



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUN 29 2007

Administrator

Washington, DC 20201

The Honorable Henry Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives
Washington, DC 20515-6143

Dear Mr. Chairman:

Thank you for the opportunity to respond to your June 22 letter regarding the Centers for Medicare & Medicaid Services' (CMS) response to the Nation's emergency care crisis. We realize these responses are not a substitute for testimony before the Committee, but I hope they will provide insight into CMS' actions in support of our Nation's emergency care providers. We provided answers on June 22 to draft questions sent by the Committee on June 19. Today, we are following up with responses to the questions we received on June 22.

CMS recognizes the significant role our programs play in financing emergency services, as well as the challenges facing our Nation's emergency departments, trauma centers, and medical first responders. We also appreciate the insight provided by the Institute of Medicine's (IOM) series of reports: "*Emergency Medical Services at the Crossroads.*" The careful deliberations that informed the reports and their recommendations are a testament to the hard work and dedication of IOM's Committee on the Future of Emergency Care in the United States Health System.

However, we realize that success in this arena cannot be achieved by our agency alone. Although Medicare and Medicaid beneficiaries account for the largest number of inpatients admitted through emergency departments, private pay patients account for the largest volume of emergency department visits overall. Thus, we are committed to moving toward a collaborative, value-driven process so that change in our Nation's emergency care system can be realized.

Finally, we look forward to working with you and your colleagues in our continuing efforts to promote better access to primary care and improved quality of care throughout the health care system. If you have any questions, you may contact me or work with Elizabeth Hall, the Director of the CMS Office of Legislation at (202) 690-5960. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Leslie V. Norwalk".

Leslie V. Norwalk, Esq.
Acting Administrator

Enclosure

1) What actions, if any, has CMS taken to address the boarding of admitted patients in emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

Emergency department (ED) boarding—the practice of holding admitted patients in hallways and other ED areas until inpatient beds become available—is the product of a complex interplay of multiple contributing factors. Ultimately, these factors affect input, throughput, and output of patients throughout their care and flow through the hospital. While CMS finances care for a significant share of the patient population seeking emergency services, it would be neither possible or appropriate for CMS to direct the day-to-day operations of how hospitals manage their workflow.

Consequently, CMS has leveraged its influence by using its strategic and programmatic initiatives to address some of the underlying causes of ED boarding, to support hospital operations more globally, and to develop incentives to achieve improved clinical outcomes. These incentives are focused on the three broad areas of input, throughput, and output of emergency patients, with particular impact on patients requiring admission to the hospital..

I. INPUT

To the extent that CMS can improve access to primary care services, increase healthy behavior and the use of prevention services, and improve chronic disease management, one would expect less demand on emergency services for acute exacerbation of chronic illnesses that lead to hospitalizations as well as make up the preponderance of Medicare admissions via the emergency department. Examples of initiatives to reduce emergency department usage and acute care hospitalizations were provided in our prior response and are reiterated here.

a) Disease Management and Chronic Care Management:

Medicare inpatient admissions through the emergency department are overwhelmingly chronic in nature. Because of this, CMS has sought to implement disease management and chronic care management programs in order to reduce admissions that are often preventable. CMS has two major initiatives underway to further enhance support for chronically ill Medicare beneficiaries, which may have a favorable impact on emergency department services: the Medicare Health Support Program and the Care Management for High Cost Beneficiaries Demonstration. Both programs are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency department visits, and help participants avoid costly and debilitating complications.

Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the development and testing of voluntary chronic care improvement programs, now called Medicare Health Support (MHS). MHS programs are designed to help reduce health risks, improve quality of life, and provide savings to Medicare. Phase I is a pilot phase that will run for three years. Phase I, which is currently underway, is operating in six geographic areas across the country and serves about 120,000 beneficiaries who are enrolled in traditional fee-for-service (FFS) Medicare and who have heart failure and/or complex diabetes

among their chronic conditions. Depending upon the success of Phase I, the statute calls for a Phase II expansion of MHS programs or program components.

The Care Management for High Cost Beneficiaries (CMHCB) Demonstration is a 3-year project that tests provider-based care management services as a way to improve quality of care and reduce costs for FFS beneficiaries who have one or more chronic diseases and generally incur high Medicare costs. The CMHCB project is operating in several areas around the country, through six different organizations, and serves approximately 25,000 Medicare beneficiaries who are enrolled in traditional FFS Medicare.

Participants in both the MHS Program and the CMHCB Demonstration have access to Case Managers, who help the beneficiary to self-assess his or her health status, and to determine the most suitable treatment modality, thus potentially avoiding costly and inappropriate hospitalizations and emergency treatment.

One CMHCB site is testing the concept of "on-demand" physician home visits. Providing these patients with direct and timely access to a doctor 24 hours a day, seven days a week, allows for the intensive management of chronic conditions and patient monitoring in times of crisis that would otherwise require expensive emergency department visits and/or hospitalization.

Both the MHS Program and CMHCB Demonstration illustrate CMS' continuing commitment to pursuing innovative and beneficiary-centered solutions to the growing concern surrounding emergency department care.

b) Prevention Initiatives:

- *Promotion of Preventive Benefits:* This year, as part of the "A Healthier US Starts Here" initiative, the U.S. Department of Health and Human Services (HHS) and CMS joined with local officials and other partners to raise awareness of the importance of preventing chronic disease and conditions, promote Medicare's preventive benefits, and provide information on how beneficiaries can take action to maintain and improve their health. Medicare began covering preventive services in 1981 with pneumococcal vaccinations, and many other screening and preventive benefits have been added to the program since that time. CMS is committed to promoting the appropriate use of Medicare's preventive benefits. Current preventive benefits include: bone mass measurement, cardiovascular disease screening, cervical cancer screening, colorectal cancer screening, breast cancer screening, prostate cancer screening, diabetes screening, diabetes self-management, glaucoma screening, adult immunizations, medical nutrition therapy for beneficiaries with diabetes or renal disease, smoking cessation counseling, and a one-time "Welcome to Medicare" physical exam (including referral for an abdominal aortic aneurysm ultrasound). CMS has done, and continues to do, extensive outreach to health care professionals to help increase awareness of preventive services covered by Medicare and provide coverage and billing information needed to effectively bill Medicare for preventive services provided to Medicare patients. This outreach includes communication through CMS provider listservs, professional associations at the national and local levels, and Medicare claims processing contractors, in addition to distribution

of materials at health professional conferences. A complete list of CMS educational materials developed to promote preventive services can be viewed at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp. As these efforts succeed, CMS expects to see reductions of acute exacerbations of chronic illness requiring emergency intervention and hospitalization.

