provider community do not lend themselves well to the practice of emergency medicine. Existing payment models associated with resource utilization, chronic care management, and electronic health records have not taken into account the role of the emergency department and its contributions to the desired goal expressed by the Committees in the proposal.

II. Value-Based Performance Payment Program

EDPMA and ACOEP support efforts to report and reward quality patient care. In fact, our members are already participating in quality programs at extremely high rates and have done so for many years. Emergency medicine physicians have actively participated in the Medicare quality reporting system since its inception. In 2011, over 67% of emergency physicians participated while the average participation rate for all physicians was 32%. And over 70% of all physicians – and nearly all emergency physicians – participated in the program via claims-based reporting.

We strongly urge the Committees to include legislative language that would retain claims-based reporting until the proposed changes to quality programs are fully implemented and cost-effective alternatives to claims-based reporting are available to all types of providers. The EHR and registry options are not optimal options at this time. Currently, information often is not captured on an EHR consistently, meaningfully, and accurately without placing a disproportionate cost or burden on physician practices. Additionally, emergency providers must rely on the EHR's selected and maintained by their hospital partners, which do not always reflect the nuanced reporting measures associated with the emergency department. Traditionally, registries were developed for primary care, and emergency physicians simply do not yet have similar or timely registry options available. Emergency physician practices have developed systems to utilize claims-based reporting and are heavily reliant on this mechanism. Furthermore, the proposal includes many changes to value-based programs which are likely to increase the cost of participation. The legislation should ensure that physicians are not mandated to transition off claims-based reporting at the same time.

Moreover, we have serious concerns about the manner in which the new combined value score will be calculated. Because all of the scoring elements are not necessarily applicable at this time to emergency physicians, we believe it is premature to mandate a program as proposed as it may make it impossible for emergency physicians to qualify for an increased payment even when they provide high quality care. Until such time that composite score elements are tested and made available to all recognized practice specialties groups, it would be inherently unfair to those who are not eligible for all programs and measures that are used to make up the final score.

Resource Use/Quality Incentives/Measures

We urge you to include legislative language that would prevent CMS from mandating quality measurements that simply do not work for some providers. For instance, CMS recently proposed mandating quality tiering for physician groups with more than 10 providers. Yet, the current methodology used for quality tiering – which does not attribute any patients to emergency physicians – would subject emergency physicians to reductions in payments for not reporting but would not allow any emergency physicians to qualify for an increased payment. We instead propose a quality tiering methodology that reflects the aspects of our practice: episodic care offset by varying levels of acuity and the degree of presenting symptoms.

Clinical practice improvement activities

We support the Committees' approach to establishing a collaborative process for physicians and other stakeholders to prepare to transition to APMs. Regarding the specific activities that have been identified in the Discussion Draft (page 4), we would urge the Committees to be clear that all types of physicians, especially emergency physicians, are eligible for the care coordination activities regarding timely communication of clinical information. As noted above, we believe

that communication among physicians and other providers is critical and this should not be limited to medical homes, "remote monitoring" or "telehealth" nor should it be limited to particular specialties. Care coordination is particularly important for patients seen by emergency physicians, as it promotes and rewards clear communication, reduces redundant and wasteful utilization, enhances patient safety, and assists with appropriate engagement of patients in their care.

EHRs

The proposal would freeze FFS payments but allows providers to earn incentives, such as quality points for meaningful use of an EHR. Yet, emergency physicians are not eligible for EHR incentives. Thus, emergency physicians should have the ability to earn additional quality points in other ways beyond the EHR.

Performance Assessment and Category Weights

EDPMA and ACOEP believe additional clarification of the proposed methodology for combining measures is necessary. We are concerned that physicians who are not eligible to participate in all three quality programs will be unfairly disadvantaged. It appears that the program will be comparing the scores of a physician who is eligible for the meaningful use program with a physician who is not eligible (essentially, comparing apples to oranges). If this were true, it would be very difficult for physicians who are ineligible to receive a score that can be compared to others. We believe there is an inherent bias in the proposed formula which, as it currently stands, would prejudice emergency physician groups and others who are not eligible for the EHR incentive.

