



## What Happens to Emergency Medicine in Healthcare Reform?

*Dennis Beck, MD, FACEP*

*President and CEO, Beacon Medical Services*

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This is an extraordinarily complex question particularly since as we go to press there are more questions than answers as far as what, if anything, will happen in Washington. Regardless of what eventually plays out in DC there is no doubt that the healthcare landscape is transitioning and the future of emergency medicine should be on every emergency physician's mind. What we do know is that we have the most expensive healthcare system in the world (by a factor of 2 compared to most industrialized nations), that we fail to insure 48 million citizens (many of whom are working) and that according to the World Health Organization, the United States ranks # 37 (between Slovenia and Costa Rica) in quality. Simply put, we pay more for healthcare than any other country in the world and in terms of maintaining a healthy population our system is ineffective at best. The overarching goals of reform have been defined as expanding coverage and reducing costs. While there are many questions on the coverage side – public option vs. insurance reform, mandates, the insufficient number of primary care to provide access and identifying funding sources – today I will focus on the cost side and how it might impact EM.

If you want sound a little wonky and impress friends and neighbors you should say that we must "bend the cost curve" which pretty much means that the rate of increase in healthcare spending needs to decrease (as opposed to an absolute reduction) in the coming years. The yellow brick road to bending the curve is paved with a payment reform principal referred to as Value Based Purchasing. And pay attention here (or check the CMS website) because VBP, independent of any legislative action, is here now and will be staying for a while. Governmental and private payers are devising strategies, models and demonstration projects with the expressed goal of rewarding *value* rather than *volume*. The story line goes like this – payers currently reimburse/pay/reward providers for volume and intensity of services. Providers see more patients, do more things to them and get paid more dollars regardless of outcomes. The new world order of VBP is premised upon payment reform as a strategy to maintain a healthy population. VBP based payment strategies reward outcomes, coordination of care, quality and population health. Payment policy is driven by prospective pricing tools that are based on outcomes, resource utilization and attainment of certain quality markers.

OK, so where does the ED fit in? Aren't we the safety net that provides a community service not unlike police and fire protection? When H1N1 comes to town, who you gonna call? Aren't we the folks that provide immediate assessment and treatment for time sensitive presentations like STEMI, stroke, sepsis and major trauma? Yes. But its time to wake up and look around. How many "friends" does EM have in healthcare reform? None. We are literally the poster child for everything that's wrong with healthcare today. Keep all those unnecessary visits out of the ED and we'll save a gazillion dollars. Every politician, analyst and physician repeats this enough so that it has become an accepted axiom. Reducing ED visits is about the only aspect of emergency care that has made it into any VBP proposals. In fact, in Massachusetts – which is an interesting state to track – they now have universal coverage (about 97%) and not surprisingly ED use increased by 7%. This is no surprise given the shortage of PCP's and our safety net role. So they did a study and determined that 50% of all ED visits were preventable or unnecessary and intend to fund global care based on that premise. The study methodology was badly flawed but it produced the results they wanted to hear. Now a lot of policy makers are looking to Massachusetts as a potential national model so the question that should be posed is "how would we function if the funding for ED care was cut by 50%?"



This is not a pretty picture. And the point here is that in the current environment of reform and VBP, emergency medicine as we know it and practice it today, is facing its greatest crisis since becoming a specialty. The sky isn't falling, but it might. The AMA and various specialty societies have been engaged and are actively pursuing VBP strategies to protect their interests. Witness the efforts from the primary care based societies around Patient Centered Medical Home. While our DC office continues to do strong work on the Hill with regards to potential legislative proposals, we need to do be doing more. There are messaging issues and challenges as far as developing strategies to demonstrate value. To that end ACEP leadership has appointed a Value Based Emergency Care Task Force with the stated goal being to put together a framework or blueprint for developing an EM VBP strategy. The VBEC TF consists of 15 ACEP members from diverse ACEP Committees and Sections and includes 2 ACEP Board members. There are experts from quality, reimbursement, government affairs, informatics, academia and research as well as practice management on the task Force. COACEP is well represented as I am Co-Chair along with Bruce Auerbach. Steve Hoffenberg is also on the Task Force representing the practice management perspective. We will be presenting our draft plan to the ACEP Board at Scientific Assembly in October.

For now, I see our challenge as twofold – to protect members and patients from intended and unintended consequences of reform and VBP efforts and to develop payment strategies that demonstrate the value of emergency care. To the former, for example, CMS is very focused on 30 day readmission rates and will likely implement payment sanctions or incentives to reduce these numbers. It's easy to see how EP's could be placed under extraordinary pressure if a hospital or admitting physician didn't get paid for that 2nd admission. Another challenge is bundled payments. In oversimplified terms, this is a payment strategy where an episode of care, for example MI or hip replacement, is paid for with a single payment that covers the hospital and all the providers. Payment might go to the hospital or something called an Accountable Care Organization. While certain practice models such as Geisinger, Mayo or Kaiser may be well positioned for this, most emergency medicine practice does not fit very well at all into the episodes methodology. The potential for major change in clinical, financial and practice structure is huge.

The second piece, demonstrating the value of emergency care and melding that into payment policy is perhaps even more challenging. Do we do this through process measures as a kind of P4P on steroids? Do we look at certain identified targets like reducing imaging costs or admissions? Or do we develop something altogether new along the lines of an ED episode of care. For example, such an episode might be based on a risk adjusted presenting complaint driven clinical guideline. Adherence to the guideline might drive payment incentives based on resource utilization and achievement of certain quality markers. Needless to say, some degree of tort reform would be an essential part of this. Perhaps it could take the form of a litigation safe harbor for adherence to the guideline with preset awards for an unexpected bad outcome. These are just some of the strategies being considered by the VBEC TF.

For now, the take home message is that ACEP is engaged and is being proactive in these challenging times. For all of us and our patients, healthcare reform represents a potential threat as well as a great opportunity. I welcome any comments or discussion with you and will do my best to keep all of our COACEP colleagues engaged and informed.