- *Tracking Long-Term-Care (LTC) Immunizations:* Another example of CMS' focus on increasing utilization of covered preventive benefits is the tracking of pneumococcal and influenza immunizations in nursing homes. Tracking patients admitted to the LTC arena for appropriate and timely immunizations can prevent hospitalization. Additionally, CMS ensures through the survey process that residents who have not already received these vaccinations are given the opportunity to receive or decline them.
- *Prescription Drug Coverage Under Part D:* One of the most significant advances in the Medicare program since its inception in 1965 is the addition of prescription drug coverage. Roughly 38 million Medicare beneficiaries have prescription coverage, to date. The latest Medicare Rx Education Network Survey (September 2006) shows that 1 in 5 seniors in stand-alone drug plans report no longer skipping or reducing needed medications. Sixty-seven percent feel better off now than before Part D, and 80% of seniors are satisfied with the program. Thus, we are moving Medicare towards providing drug usage for prevention and maintenance rather than "rescue" therapy delivered in ED and hospital settings.

c) **State Initiatives:**

- *Rhode Island Connect CARRE Program:* The State of Rhode Island seeks to control program costs and improve the quality of care for disabled and elderly adults in its fee-for-service Medicaid program through the Connect CARRE Program. The target population includes a culturally diverse and economically disadvantaged group of disabled and chronically ill Medicaid beneficiaries age 22 and older with congestive heart failure, chronic obstructive pulmonary disease, sickle cell anemia, asthma, diabetes, and depression. The target population also includes Medicaid beneficiaries who are frequent users of acute care services, who reside in a community setting but lack social and community supports, or who are at risk for recurrent adverse medical events, frequent hospitalizations, and emergency department visits. The program assures that each participant has a medical home, a plan of care that responds to the individual's unique service needs, the skills necessary to manage and monitor chronic conditions, and the ability to recognize situations that require medical intervention. Utilization data and performance measures indicate that the program has reduced unnecessary hospitalizations; improved access to providers, services and care in the community; and enhanced the quality of life for participants. For calendar year 2003, acute hospitalizations cost \$1,000,000 less for a subgroup of 45 Connect CARRE enrollees than a control group of 45 recipients who were eligible but refused enrollment.
- *Washington State's Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program:* Individuals with substance abuse problems have had difficulty gaining access

to needed services in the State of Washington. Under the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program, chemical dependency professionals placed in the State's busiest hospital emergency departments screen individuals suspected of having a substance abuse problem and refer them for treatment, if necessary. This approach is based on the premise that clients with substance abuse problems are most likely to be motivated to seek treatment in moments of crisis. By initiating substance abuse interventions in the emergency department, the State hopes to reduce subsequent emergency department utilization, medical costs, criminal behavior, disability, and death of patients with alcohol or other drug problems. An in-depth evaluation of the WASBIRT program will be conducted in 2007. Preliminary surveys show that screened patients' use of alcohol and drugs has declined, abstinence has increased, and brief chemical dependency and alcohol treatment has resulted in significant declines in use of alcohol.

- *West Virginia's Medical Home Model:* A key concept in the Deficit Reduction Act (DRA) reform package implemented by West Virginia in 2006 involves the creation of a "medical home" for Medicaid beneficiaries in the state. Beneficiaries establish a relationship with a primary care provider and contract with that provider to be responsible for their own good health habits and proper utilization of the health care system. One of the twelve specific clauses in the contract commits the patient to use the hospital emergency department only in true emergencies. It is expected that this agreement, together with the improved patient compliance required by other clauses in the agreement, will significantly reduce the number of unnecessary emergency department visits.
- *Nevada's FQHC Expansion:* The Nevada legislature is reviewing a plan to allocate ten million dollars to expand the capacity of its Federally Qualified Health Centers (FQHCs) to relieve overcrowding of the State's emergency departments due to the influx of patients who would be better handled in a clinic setting. Many patients in Nevada emergency departments come in for complications of diseases like asthma and diabetes that would probably never occur if the patients were connected to a primary care provider and receiving appropriate care for their disease. Nevada's proposed expansion of FQHC capacity and expansion of its Medicaid Program eligibility to create primary care capacity would relieve pressure on the State's emergency departments.

d) Grants for Non-Emergency Service Providers:

Section 6043 of the DRA provides \$50,000,000 over four years in grant funding to States to establish non-emergency service providers and provider networks, particularly for those in rural and underserved areas and those in partnership with local community hospitals. These facilities are designed to assist people to receive non-emergency care outside of an emergency department and would be a resource to deter the inappropriate use of emergency departments. The grants are designed to help establish working arrangements between emergency departments and the alternative providers to direct patients to the appropriate care setting. Alternative facilities can provide treatment to individuals who, after an emergency medical screening, have been

determined to have a non-emergency condition. CMS is in the process of developing guidance for States to apply for grant funding, which will be released shortly.

e) **Increased Reimbursement for Evaluation and Management Codes:**

Beginning in 2007, Medicare payments to physicians for many evaluation and management (E/M) services have increased significantly. These increases are a result of the statutorily mandated 5-year review of the work relative value units (RVUs) under the physician fee schedule that was conducted last year. Work RVUs for E/M services reflect the time and effort physicians spend with patients in evaluating their condition and advising and assisting them in managing their health. The work RVUs for a hospital visit requiring moderately complex decision-making increased 31 percent and by 29 percent for a similar level office visit. These E/M codes are in the top ten most frequently billed physicians' services. The increase in payment to physicians for spending time to manage the care of patients will help to provide better access to primary care services, and ensure more efficient use of health care resources and better outcomes for patients.

f) **Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens:**

Under Section 1011 of the MMA, the Secretary of Health and Human Services must directly pay hospitals, physicians, providers of ambulance services, and Indian Health Service and Tribal organizations, for their otherwise unreimbursed costs of providing services required by Section 1867 of the Social Security Act (EMTALA) to certain individuals. These individuals include undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa.

Section 1011 authorizes \$250 million per year for fiscal years (FY) 2005 through 2008. Two-thirds (\$167 million) is allotted to all 50 States and the District of Columbia, based upon their relative percentages of the total number of undocumented aliens. The remaining one-third (\$83 million) is allotted to the six States with the largest number of undocumented alien apprehensions (currently, AZ, CA, FL, NM, NY, TX). Unspent funds under the program roll over each year and are available until expended.