The proposal states that providers will be scored on all "applicable" categories and measures. Emergency physician groups are not eligible for EHR incentives. So, the EHR score appears to be "inapplicable" to emergency physicians. Yet, under the current proposed formula which combines all three scores, the scores that emergency physicians receive would be compared with the scores of physicians who are eligible for the EHR incentive. Therefore, it may be impossible (or extremely difficult) for emergency physicians to qualify for any increased payment (or avoid a reduction). **We urge you to clarify that quality scores given to emergency physician groups (and others in a similar predicament) will not be negatively impacted by categories and measures for which they are not eligible.**

Unfortunately, this issue may not be limited to the EHR program. The current methodology used for quality tiering under the value-based payment modifier – which does not attribute any patients to emergency physicians – currently makes it impossible for emergency physicians to qualify for a positive update. If this methodology were also adopted under the proposed reimbursement formula, emergency physician groups could be ineligible for a positive quality score in both the EHR program and the VBPM program! We urge you to address this predicament in the legislation. Please ensure that the formula for assessing performance is fair to

emergency physician groups and is not simply based on the primary care and hospital inpatient models of care.

III. Increasing Participation in Alternative Payment Models (APMs)

We understand that the proposal intends to encourage adoption of alternative payment models, especially models where providers share financial risk. However, it's important to recognize that current APMs were not developed for emergency physician groups. This is likely due to the many unique aspects of emergency care. For instance, emergency physicians are not in control of the health status of its patients when they arrive at the emergency department. Similarly emergency department physicians exhibit only a certain degree of control when care is performed elsewhere. The type of care needed by these patients varies tremendously depending on the strength of the primary care network in the area as well as other resources available to the patients. It is difficult to develop an appropriate APM given these and many other limitations.

Moreover, current Alternative Payment Models that impact hospital care and primary care for the most part were developed without input from emergency physician groups. Emergency physician groups serve about half of the 130 million patients who visit Emergency Departments each year. Emergency physicians are major decisionmakers in about half of admissions and are critical partners in helping hospitals meet their statutory obligations to provide emergency care without regard to ability to pay (EMTALA). Emergency Departments handle 28% of first contact care and primary care physicians increasingly rely on the Emergency Department to handle work-ups, overflow, after-hour, and weekend care, and to evaluate complex patients with potentially serious problems.[1]

Nevertheless, APMs are typically developed without our input. In addition, incentives for primary care, complex care, chronic care, and transitional care often ignore our important contributions. We urge you to reverse this problematic trend.

We urge you to include legislative language that specifically encourages development of an APM or incentive payment that recognizes the important contributions of emergency physician groups as partners in providing primary care, transitional care, and chronic care management. Specifically, emergency physicians are critical partners with primary care physicians and other physicians and facilities that treat individuals with both acute problems and those with chronic conditions. We believe that emergency physicians should be eligible for payment incentives that reward appropriate chronic care management and the provision of primary care. The failure to include the ED in these incentives may promote additional admissions, more use of advanced imaging, and sub-optimal care coordination, ultimately costing Medicare more dollars without proportionate benefit for health care outcomes. Conversely, inclusion of the ED in incentives promotes judicious use of hospital admission, timely consideration of alternatives to hospital admission, prudent coordination of care with primary and specialist physicians, and less episodic care that is relatively disconnected with the greater health care delivery system. Moreover, emergency physicians should be involved in the development of new payment mechanisms

and/or refinements of current performance-based incentives as they serve a critical role in transitioning care between providers and other physicians.

