

REPORT NUMBER SIXTY-TWO

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physician Fee Schedule Final Rule, Outpatient Prospective Payment System
and Ambulatory Surgical Centers Final Rule, Medicare Demonstration Projects,
Physicians Regulatory Issues Team Update, Stark Phase III Update, Quality
Improvement Program, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare and Medicaid Services

Washington, DC

December 3, 2007

SUMMARY OF THE DECEMBER 3, 2007, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, December 3, 2007 (see Appendix A). Tye Ouzounian, M.D., standing in for the chair (Anthony Senagore, M.D.), welcomed the Council members and thanked them for taking the time to give their input and guidance on issues that affect the medical community.

Agenda Item B — Welcome

Herb Kuhn, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), said the Council has influenced how CMS thinks about programs such as the Physician Quality Reporting Initiative (PQRI), the recovery audit contractors (RACs), and the Final Rules on the physician fee schedule, the Outpatient Prospective Payment System (OPPS), and ambulatory surgical centers (ASCs). He noted that the Sustainable Growth Rate and the planned 10.1-percent negative update to the physician fee schedule for 2008 were not on the agenda because they are under discussion by Congress, but he welcomed PPAC input on those topics nonetheless.

PPAC members indicated that they would like an opportunity to comment on any substantial changes to the PPAC process and to participate in related advisory groups that Congress might mandate to address physician issues.

OLD BUSINESS

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the August 27, 2007, meeting (Report Number 61).

61-E-1: PPAC recommends that CMS increase awareness and education among medical specialty communities regarding the availability of coverage with evidence development (CED) and funding of clinical trials.

CMS Response: CED will only be used in the context of a national coverage decision (NCD). CMS may require CED as a condition of coverage when there is limited evidence of benefit of a particular service. In addition, every NCD final decision that is made is followed with a CMS change request package. That package includes the NCD Manual instruction, detailed business requirements targeted to the systems maintainers and contractors that must implement the NCD policy, and an updated claims processing manual (if applicable), explaining the coding and payment scenarios specific to the NCD policy.

Further, every business requirement document includes standard language directed at all CMS contractors responsible for implementing the NCD. That language indicates that a related provider education article, referred to as an MLN Matters article, will be available at <http://www.cms.hhs.gov/MLNMattersArticles>

shortly after the change request is released. The MLN Matters article is a detailed, plain text synopsis of the NCD policy and all corresponding implementing instructions. The MLN Matters listserv subsequently sends notification of the article to the contractors, who in turn post it, or a direct link to it, on their websites. All affected Medicare contractors also include information about them in their own listserv messages within 1 week of the availability of the MLN Matters article, and include the article in their next regularly scheduled bulletin. Medicare contractors also host regular provider/supplier contractor advisory group meetings comprised of members of their respective provider/supplier community.

The MLN Matters website is comprised of quite an extensive array of provider education tools in and of itself. It uses mechanisms such as the Internet, national educational articles, brochures, fact sheets, web-based training courses, and videos, to deliver a planned and coordinated provider education program designed to accommodate busy health care professionals with the least amount of disruption to day-to-day business.

NCDs, as well as prospective NCDs under review, are communicated to the public and the health care industry at large through other means as well. Dependent upon the complexity, interest, and/or sensitivity of the issue, CMS also utilizes guidance documents, question-and-answer documents, individualized listservs, Open Door Forums, Town Hall Meetings, the Medicare Coverage Development & Coverage Advisory Committee, technology assessments, and a quarterly provider update in the *Federal Register*, as well as informational meetings upon request.

The medical specialty community can track new NCDs issued by CMS on the Coverage Center website. Please see <http://www.cms.hhs.gov/center/coverage.asp>.

61-G-1: PPAC recommends that CMS continue to work collaboratively with the American Medical Association (AMA) to disconnect payment denials for anesthesia when a RAC retroactively determines that surgery was unnecessary.

CMS Response: CMS will continue to work collaboratively with the AMA and other appropriate stakeholders on all RAC issues.

61-G-2: PPAC recommends that CMS direct the RAC program to create clear, uniform notification and demand letters. The objective of the letters should be to decrease confusion and inefficiency and increase clarity and compliance.