The effective date of the Section 1011 program is for payment requests (i.e., claims) with dates-of-service on or after May 10, 2005. While this effective date resulted in payments for less than the full 2005 fiscal year, the entire \$250 million was made available for dates-of-service May 10, through September 30, 2005. Almost 16,000 health care providers have enrolled in the Section 1011 program. To date, six quarterly payments have been made, amounting to approximately \$250 million. Data also indicate continually increasing utilization of the program.

g) **Other Initiatives:**

In addition, through its demonstration authority, CMS has implemented a number of other program initiatives that could reduce demand for acute and critical emergency care services

through better chronic care management. The following demonstration projects are either in development or underway.

- *Medicare Medical Home Demonstration (Section 204 of the Tax Relief and Health Care Act of 2006 (TRHCA))*: This demonstration in up to 8 states provides targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (that is, with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.)
- *Medicare Health Care Quality Demonstration (MMA Section 646)*: This will be a five-year demonstration program under which projects enhance quality by improving patient safety, and reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines, encouraging shared decision making, and using culturally and ethically appropriate care. Eligible entities include physician groups, integrated health systems, or regional coalitions of the same.
- *Medicare Care Management Performance Demonstration (MMA Section 649)*: Modeled on the "Bridges of Excellence" program, this is a three-year pay-for-performance demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients. Doctors who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes will receive bonus payments for managing the care of eligible Medicare beneficiaries. In contrast to the Physician Group Practice Demonstration, this demonstration, which is currently under development, is focused on small and medium-sized physician practices. The demonstration will be implemented in California, Arkansas, Massachusetts and Utah, with the support of the Quality Improvement Organizations (QIOs) in those states.
- *Physician Group Practice (PGP) Demonstration*: This program rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Under this demonstration, 10 participating physician groups continue to be paid on a fee-for-service basis and are eligible for performance payments derived from savings from the implementation of care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care.

II. THROUGHPUT

Although throughput is primarily a function of internal hospital operations and management, and should remain so, CMS has clarified a number of policies to allow hospitals increased flexibility to improve patient flow. These include actions taken by CMS in response to interim recommendations of the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group (TAG), as well as other initiatives, as described below.

a) **Provider Agreement Regulations and Conditions of Participation:**

- *Provider Agreement Regulations:* CMS responded to testimony and public comments received by the EMTALA TAG by revising the hospital Inpatient Prospective Payment System (IPPS) final rule in 2006 to include changes in the provider agreement regulations implementing EMTALA. This revision stipulated that a hospital that has specialized capabilities is required to accept appropriate transfers of patients, regardless of whether the hospital has a dedicated emergency department. This clarification was intended to improve timeliness of necessary and appropriate transfers by assuring that hospitals with specialized capabilities, including specialty hospitals, are aware of their obligation to accept transfer requests.
- *Conditions of Participation:* CMS has utilized the Conditions of Participation (CoPs) that health care organizations must meet in order to participate in the Medicare and Medicaid programs to facilitate the flow and throughput of inpatients. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. In addition to specific standards to which CMS holds the hospital for the provision of emergency services, the general CoP provisions provide guidance for the safe provision of care and services as the patient enters into the hospital system.

Established within the requirements for participation in the Medicare program are avenues to assure that traffic flow of the patient will include the provision of care in a safe setting. Patients are expected to be assessed in a timely manner by staff, with sufficient staff available to meet the patients' needs. Ensuring sufficient numbers of staff is the responsibility of the hospital's governing body. Administrative and medical staff must share the responsibility for managing the patient flow process in admission decisions, transfer and discharge decisions, along with the scheduling of patient tests and patient interventions.

While the requirements do not specifically prohibit the boarding of patients in hallways, wherever their care is provided, all requirements must still be met. The existing requirements stipulate that care must be furnished in a safe environment, including compliance with standards for infection control practices as well as those for fire safety and evacuation routes. Patients are to be treated with dignity and the confidentiality of medical treatment must be assured. The patient's plan of care in a therapeutic environment is monitored through the assessment of the nursing process.

In November 2006, CMS published a final rule revising the hospital Conditions of Participation. We addressed concerns about the burden and restrictiveness of several of our requirements. We extended the authority to conduct the history and physical examination required for each patient to other qualified individuals (besides physicians) in accordance with state law, and lengthened the timeframe for conducting the examination to 30 days prior to, or 24 hours after, admission. We also expanded the individuals qualified to conduct post-anesthesia evaluations, as well as to authenticate verbal orders. Finally, we revised the requirements governing the securing of drugs and

biologicals to achieve a more appropriate balance between enhancing efficient access to promote patient safety and avoiding unauthorized access.

b) **Financing Initiatives:**

- *Emergency Department Visit Payment Refinements:* Since the inception of the hospital Outpatient Prospective Payment System (OPPS), hospitals have reported emergency department visits according to their own internal hospital guidelines based on five levels of CPT codes, depending upon the resource intensity of the visits, with level 1 visits requiring the fewest and level 5 visits requiring the greatest facility resources. However, hospitals were paid for these visits at only three payment levels. In calendar year (CY) 2006, payments ranged from \$74 for level 1 and 2 visits, to \$129 for level 3 visits, to \$225 for level 4 and 5 visits. In the CY 2007 hospital OPPS final rule (71 FR 68134), CMS finalized a policy that reimburses emergency department visits at five payment levels instead of the prior three in an effort to more accurately tie payments to the intensity of the hospital resources utilized, with higher payment, in particular, for the most resource-intensive emergency department visits. Accordingly, for CY 2007, these payment rates are \$50, \$83, \$130, \$210, and \$325 for levels 1 through 5 visits, respectively. CMS believes that this refined payment methodology will provide more accurate payments for hospital emergency department visits, particularly for the most resource intensive emergency department visits provided by hospitals to outpatients.
- *Trauma Activation:* Since the inception of the hospital OPPS, hospitals have been paid at one payment level for outpatient critical care services lasting at least 30 minutes, into which hospital payment for a trauma response, if provided, was packaged. In response to public comments on the CY 2007 OPPS proposed rule and to a recommendation of the Advisory Panel on Ambulatory Payment Classification Groups, CMS finalized a policy in the CY 2007 hospital OPPS final rule (71 FR 68134) that would provide an additional separate payment for trauma activation in association with critical care services, to recognize the significant hospital resources associated with a trauma response for Medicare beneficiaries treated as hospital outpatients.

