Congress to Contend with Doc Fix, Health Reform Legislation in 2nd Session

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In December, Congress passed the Bipartisan Budget Act of 2013, a significant budget agreement on spending levels for 2014 and 2015. The package also included a three month patch to the Medicare Sustainable Growth Rate ("SGR," or "doc fix"), preventing a 24% cut in physician payments that would have commenced on January 1st. The bill was paid for in part by a provision that extended the 2% across the board Medicare cut for providers that was enacted as part of the Budget Control Act (BCA) of 2011. The cut had been set to expire in 2021 but will now be in place until 2024, following passage of the budget deal and a subsequent fix to pensions for military veterans.

Key House and Senate policymakers cite continued progress towards a permanent SGR fix, but they must still decide how to pay for the measure, which is expected to cost over $120 billion. SGR fixes are typically financed with other cuts in the health care sector, and Congress is mulling a list of dozens of policy changes that could save the government anywhere from $50-250 billion over the ten year budget window. An agreement on major entitlement reform has eluded negotiators from Congress and the administration over the last several years, so the focus has shifted to consideration of smaller cuts.

In February, three key congressional committees introduced the S*GR Repeal and Medicare Provider Payment Modernization Act* (H.R. 4015), a bipartisan, bicameral bill to permanently repeal the SGR and replace it with a positive payment update for physicians of 0.5 percent over each of the next five years. A period of stable, positive updates is an approach endorsed by numerous physician advocacy groups. Following this period, payments will again be updated, and physicians would be able to begin earning additional payment adjustments for meeting certain benchmarks.

Other aspects of the legislation include (1) improving fee-for-service by reforming the current system by merging existing quality programs into a single "Merit-Based Incentive Payment System;" (2) encouraging adoption of alternative payment models (APMs) by providing bonus payments to physicians who enter into APMs or patient centered medical homes (PCMHs); and (3) increase Medicare transparency by providing more data to patients and allowing certain data to be used for quality improvement and patient safety.

While the House and Senate have been working on plans to repeal the SGR for the past year, the introduction of this legislation marks the first time in this Congress that a bill has been introduced that has the endorsement of the key Committee leaders. In its current form, the legislation does not specify how the permanent fix would be paid for, but key members of Congress continue to maintain that provisions to offset the cost of the bill would be attached prior to it being brought before the full House or Senate.

In the meantime, with the SGR fix set to expire at the end of March, Congress is now looking for ways to enact another temporary patch while negotiators continue to work on permanent repeal. Congressional leaders had considered attaching a nine or 21-month SGR patch to legislation extending the nation's debt limit, which would have prevented cuts from occurring until the end of 2014 or 2015. The debt limit has now been signed into law without the SGR patch, which means Congress will likely try to pass a short-term patch (nine months or less) to prevent the cuts from occurring on April 1st.

Congress is continuing to closely monitor implementation of the Affordable Care Act (ACA). The White House is touting numbers released in February that suggest a significant uptick in enrollment through the exchanges, as 3.3 million people had enrolled through the end of January. While it remains unlikely that the initial target of 7 million enrollees by the end of March will be reached, the administration also argues that a surge in young people signing up for insurance is a sign that the law is working. The White House has announced a number of changes to the law in response to concerns from lawmakers and other groups, notably that individuals with health plans that were cancelled are eligible to purchase catastrophic plans through the law's "hardship exemption." Congressional Republicans contend that this and other changes and delays announced by the administration demonstrate that the ACA is not working, and the modifications are contributing to the public's confusion about the law.

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In January, several key Senate Republicans unveiled an alternative to the ACA, entitled the *Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Act*. The sponsors wrote about their intent to "further refine and improve upon the proposal" before formally introducing legislation. The framework includes a number of concepts and ideas, notably the capping of non-economic damages for claims under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) statute. Other aspects of the plan include: Repeal of the Affordable Care Act (ACA); requiring health plans to continue to allow dependent coverage up to age 26 and to allow individuals with pre-existing conditions to remain covered as long as they were "continuously enrolled" in a health plan; incentivize states to examine medical liability laws; enhance ability for states to enact Medicaid reform in ways that increase accountability.

The House has already enacted several smaller bills related to the ACA this year, including legislation pertaining to data security and mandating enhanced transparency for the exchanges. The House also plans to introduce and vote on a legislative alternative to the ACA in 2014. The White House opposes these bills and the Senate is not likely to consider any of these measures in the coming months.

CMS Issues Guidance on Appropriate ED Use, Announces Public Release of Physician Medicare Billings

In January the CMS Center for Medicaid and Chip Services (CMCS) released an informational bulletin entitled "Reducing Nonurgent Use of Emergency Department and Improving Appropriate Care in Appropriate Settings." In the memorandum CMS identifies the need to reduce unnecessary ED usage, as utilization of services across the health care system increases as a result of individuals gaining coverage under the ACA.