The Discussion Draft includes a directive to enhance and use resource metrics associated with specific care episodes. We urge the Committee to consider authorizing APMs or performance-based incentives which would allow one or more specialties of physicians and/or subsets of physicians and other providers of care to separately or jointly create an entity or a risk-sharing/gains sharing mechanism to integrate the care delivered (and share responsibility for the financial risk) for the particular "care episode" of the period of 3 days before and 30 days after a hospital admission episode. Such an approach could encourage hospital - based physicians (such as emergency physicians, hospitalists, intensivists, surgeons) to collaborate to address quality, patient satisfaction and performance metrics for care provided during this critical period. This mechanism or others could also be used to permit such physician groups to collaborate with other providers in the community such as providers of post-acute care (e.g., SNFs, HHAs). We believe such approaches promote accountability and value, but may be more flexible and targeted than the larger risk-taking approaches which are being arranged through Medicare's current Shared Savings Program (ACOs).

IV. Complex Chronic Care Management

EDPMA and ACOEP support the Committees' efforts to reward complex chronic care management. However, we urge you not to limit this incentive to medical homes and similar care models. We also urge you to make the incentive available to all qualified providers who can offer these important services. ED physicians are in a unique position to offer these services because we often treat patients when they first become aware of a chronic condition and continue to provide services when these patients need to return to the ED. We regularly work with post-acute care providers as patient's transition out of the ED and actively seek alternatives to otherwise costly hospital admissions (when patient outcomes are equivalent or better).

Medical Homes

EDs often play a significant role in care coordination and transitional care services, especially for challenging and costly patient populations. Unproductive or unnecessary barriers to participation may deter ED physician practices from actively participating in cost-effective solutions that improve patient outcomes and experience.

EDPMA and ACOEP oppose approaches that require medical home clinic staff be directly employed by the physician because many contract employees – including hospital employees - work with independent physician groups. Requiring employment (when the essential functions of the affected workforce are delivered regardless of status as an employee, independent contractor, or contracted service) inappropriately focuses on a mechanism or structure, and ignores the benefits to patients. Additional, wasteful mechanisms and structures may result from

this requirement. This structural requirement does little or nothing to further the overall objectives for Medicare beneficiaries.

V. Payment Methodologies/Technical Implementation Issues

As discussed earlier, we strongly urge the legislation to include language that retains claims-based reporting.

In addition, emergency physicians providing care in the nation's emergency departments are organized in many different ways (e.g., emergency physician group employees, independent contractor physicians, hospital employees). Moreover, an emergency physician may be participating in more than one ED physician group. As payment models change, Medicare reimbursement must continue to recognize these varied structures and ensure that reporting mechanisms are streamlined for both ED physician groups and physicians who participate in more than one ED physician group.

We are interested in the proposal to allow physicians to adopt the quality scores of the group and the hospital. We urge you to reach out to us when drafting these provisions to ensure that they work for all emergency physician groups including large groups that provide care in many different hospitals, regions, and states.

Conclusion

In summary, the EDPMA and ACOEP fully support the need for the Committee to take on this important undertaking of permanently addressing the SGR: a highly flawed component to the Medicare Physician Fee Schedule. We also applaud and support the Committee's desire to seek quality and value from the fee-for-service delivery system. Nonetheless, we ask this committee to recognize the role of the emergency department and delivery of emergency medical services in overall health care delivery system. We further ask this committee to incorporate the findings of the Rand Study as a mechanism for developing resource measures associated with quality and chronic care and continuum of care, as well as the use of EHRs and the design of APMs, so that emergency medicine providers can fully participate in the design and goals set forth in this proposal.

We welcome the opportunity to participate in future dialogue to assist in the design of measures applicable and relevant to the care we provide.

Thank you again for the opportunity to provide feedback to the Committees.

Please feel free to contact Elizabeth Mundinger, EDPMA's Executive Director, at 703 610-9033 if we can be of any assistance on this topic or in any other area.

Sincerely,

James A. Kolka, D.O., FACEP
Chair, EDPMA Board of Directors

Mark Mitchell, DO, FACOEP
President, ACOEP