As noted in the final rule, CMS' claims analyses revealed that the typical hospital cost for the provision of a trauma response in association with critical care services was about twice the cost of critical care services without a trauma response. Therefore, under the CY 2007 OPPS, when a hospital trauma center reports a charge for trauma activation in accordance with established guidelines regarding prehospital notification based on triage information, and provides an appropriate trauma team response associated with critical care services, the hospital will receive a second separate payment in addition to their payment for critical care services. CMS believes that this differential OPPS payment for critical care services with and without trauma activation will improve the accuracy of OPPS payments relative to the required hospital resources, to ensure that trauma centers are paid appropriately for the costs associated with their preparedness and delivery of outpatient emergency trauma services to Medicare beneficiaries.

- *Inpatient Psychiatric Facility Adjustment:* Inpatient psychiatric facilities are paid under a per diem payment system, known as the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). The IPF PPS includes an adjustment to recognize the higher cost of psychiatric facilities with emergency departments, including psychiatric units in hospitals with emergency departments. In so doing, the IPF PPS provides an approximately 12 percent positive adjustment for the first day of care for facilities with qualified emergency departments (e.g., they are open 24 hours a day, seven days a week) in order to recognize the higher costs incurred in the early days of a psychiatric stay.
- *Redistribution of Residency Slots.* Medicare pays hospitals that train residents in approved programs additional graduate medical education (GME) payments. Hospitals are paid for GME based on the number of residents they train up to a hospital-specific cap. Section 422 of the MMA required the Secretary to redistribute “unused” residency slots (many hospitals were historically training fewer residents than their caps) to other teaching hospitals. An additional 2,500 slots were redistributed under this provision to hospitals nationwide. In recognition of the need for more emergency medicine physicians, CMS specifically gave priority to hospitals that were beginning to train residents in emergency medicine. This will help to address the shortage identified by the IOM.

c) **EMTALA TAG Initiatives:**

Section 945 of the MMA required the Secretary to establish a Technical Advisory Group (TAG) to provide the Secretary with advice concerning issues related to EMTALA regulations and implementation. The members of the EMTALA TAG include the Administrator of CMS, the Inspector General of HHS, hospital representatives and physicians representing various specialties, patient representatives, and representatives of organizations involved in EMTALA enforcement.

The EMTALA TAG is expected to complete its work and offer final recommendations later this year. However, several interim recommendations have already been proposed by the TAG and adopted by CMS, including the application of EMTALA requirements to hospitals without dedicated emergency departments, as described above. This clarification was finalized in the FY 2007 hospital inpatient prospective payment system final rule (71 FR 48097), which extends the requirements of EMTALA concerning acceptance of appropriate transfers to hospitals that have specialized capabilities but are without dedicated emergency departments.

In addition, CMS recently clarified that a hospital or critical access hospital may use remote telecommunications technology to obtain a consultation from another physician without violating EMTALA. Specifically, a Survey and Certification letter dated June 21, 2007, states that the treating physician in a hospital’s or critical access hospital’s dedicated emergency department who is conducting a medical screening examination and/or providing stabilizing treatment of an individual as required by EMTALA may, without violating EMTALA, consult on the individual’s case with a physician who is not present in the dedicated emergency department by means of any telecommunications medium that the physicians choose to use.

Another on-going focus of discussion by the EMTALA TAG is the extent to which EMTALA requirements would apply in disaster situations, and the circumstances under which some provisions might appropriately be waived. CMS looks forward to the EMTALA TAG's final recommendations on this and other issues, and will carefully consider whether regulatory changes or legislative proposals may be warranted.

d) Quality Measurement:

CMS is actively engaged in hospital quality measurement endeavors. A number of existing quality measures relate to the timeliness of emergency care for particular conditions. Additional quality measurement development is underway to more broadly measure emergency department throughput. When implemented, the use of these standards will help measure and promote improvement in patient throughput at the facility level. The development and use of quality measures are more fully described in the response to Question #4.

III. *OUTPUT*

Once patients are hospitalized, their lengths of stay can be reduced -- and consequently bed availability increased -- through improved options for home, community, skilled nursing facility (SNF), and hospice care. In addition, as more procedural care is moved into the outpatient setting, more in-patient beds can be available for emergency patients admitted through the emergency department, which by and large tend to be chronic care admissions.

a) Initiatives Through the Use of Section 1115 Waivers That Facilitate Community-Based Care:

CMS continues to work with States to expand health care coverage to low-income uninsured populations under demonstration projects. A major element of these demonstration programs is encouraging the provision of care in the most appropriate setting. Many of the individuals covered under these demonstrations are the parents of Medicaid or SCHIP-eligible children who would otherwise lack health care coverage.

Major health care coverage expansions as in Massachusetts, a state with a CMS-approved demonstration that is nearing universal coverage, are helping to eradicate the "old culture" of low-income Americans receiving non-emergency services in the emergency department. As the number of uninsured individuals decreases, there is a parallel movement towards the most appropriate settings to deliver the care that low-income people need. Specifically, in the case of Massachusetts, CMS was able to work with the State to ensure that the demonstration provided additional health insurance coverage, while at the same time offering the necessary financial stability to hospitals that provide emergency services.

Massachusetts, Oregon, Vermont, Oklahoma, and other states are moving towards private coverage models. In doing so, they build upon the strengths of the employer-based model, rather than addressing the issue of the uninsured by expanding public coverage programs. Private coverage models, in which financial accountability for providing quality care is placed front-and-

center, also encourage efficiencies and, therefore, encourage care in appropriate settings with an emphasis on prevention.

CMS has also worked with States to develop demonstrations that appropriately align incentives for consumers with settings that emphasize prevention and an ongoing relationship with a primary care provider. One straightforward way to incentivize individuals to be aware of the costs of medical care is through the pricing of the service. Therefore, appropriate financial incentives are another tool States are testing as a motivator to encourage timely care in the most appropriate setting. Under Utah's demonstration, higher-income people are charged \$30 for emergency department visits, compared to \$5 for outpatient office visits. Other States are considering different mechanisms to guide individuals to appropriate settings. Indiana is currently working with CMS on an account-based model that is expected to offer \$500 of first-dollar coverage for preventive services to uninsured adults to encourage the use of these services. This prevention-focused approach would be tied to a charge as high as \$25 for use of the emergency department, providing additional incentives to think about the costs of care and where care is most appropriately received.