The first section of the bulletin, "Strategies to Reduce ED Use," outlines three strategies that CMS has identified to reduce inappropriate ED use. Options cited in the paper include broadening access to primary care services, including extended hours for primary care medical and health homes, and increasing urgent care and retail clinic access for patients with non-emergency conditions at alternative primary care sites. It is also suggested that state and local entities focus on frequent ED users or, "super-utilizers," who are commonly defined as individuals with four or more ED visits annually. As an example, CMS cites an ambulatory ICU clinic built on site at Minnesota's Hennepin County Medical Center. The clinic was created to provide enhanced outpatient care to super-utilizers, and a 38% decrease in ED visits and 25% decrease in hospitalizations among its client population was observed during the first year.

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Finally, CMS suggests a targeted strategy to reduce high utilization by individuals with substance abuse or mental health problems. The bulletin said that states and health plans have had "dramatic success" in reducing overall ED usage by this population, and notes that in many examples case managers are used to connect this population with the appropriate behavioral health entities that can help meet their needs.

The second part of the paper, entitled "Differentiating Emergency and Non-Emergency Use of the ED," notes that states can utilize payment methodologies that encourage providers to "direct patients to more appropriate cost settings," and can implement cost sharing "based on a distinction between non-emergency and emergency use of the emergency department." CMS points out that some states have approved payment strategies designed to reduce inappropriate ED use, such as lower reimbursements for non-emergent ED visits, as "determined retrospectively by chart review, or based on a coding algorithm." CMS states that these payment strategies must not be designed in a way that impede care in the ED and that they must be compliant with the EMTALA statute.

CMS and Congress are very interested in ED utilization following passage of the ACA. When AAEM is on the Hill, emergency physicians are frequently asked to comment on their experiences with the law and whether or not they are seeing an increase in patients following the expansion of Medicaid and the opening of the state and federal health insurance exchanges.

On January 17, CMS published a "Modified Policy on Freedom of Information Act Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program." Beginning on March 18th, CMS will disclose Medicare physician billings on a case-by-case basis in response to requests made under the Freedom of Information Act. Under the new policy, CMS plans to "weigh the balance between the privacy interest of individual physicians and the public interest in disclosure of such information." Prior to the new decision, HHS was prohibited from disclosing identifiable Medicare reimbursement payments of individual physicians.

In August, CMS requested public comment on the potential release of Medicare physician data. AAEM has been a vocal advocate for enhanced billing transparency, and submitted comments urging the adoption of a responsible policy that would provide emergency physicians the ability to see what is being billed and collected in exchange for their professional services. It is not clear whether the new policy will give physicians access to additional information. AAEM has also applauded Congress' willingness to consider Medicare transparency provisions as a part of SGR legislation. ■

Advocacy Fellowship Rotation on Capitol Hill Approved

William T. Durkin, Jr., MD MBA FAAEM
AAEM Immediate Past President

"OK, let's do it!" With those words Congressman Raul Ruiz (D-CA) ended a four month long discussion between myself and his office, which began during the RSA's Advocacy Day last fall. Working through our lobbyists, Williams and Jensen, I met twice with the congressman and had several discussions with his aides about setting up a month-long rotation in his office, whereby an interested resident could get a firsthand view of how the legislative process really works. Dr. Elizabeth Johnson, who is currently working for the congressman, was a real champion of this cause. After I met her last December, she facilitated the entire process and we came up with a written plan, which the congressman approved a week before the Academy's Scientific Assembly in February.

The experience promises to be invaluable for all involved. The congressman wants the participant to be able to brief him on hearings, know how to write a position paper, help with legislative efforts, and spend a week in his district seeing how the office works at the grassroots level. The participant will be awarded a certificate at the end of the fellowship and will then become part of Congressman Ruiz's "alumni network," which he may wish to consult from time to time on legislative matters regarding health care. The Academy will gain a cadre of members who have experience on Capitol Hill and will be able to assist, along with Williams and Jensen, in our advocacy efforts. **We are the only professional society in emergency medicine to offer such an experience to its members.**

Applications are available to anyone interested. The application process includes two essays, the Academy and AAEM/RSA will select candidates for each month-long rotation and send these names to Congressman Ruiz's office, where he and his staff will make the final selection. Those interested must fund themselves. Matt Hoekstra and Jenny DiJames, of Williams and Jensen, have offered to assist in orienting selected candidates to the area and to congressional protocol and procedure.

I would like to extend our deep appreciation to Congressman Ruiz for volunteering to provide this opportunity to our members; to Dr. Elizabeth Johnson for her part in facilitating this; and to Matt Hoekstra, Jenny DiJames, and Susan Hirschmann for their help in making this possible.

For more information and to apply, please visit: www.aaemrsa.org/congressional-fellowship. ■