CMS Response: CMS is moving toward standardized letters for use by each RAC. CMS anticipates the standardized letters will be available by March 2008 in the Medicare Financial Management Manual, Chapter 4, section 100. Use of the standardized letter will be required; however, each RAC will add additional

information pertinent to each overpayment identification. We will seek input from the AMA and the American Hospital Association (AHA) as we develop these standardized letters.

61-G-3: PPAC recommends that CMS and its contractors consider the medical necessity of each service provided downstream of a denied service on the original merits based on the information that was available to the downstream provider at the time the downstream service was provided.

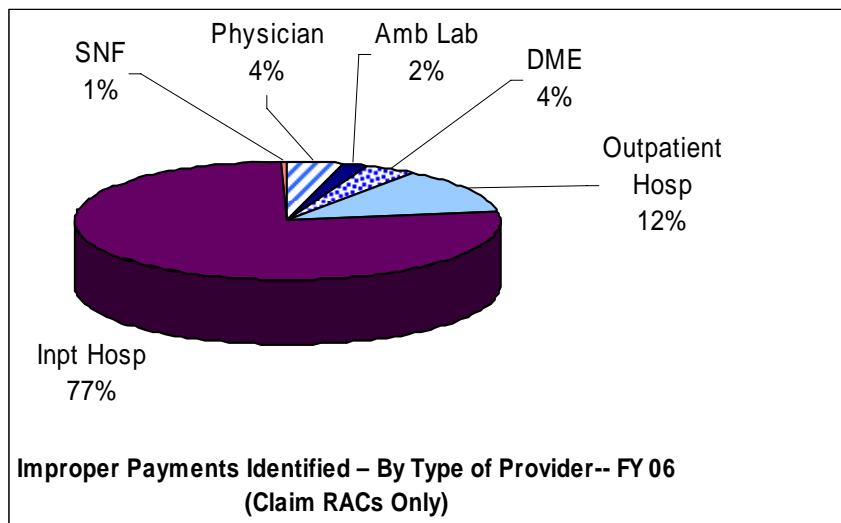
CMS Response: CMS appreciates PPAC raising this issue. The RAC team will continue to work collaboratively with provider associations such as the AMA and the AHA on these types of issues.

61-G-4: PPAC recommends that CMS direct the RACs to provide to PPAC data reflecting the percentage of physician chart audits that results in payment modification.

CMS Response: CMS does not have enough data yet to answer this question. We are currently working with the RACs to gather this data and will make it available in the future.

61-G-5: PPAC recommends that CMS provide PPAC with RAC audit data specific to physicians only, not combined with any other provider group.

CMS Response: See chart below of improper payments.



Numbers associated with these percentages are not available for the fiscal year (FY) 2006 data. However, when CMS releases the FY 2007 RAC findings we will include both physician numbers and percentages.

61-H-1: PPAC recommends that CMS make the medically unlikely edits (MUEs) available to the public.

CMS Response: CMS is in the process of surveying national medical associations (e.g., AMA, AHA) specialty societies, contractor medical directors, components within CMS, program safeguard contractors and other stakeholders for their perspectives regarding the possible public release of MUEs. In particular, CMS is interested in the assessment of the advantages and disadvantages of such release.

61-H-2: PPAC recommends that CMS allow the use of modifiers—including modifiers 59, 76, 77, and 91—when medically necessary and appropriate, that exceed MUE limits.

CMS Response: The MUE Project is currently allowing the use of modifiers (59, 76, 77, 91, and the anatomical modifiers) when medically necessary and appropriate.

61-I-1: PPAC recommends that CMS consider using data from the Physician Insurers Association of America because it is more timely than data CMS currently uses.

CMS Response: CMS is engaging in conversations with the Physician Insurers Association of America to gain a better understanding of the data it collects, including the costs and limitations of the data from this source.

61-I-2: PPAC recommends that CMS provide the geographic practice expense data that will be used to calculate the proposed geographic adjustment factor changes so that PPAC can verify the agency's calculations. PPAC recommends that CMS update the payment localities every 3 years using the 5-percent threshold. PPAC recommends that CMS maintain reimbursement in counties remaining in the original payment localities by establishing a geographic payment floor.

CMS Response: CMS appreciates the comments from PPAC on updating the geographic localities. We are studying this issue closely and will take these recommendations into consideration when making changes to the locality structure. We do not have the legislative authority to establish a geographic payment floor.