In addition to covering more people, moving towards private coverage models, and making consumers aware of the costs of medical care – all of which can help create a health care system that focuses more on prevention and higher-quality health outcomes – CMS encourages States to develop program enhancements through demonstration projects. Iowa, for instance, offers under its demonstration project a 24-Hour Nurse Hotline. Operational since late 2006, the hotline is staffed by nurses from the University of Iowa's Hospitals and Clinics. Within the first three months of operation, the Nurse Hotline received nearly 3,000 calls. It assists in directing individuals toward the most appropriate care setting, thereby decreasing inappropriate use of the emergency department.

b) Section 5001(c) of the Deficit Reduction Act (DRA):

Section 5001(c) of the DRA implemented a quality adjustment in the DRG payment for certain hospital acquired infections. Effective for discharges on or after October 1, 2008, the DRG to be assigned shall be the DRG group that does not result in a higher payment based on the presence of a secondary diagnosis code. The secondary diagnosis code must describe a condition that could have reasonably been prevented through the application of evidence-based guidelines. By implementing Congressional intent to incentivize hospitals to eliminate preventable complications, hospital stays are shortened, improving hospital throughput.

Finally, the initiatives discussed above should also serve as a model for private insurers. Even though Medicare and Medicaid beneficiaries account for the highest number of inpatients admitted through the emergency department nationwide, private pay patients still account for the largest volume of emergency department visits. It is important that none of these initiatives be viewed in isolation. Rather, the changes CMS has already implemented as well as our future plans are part of a broad, strategic plan to leverage our position in the market as well as our role as a public health agency to address the emergency care crisis.

2) What actions, if any, has CMS taken to address the diversion of ambulances from emergency rooms at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

As with boarding of inpatients in emergency departments, ambulance diversion is a symptom of larger healthcare delivery issues facing the emergency care system. The types of initiatives listed in response to Question #1, focusing on the drivers behind emergency department crowding, would similarly reduce the necessity for ambulance diversion. In addition, CMS has specifically addressed issues related to ambulance capacity, from clarifying hospital responsibilities to adjusting ambulance payments, as described below.

a) EMTALA Clarification for Hospitals:

CMS heard complaints from EMS providers that some hospitals were refusing to take responsibility, often for lengthy periods, for patients transported by ambulance to the emergency department, requiring the ambulance crew to remain with the patient, thereby reducing EMS capability to respond to other emergency calls. CMS issued Survey and Certification memoranda on July 13, 2006 and April 27, 2007 reiterating that a hospital with a dedicated emergency department has an EMTALA obligation that begins when an individual arrives on the hospital's property, and that "parking" of patients with the ambulance crew was not acceptable. On the other hand, CMS also recognized that there might be extraordinary circumstances where emergency department staff are so busy with other emergent cases that it could be reasonable for them to ask EMS providers to briefly monitor a less urgent patient. CMS sees the emergence of such conflicts between EMS providers and hospitals as evidence of the rapid growth in demand for both types of services that has occurred in recent years.

b) Ambulance Payment:

In its 2006 report, *Emergency Medical Services at the Crossroads*, the IOM recommended that CMS consider the inclusion of readiness costs in Medicare payment for ambulances, and permitting reimbursement for EMS services rendered without transport. Recognizing the increased cost to ambulance services to be able to respond to emergency 911 and equivalent calls, the ambulance fee schedule already differentiates payment for emergency response from other routine ambulance transports. Ambulance costs include the direct costs of each emergency response, as well as the readiness costs associated with maintaining the capability to respond quickly, 24 hours a day, seven days a week. Medicare's ambulance fee schedule payment structure (which recognizes seven levels of service) was devised by a Negotiated Rulemaking Committee representing all aspects of the ambulance industry. When defining "emergency response" and setting payment levels for emergency level services, the Negotiated Rulemaking Committee recognized the cost of readiness and built it into the payment structure of the fee schedule.

With respect to payment for EMS services without an ambulance transport, it is important to note that Medicare coverage of ambulance services is limited by statute. The Medicare ambulance benefit is defined in Section 1861(s)(7) of the Social Security Act, which states that ambulance services are covered "when the use of other methods of transportation is contraindicated by the

individual's condition." CMS interprets this language as limiting the benefit to instances when an actual transport occurs, as well as a determination that the services are medically necessary and other forms of transport would be medically contraindicated. Thus, services rendered without actual transport of the patient (for example, EMS services furnished at an accident scene with no subsequent transport) are not covered under the statutory parameters of the ambulance benefit.

Further details on ambulance payment are addressed in Question #9.

3) What actions, if any, has CMS taken to address the decrease in coverage by on-call specialists at hospitals receiving Medicare or Medicaid funds? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

We believe this question is best viewed in relation to the "on-call" requirement under EMTALA. In 2003, based on numerous comments that CMS' previous EMTALA guidance was overly prescriptive and that hospitals should not be required to maintain any particular level of on-call coverage, CMS adopted regulations providing more general guidance on this issue. Under those regulations, which are currently in effect (see 42 CFR 489.24(j)), each hospital is required to maintain an "on-call" list of physicians in a manner that "best meets the needs" of patients receiving services required under EMTALA, in accordance with the resources available to the hospital, including the availability of on-call physicians. However, some hospital representatives subsequently expressed concern that this more general requirement is *insufficiently* prescriptive, thereby exacerbating rather than improving the problem of insufficient on-call coverage. In response, CMS has sought comments and suggestions from the EMTALA TAG.

The EMTALA TAG has recognized that the shortage of on-call coverage is complex with multifaceted causes ranging from changes in workforce, lifestyle, and delivery models, to name just a few. They also recognize that CMS lacks the statutory authority to require physicians to provide on-call services. To better address a range of possible approaches to the problem, the TAG established a subcommittee devoted solely to on-call issues, including (among other considerations) options for regionalization of on-call services. The TAG is expected to issue its final recommendations this fall. In the meantime, it is continuing its deliberations on this issue, including substantive input from experts across the country. The TAG has also acknowledged that factors beyond EMTALA affect on-call availability and established another subcommittee to consider larger healthcare system issues, ranging from reimbursement, to liability environment, to workforce, to capacity, to disparities in care.

CMS believes any further substantive action on this issue should await the TAG's final report. The Secretary will then evaluate the TAG's recommendations and will consider any regulatory changes or legislative proposals, as appropriate.

In the meantime, CMS has moved forward with other relevant initiatives. For example, on June 22, 2007, CMS issued instructions to the State survey agencies to clarify that telecommunications technology may be used by physicians treating emergency cases as a means to consult with specialists, including ones who are not on-call at the hospital, without violating EMTALA. Furthermore, specialists who are on-call do not have to appear in person, unless the treating physician requests this. This clarification facilitates broader and more efficient access to specialty services.

