American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

June 22, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
SD-219
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
SD-219
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chairman
Senate Committee on Finance
Chronic Care Working Group
SD-219
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chairman
Senate Committee on Finance
Chronic Care Working Group
SD-219
Washington, D.C. 20510

Dear Senators Hatch, Wyden, Isakson and Warner:

On behalf of the more than 33,000 physician members of the American College of Emergency Physicians (ACEP), I appreciate the opportunity to provide comments to the Senate Finance Committee's Chronic Care Working Group. As you so convincingly pointed out, the incidence of chronic disease in America's elderly population is staggering, as are the aggregate costs.

Emergency physicians across the country are treating more and more patients with comorbidities, which often complicates proper diagnoses and treatments. Whether you live in an urban or rural area, trying to find the right level of care for seniors with not one, but several, medical conditions is an ongoing struggle that plays out nights, weekends and holidays at the hospital emergency department (ED).

Emergency physicians see large numbers of Medicare patients for acute exacerbations of their chronic conditions. According to the most recently published statistics from the Centers for Disease Control and Prevention (CDC), 18 percent of the 136 million ED patient visits in 2011 were from Medicare beneficiaries. We agree with policymakers that some ED visits and hospitalizations for chronic condition patients can and should be avoided with better-coordinated clinical and social supports in the community. ACOs, medical homes, and (the MACRA-supported) alternative payment models (APMs) efforts show promise, but they have been crafted rather narrowly and presume that all care coordination can and will be accomplished by primary care providers. This remains aspirational rather than realistic at this point and emergency physicians can and do play a very active role in information sharing and care coordination.

One of the most important elements of patient-centered care is deciding when individuals cannot by safely managed in a community setting. Emergency physicians are trained to rapidly evaluate a wide array of conditions that are complex or time sensitive, and facilitate observation or admission of the most acutely ill patients. Emergency departments are as vital as medical homes in every medical community.

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Care coordination. If one of the overarching goals is to support incentives for care coordination across settings for those who are treating patients living with chronic diseases, then broader incentives for emergency physicians and other specialists who treat these patients are required by removing overly restrictive definitions of who can use the reimbursement codes. In addition, totally inter-operative electronic health records must be supported to facilitate a high level of cooperation between community, hospital and post-acute service providers. Billions of tax dollars have been spent on EHR infrastructure, which to date has largely resulted in electronic silos created by IT vendors.

- One of the biggest obstacles for emergency physicians seeing a patient for the first time is the lack of information about the patient's history. This often leads to missed opportunities to implement care coordination. Doctors need a mandated minimum essential data set that would include prescribed medications, as well as imaging and lab test results to avoid duplicative testing. Additional investments are needed to create a truly connected care coordination electronic infrastructure to share data between electronic health record (HER) systems, as well as pharmacy, post-acute and other care settings that are not currently captured within a hospital or physician's HER.
- Medicare coverage for telehealth is cumbersome and limited by current criteria, (which was noted in MACRA) and needs timely regulatory change. The technology is evolving quickly and shows great promise for diagnostic and treatment purposes. To date, Medicare offers no telemedicine coverage for services provided by emergency physicians. However, we have members located in a state's single academic medical center providing telemedicine services to critical access hospitals in rural areas around the state. These services have avoided unnecessary interhospital transfers to tertiary care centers, often by providing real time review of scans and tests.
- Telemedicine or some other assistive technology can also be successfully used by skilled nursing facilities (SNFs) and EDs. Many SNFs automatically send any patient to the ED who falls, is suspected of pneumonia, or some other complication. After consultation with the emergency physicians, many of these patients can often be cared for in the SNF, avoiding an ED visit that is often extremely disorienting to the patient.

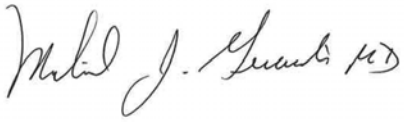
Payment policy. One of the most complex challenges for Congress and the Administration will be breaking down historic payment silos that impede care coordination and maintain out of date rules for site of service. Again, keeping patients with chronic disease out of the hospital requires significant resources by a variety of providers (mentioned above) who should share in the responsibility and payment incentives. For example, although Medicare Advantage, and now most ACOs, is exempt from the 3-day (hospital) stay rule before a beneficiary is eligible for Medicare SNF services, fee-for-service beneficiaries must adhere to the 1965 law or be subject to significant financial liability. Medical necessity criteria for SNF admissions have long been developed and refined by CMS and could be used by emergency physicians (and other doctors) to order direct admissions to SNFs for patients who need 24-hour assistance and therapy, but not necessarily daily medical intervention.

- As noted above with the CDC data, many emergency physicians see elderly patients who could appropriately be admitted to the hospital. As an alternative, given proper cooperation and support from family, a primary care provider and perhaps a home health care agency or some other community support, they could be discharged home with follow-up already scheduled. However, these are very time-consuming tasks which often include significant emergency physician time. While a costly admission or re-admission may be avoided, the doctor's additional work effort goes unrecognized by the current system. In fact, the physician could be penalized financially as a result of subsequent patients giving low patient experience (satisfaction) scores for having to wait too long to be seen. In a busy ED, demand for care usually outstrips the supply of ED beds and clinicians.
- Possible considerations may include acute care payment episodes for common conditions, e.g. congestive heart failure or pneumonia, which would use clinical guidelines/pathways that would create a single bundled retrospective payment for services associated with the acute problem including physician office, clinic, ED, labs, imaging, medications, etc.

As the 2013 RAND Corporation study on the evolving roles of emergency departments noted, most patients who seek ED treatment on a walk-in basis do so because they lacked an alternative or were sent to the ED by another health care provider. The study further suggested future policy considerations take into account the increasingly important role EDs play in both outpatient care and inpatient admissions (emergency physicians are the major decision makers for approximately half of all U.S. hospital admissions). As such, EDs should be more formally integrated into health care delivery systems rather than seen as stand-alone sites of care. This integration can be substantially facilitated through more widespread adoption of interoperable and interconnected health information technology (HIT), greater use of care coordination and case management that is inclusive of ED services, and better office- and hospital-based physician collaboration to improve patient transitions between sites of service.

ACEP looks forward to collaborating with you as you seek ways to improve care coordination for seniors with chronic conditions. Please let me know how we can help or if you have any questions.

Sincerely,



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