4) What actions, if any, has CMS taken to address the adverse health consequences of emergency room crowding, the boarding of admitted patients in ERs, and the diversion of ambulances on Medicare and Medicaid beneficiaries? If CMS has taken no action to address this issue, please supply your rationale for such inaction.

Evidence on the collective impact of ED overcrowding, boarding and diversion on health outcomes is largely anecdotal to date, with studies only now emerging as to the specific adverse outcomes related to increased lengths of stay, medical errors, morbidity and mortality, and other factors. Due to the complex interplay of individual contributing factors that vary by hospital, community and region, at this time we believe solutions to these problems are best addressed by a local approach rather than in a top-down manner from CMS.

While generally not mandating particular solutions to these and other health quality challenges, CMS does, however, require hospitals to be proactive and to employ systemic approaches to improving quality of care and patient safety. And regardless of whether a hospital is experiencing ED overcrowding, patient boarding, or diversion of ambulances, the hospital still has obligations related to quality of care, outlined by the Medicare Conditions of Participation (CoPs).

Adverse health occurrences in hospitals are dealt with through CMS' survey and certification enforcement process and the application of CoPs when specific complaints arise. Additionally, through its QIO program, CMS provides technical assistance to healthcare facilities and organizations to improve quality of care. Finally, CMS has a number of quality initiatives in this area, which are described below.

a) Conditions of Participation (CoPs):

CMS requires, through the Conditions of Participation, that hospitals develop, implement and maintain a hospital-wide, data-driven quality assessment and performance improvement program. Hospitals are expected to measure, analyze and track internal quality indicators, including adverse patient events, and other aspects of performance related to process of care, hospital services and operations. Hospitals are required to set priorities for performance improvement activities that focus on high-risk, high-volume or problem-prone areas and affect health outcomes, patient safety and quality of care. A hospital must conduct annual performance projects proportionate in number to the scope and complexity of services it offers. It would be reasonable and desirable for a hospital, as one of its quality improvement projects, to focus on the factors that increase emergency room crowding, boarding and ambulance diversion, and to undertake initiatives to address those factors within the hospital's control. CMS does not, however, mandate specific hospital quality improvement projects or methodologies, since hospitals must have the flexibility to tailor their efforts to their specific circumstances.

b) Survey and Certification Enforcement Process:

Apart from CMS' special quality initiatives, its routine survey and certification activities provide a critical foundation in ensuring that hospitals, including their emergency departments, comply with the health and safety standards established in the Conditions of Participation. Through its

complaint investigation activities, CMS surveys the compliance of both accredited and non-accredited hospitals. Through the survey process, deficiencies are identified and hospitals are required to develop and implement systematic plans to correct the identified problems and, ultimately, to provide better care for patients.

c) **Quality Initiatives:**

- *HCAHPS Survey:* Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) required the Secretary to expand the set of quality measures collected in the inpatient hospital setting, including Hospital CAHPS (HCAHPS) measures. The HCAHPS survey provides a standardized instrument and data collection methodology for measuring patients' perspectives on hospital care. The survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Survey results are publicly reported, which is designed to create incentives for hospitals to improve their quality of care and enhance public accountability by increasing the transparency of the quality of hospital care. The survey includes measures on the hospital environment and a patient's experience at the hospital as well as care from doctors and nurses. The perspectives of admitted patients will be included as part of this survey and public reporting initiative. Given the large subset of patients admitted through the emergency department, their satisfaction, often colored by long wait times and throughput, will create an opportunity for hospitals to improve patient flow.
- *Value Based Purchasing Initiatives:* CMS is also working to implement Section 5001(b) of the DRA, which authorized CMS to develop a value-based purchasing plan for Medicare hospital services beginning in FY 2009. This report will be submitted to Congress shortly and reflects extensive research on value-based purchasing in the hospital setting. The plan would utilize financial incentives and public reporting to reward both improvement and attainment on quality measures. The plan would be gradually implemented during FY 2010-2011 and would initially measure efficiency, outcomes, emergency care, care coordination, and structural and patient safety.
- *Public Reporting of Quality Measures:* Another way CMS has sought to leverage its position as a primary payer of services furnished to inpatients admitted through the emergency department is by improving the quality of care furnished to Medicare beneficiaries through public reporting of quality data. Public reporting not only provides information to the public, but is an important stimulus for hospitals to improve quality. Hospitals currently report on 22 measures, which are publicly available on the Hospital Compare website for nearly all hospitals.

Several of the measures pertain to care in hospital emergency departments and thus are indicators of quality of care in that setting. Insofar as hospital emergency department crowding may have a general impact on the quality of care rendered in emergency departments, it could be expected that the Hospital Compare measures pertaining to the emergency department may be impacted. Further, three of the Hospital Compare measures relate directly to the timeliness of care in the hospital emergency department.

These include timing of antibiotic administration for patients admitted for pneumonia, timing of percutaneous coronary intervention for a heart attack, and timing of thrombolytic therapy for a heart attack.

CMS has also embarked on a project to develop quality measures specifically directed at the timely and efficient provision of hospital emergency department care. Examples of measures that could result from this project include overall patient time in the emergency department for admitted patients and for discharged patients; percentage of emergency department patients who left without being seen by a physician; emergency department patient turnaround time for particular conditions and services; and timeliness of administration of pain medications.

Hospital Compare utilizes consensus endorsed measures, thereby representing broad consensus among stakeholders in the healthcare system. At this time there are no consensus measures available for implementation that have been adopted or endorsed by national consensus organizations that relate to throughput in hospital emergency departments.

- *Hospital Quality of Care:* Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program has been providing differential payments to hospitals that publicly report their performance on a defined set of inpatient care performance measures since FY 2004. The measures are designed to create incentives for better care, focusing specifically on some conditions that are often treated in an emergency department prior to the patient being admitted, such as acute myocardial infarction, heart failure, and pneumonia.

Since its inception, the RHQDAPU program has been expanded to provide consumers with quality of care information that will enable them to make more informed decisions about their healthcare and encourage hospitals to improve the quality of inpatient care. The hospital quality of care information gathered through the initiative is available to consumers on the Hospital Compare website. Hospitals that do not report the required set of quality measures receive a reduced payment update.

d) Quality Improvement Organizations:

The Quality Improvement Organizations have considerable responsibilities in quality improvement with providers nationally. Currently, QIOs work with nursing homes, home health agencies, hospitals, and physician offices. The following are clinical activities that QIOs are working on with providers to reduce patients' need for hospitalization:

- Preventing readmission to the hospital through appropriate care by home health agencies,
- Influenza and Pneumococcal vaccinations,
- Management of pressure ulcers,
- Management of depression,
- Improving primary care physicians' use of care management, measuring clinical care, and providing preventive care.

CMS has also charged the QIOs with implementing a number of initiatives to provide health information technology (HIT) services across the continuum of provider settings. Fewer emergency room visits and hospitalizations are key benefits that will result from care management and HIT implementation. Through the Doctor's Office Quality Information Technology (DOQ-IT) initiative, over 4,000 practices representing 13,200 physicians across the U.S. have taken a baseline survey as the first step in adopting and implementing electronic health records (EHRs). Also, on April 11, 2007, CMS launched DOQ-IT University (DOQ-IT U), a nationally available, first-of-its-kind, free e-learning system to support HIT in physicians' offices (accessible at <http://elearning.qualitynet.org>).

The Care Management Module provides a web-based learning opportunity for all physicians. Modules will focus on adopting and implementing HIT in the physician's office setting, improving the physician/patient relationship and dialogue, overall strategies for motivating patients to engage in their care, optimizing decision-making by providing choice of individual tests/therapies based on specific guidelines, costs and therapeutic value, preventing errors through averting errors of omission, improving care processes such as providing better care documentation, enhancing preventive care, and improving understanding of drug interactions and use in the elderly.

This systemic approach to care management will help to prevent emergency room visits and hospitalizations. Care management modules will also include disease-specific tools and templates to engage patients in their own care (including for diabetes, coronary artery disease, hypertension, and congestive heart failure, as well as preventive care)

5) CMS has issued a final rule that would limit Medicaid payments to government providers, including safety net hospitals that furnish emergency care and level 1 trauma services. (72 Fed. Reg. 29748 (May 29, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of the Office of the Assistant Secretary for Preparedness and Response (OASPR) as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

In developing the proposed Medicaid Payment Reform Proposal as well as the final rule, published on May 29, 2007, CMS used standard clearance and review processes including the review of components of the Department of Health and Human Services (DHHS). However, CMS did not specifically request input from OASPR because that Office is not likely to have expertise in Medicaid financing arrangements, which is the subject of the rule.

In general, this rule should not negatively impact safety net providers. As noted in our response to previous questions from the Committee on this issue (using Grady Memorial Hospital as an example), providers are unfairly bearing the burden of financing the non-federal share of the Medicaid program. Our rule would, in fact, benefit these providers.

To the extent that a provider is not governmentally operated, this rule does not impact Medicaid payments made to them by the State. It would, however, offer further protection against States requiring non-governmental providers to assist in the funding of the Medicaid program as well as clearly stating that the provider must retain all of the Medicaid payments it receives.

To the extent that a provider is governmentally operated, the rule stipulates that the provider is entitled to receive Medicaid payments up to their full cost of providing services to Medicaid eligible individuals.

6) CMS has issued a proposed rule to eliminate federal Medicaid matching payments for the costs of Graduate Medical Education (GME), including the costs of residents who staff emergency rooms and trauma centers. (72 Fed. Reg. 28931 (May 23, 2007)). In developing this proposal, did CMS seek the opinion, formal or informal, of OASPR as to whether the proposed rule would have an adverse effect on the nation's disaster preparedness? If not, please explain why CMS did not seek the OASPR's opinion on this matter. If so, please provide a copy of any document received from the OASPR relating to its opinion on this matter.

In developing the proposed Graduate Medical Education (GME) rule published on May 23, 2007, CMS used standard clearance and review processes including the review of components of the Department of Health and Human Services (DHHS). However, CMS did not specifically request input from OASPR because the rule did not directly address payments to "safety net hospitals" nor did it target Medicaid payments for emergency departments or trauma centers.

The proposed GME rule specifies that states may not make medical education payments under their Medicaid State plans because Congress has not authorized GME as a reimbursable service under Title XIX as they directly have under Title XVIII. The proposed rule indicates that States are able to recognize increased costs associated with providing services in teaching hospitals by increasing the rates paid for those services. In addition, States would also be able to include the Medicare adjustment known as indirect medical education (IME) when calculating the Medicaid upper payment limit applicable to Medicaid rates. The Medicare IME adjustment is the payment Medicare uses in its reimbursement system to recognize the increased service costs in teaching hospitals.

In addition, limitations regarding graduate medical education payments should not adversely impact the nation's disaster preparedness as the Medicaid program is a federal-state partnership to provide medical benefits and services to low-income citizens of the United States.

7) In its June 2006 report, *The Future of Emergency Care*, the Institute of Medicine (IOM) recommended that “CMS should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring and enforcement of these standards.” What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

We recognize that the strain and stresses of the emergency care system go beyond what CMS alone can address. To assure a comprehensive, coordinated approach to provide CMS with direction for current and future initiatives, CMS’ first steps in response to the IOM report were:

- Participation in an HHS-wide workgroup
- Presentation at the IOM’s Capstone Workshop
- Participation in the Federal Interagency Committee on Emergency Medical Services (FICEMS)
- Continued participation in EMTALA TAG

a) HHS-wide workgroup:

Soon after the IOM reports were released, HHS convened an internal senior staff level workgroup to examine the three reports, discuss the 22 recommendations directed at HHS, evaluate initiatives and suggest a strategy to move forward. We appreciate the IOM’s careful analysis of the problems relating to emergency care, and we are continuing, together with the rest of the Department, to evaluate the recommendations of their reports. In particular, the Office of the Assistant Secretary for Preparedness and Response (ASPR) is developing a coordinated response to the IOM report. CMS has been an active member of the HHS-wide workgroup since its inception along with representatives of the NIH, AHRQ, CDC, FDA, ASH, and HRSA. This workgroup has been beneficial in providing a forum for evaluation of the emergency care crisis from a global HHS viewpoint rather than examination of the CMS role in isolation.

b) IOM’s Capstone Workshop:

In December 2006, CMS provided testimony at the IOM’s Capstone Workshop in Washington D.C., which provided a forum to engage public and stakeholder groups in a national discussion of issues identified in the three IOM reports, outlining some of CMS’ initial responses to the IOM reports in conjunction with other HHS agencies.

c) FICEMS:

CMS has been an active member of the Federal Interagency Committee on Emergency Medical Services (FICEMS) since its inception in December 2006. FICEMS was established by the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (42 U.S.C 300d-4). FICEMS is charged with coordinating Federal Emergency Medical Services (EMS) efforts for the purposes of identifying State and local EMS needs, recommending new or

expanded programs for improving EMS at all levels, and streamlining the process through which Federal agencies support EMS. The Secretary of Transportation, the Secretary of Health and Human Services, and the Secretary of Homeland Security, acting through the Under Secretary for Emergency Preparedness and Response has established a Federal Interagency Committee on Emergency Medical Services. The Committee is in the process of developing recommendations that are pertinent to the IOM report. Again through active participation in such workgroups, CMS can assure its efforts are consistent and coordinated with the federal community at large.

d) **EMTALA TAG:**

CMS has had formal representation on the Emergency Medical Treatment and Labor Act (EMTALA) technical advisory group (TAG) established by the Medicare Modernization Act. The 19-member TAG was created to review issues related to EMTALA regulations, provide advice and recommendations to the Secretary regarding those regulations, solicit comments and recommendations regarding the implementation of regulations, and disseminate information regarding the application of such regulations. Following release of the IOM reports, the TAG requested formal testimony from the IOM to better understand their concerns and suggestions. This Fall 2007, the TAG will be issuing recommendations for changes in statute, regulations, or policy related to EMTALA.

Active involvement in such forums and Department-wide workgroups are an essential precursor to establishing any internal CMS working group. CMS will continue to work with HHS' Office of the Assistant Secretary for Preparedness and Response and with other appropriate agencies to address boarding and diversion concerns. This will foster a department-wide approach to the nation's emergency care issues. Moreover, as noted in responses 1 - 4, even in the absence of a formal internal working group, CMS has already taken action on numerous initiatives designed to improve emergency department crowding.

8) In its June 2006 report, IOM recommends that CMS “remove the current restrictions on the medical conditions that are eligible for separate clinical decision unit (CPU) payment.” What actions, if any, has CMS taken to implement this recommendation? If CMS has taken no action to implement this recommendation, please supply your rationale for such inaction.

Under the hospital Outpatient Prospective Payment System (OPPS), Medicare provides payment for observation care. Such care is described as a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment of patients before a decision can be made regarding whether they will require further treatment as hospital inpatients or if they can be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery, and to patients who present to the emergency department and require a significant period of treatment or monitoring before a decision is made concerning their next placement. “Clinical decision units” may be developed by hospitals specifically for observation of patients with certain medical conditions, in order to improve the efficiency and quality of care for those patients.

The OPPS provides payment for all medically reasonable and necessary observation services. In the majority of cases (approximately 70 percent of occurrences), payment for observation is bundled into the payment for other separately paid services provided to patients, including surgical procedures, emergency department visits, and diagnostic tests. This bundling of payment is consistent with the OPPS principle of prospective payment for clinically similar groups of services. The observation care is inextricably linked to these other services, and its costs are considered in establishing the OPPS payment rates for these services. For three medical conditions, specifically asthma, congestive heart failure, and chest pain, the OPPS provides separate payment for observation care based upon the observation care costs determined from hospital claims data for patients with these conditions. For separate payment to be provided, a variety of criteria must be met, including a minimum of eight hours of observation care. Hospitals may determine the most appropriate approaches to providing observation care in their facilities, including developing clinical decision units, because bundled or separate payment for this care for all clinical conditions is provided under the OPPS.

The Advisory Panel on Ambulatory Payment Classification Groups (APC Panel), which advises CMS on the OPPS, has an active Observation and Visit Subcommittee that studies observation issues. The APC Panel has made recent recommendations to provide separate payment for observation for additional diagnoses, specifically syncope and dehydration, and to evaluate other clinical conditions for which separate payment for observation care could be appropriate.

The June 2006 IOM Report encourages hospitals to apply tools to improve the flow of patients through emergency departments, including developing clinical decision units. CMS encourages the current efforts by hospitals to streamline their care for patients receiving emergency services, including those patients for whom a period of observation care is necessary before a decision about patient admission or safe discharge from the hospital can be made. CMS is currently considering the recommendations of the APC Panel and examining all of the current OPPS payment policies for observation services, which are presently provided to Medicare beneficiaries with many different clinical conditions, to assess whether any changes to those

policies would provide more appropriate payment to hospitals for observation care. This assessment includes evaluating whether different packaged and separate observation payment policies should continue to be associated with observation care for specific clinical conditions. Any changes to the current observation payment policies would be proposed through the annual OPPS rulemaking cycle.

9) A recent GAO study concludes that Medicare payments for EMS services are 6% below the average cost of an ambulance transport, and 17% below cost in super-rural areas. (U.S. Government Accountability Office, *Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly* (May 2007) (GAO-07-383)). What actions, if any, does CMS intend to take to address the GAO findings?

On April 1, 2002, CMS implemented the Medicare ambulance fee schedule in a budget neutral manner, with a 5-year transition period. The relative values in the fee schedule were established through a negotiated rulemaking process, as required by the statute. During the transition to the national fee schedule, the Medicare Modernization Act (MMA) added several temporary payment provisions to address the cost of ambulance services including a substantial add-on for ambulance trips originating in "super rural" areas (expiration date December 31, 2009) as well as an additional payment for long rural trips (expiration date December 31, 2008) and a regional adjustment for ambulance companies located in areas that would not have received as great a benefit under the national ambulance fee schedule's original transition formula (expiration date December 31, 2009). A provision supplementing payments for rural and urban ambulance trips by 2% and 1%, respectively, expired on December 31, 2006. We note that the Government Accountability Office (GAO) used predominately 2004 data to compile its May 2007 report (*"Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly"* (GAO-07-383)), which was prior to the implementation of the MMA provisions.

CMS greatly appreciates the attention GAO paid to this issue and we welcome its recommendation for continued scrutiny. Specifically, GAO recommended that CMS monitor utilization of ambulance transports to ensure that Medicare payments are adequate to provide for beneficiary access, particularly in "super rural" areas. As stated in the Agency's comments on the GAO report, CMS is committed to continuing to monitor payment under the fee schedule and to make adjustments, as needed, to ensure that payment rates reflect the realities of ambulance services provided to Medicare beneficiaries. CMS also noted that the implementation of Rural Urban Commuting Areas (RUCAs), in conjunction with the 2000 decennial census population data, will allow us to recognize levels of rurality in every zip code across the country.