The data used to calculate the Geographic Practice Cost Index come from publicly available sources, such as the Census Bureau and the Department of Housing and Urban Development.

61-L-1: PPAC recommends that CMS incorporate into the Medicare Contractor Provider Satisfaction Survey (MCPSS) a measure to assess satisfaction of physicians who have participated in the RAC program.

CMS Response: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, specifically Subtitle B-Contracting Reform, Subtitle B, Section 911(b)(3)(B), calls for the Agency to develop performance requirements which shall include provider satisfaction levels. These requirements shall be set forth in the contracts with our Medicare Administrative Contractors, the entities responsible for both provider and payment functions. The RAC activities are not performed by any one of our Medicare Administrative Contractors, and CMS did not consider RAC-related questions as part of the MCPSS instrument. However, CMS conducts a separate provider satisfaction survey for providers who were contacted by one of the RACs. Results of the RAC provider satisfaction survey will be made available in the FY 2007 RAC Status Document (available on or before 1/31/08). CMS will continue to administer the MCPSS instrument and the RAC survey instrument separately.

61-P-1: PPAC recommends that CMS strongly protest the cessation or curtailing of PPAC activities and continue to support quarterly PPAC meetings. PPAC requests that CMS keep the Council informed on the status of efforts to curtail or disband the Council, including the possible ramifications of disbanding the PPAC.

CMS Response: CMS acknowledges the role of and the recommendations and input from the Council. We will promptly inform PPAC members of any statutory change that may affect the Council.

NEW BUSINESS

Agenda Item D — Physician Fee Schedule Final Rule

Whitney May, Deputy Director of the Division of Practitioner Services for the Center for Medicare Management, outlined the changes in the Final Rule that will take effect in January 2008 (Presentation 1). She noted that the Physician Assistance and Quality Improvement Fund has \$1.35 billion allotted to pay bonuses under the PQRI; bonuses will be calculated on the basis of 2008 claims. In response to members' questions, CMS Medical Officer Edith Hambrick, M.D., J.D., noted that the Secretary has the discretion to use the Physician Assistance and Quality Improvement Fund to offset the negative update but chose to retain it for PQRI bonus payments.

Recommendation

62-D-1: PPAC recommends that CMS use the Physician Assistance and Quality Initiative Fund to partially offset the planned negative update for 2008 and allow all physicians to benefit from the fund.

Agenda Item E —OPPS and ASCs Final Rule

Stephanie Kaminsky, J.D., Deputy Director of the Division of Outpatient Care for the Center for Medicare Management, described changes to the payment process for outpatient procedures in hospitals and ASCs that will take effect in January 2008 (Presentation 2). CMS uses a system of weighted measures that are revised annually to determine reimbursement rates and maintain budget neutrality within its payment systems. CMS relies on input from the public, including medical specialty societies, to evaluate which procedures should be covered in the ASC setting; ideally, such input includes data applicable to the whole country that support the perspective of the commenter. In 2008, hospitals will be required to report certain quality measures, e.g., treatment of acute myocardial infarction in the emergency department and perioperative care.

Recommendations

62-E-1: PPAC recommends that CMS develop a simpler, better, alternative approach to the ASC payment system planned to take effect in 2008—such as paying ASCs a defined, flat percentage of what is paid to hospitals for each procedure—that would not vary every year.

62-E-2: PPAC is concerned that Medicare patients receiving brachytherapy for prostate cancer at an ASC will be denied care as of January 1, 2008, because the Final Rule does not require payment of such sources. PPAC recommends that CMS address this issue immediately, for example, by maintaining the current methodology or implementing a temporary solution to allow patients to receive timely care.

Agenda Item G — Overview of Medicare Demonstration Projects

Linda Magno, Director of the Medicare Demonstrations Program Group in the Office of Research, Development and Information, described new demonstration projects as well as some that have already yielded results and valuable insights (Presentation 3). CMS is establishing the Medical Home Demonstration, mandated by Congress, which will encourage patients with chronic disease to be more engaged in managing their health and to have a “personal physician” who helps coordinate their care.

Agenda Item H — Physicians Regulatory Issues Team (PRIT) Update

William Rogers, M.D., Director of PRIT, gave an update on issues recently addressed by PRIT (Presentation 4). The PRIT website provides details on issues under consideration, such as a state Medicaid program’s decision to use 1995 evaluation and management codes instead of 1997 codes; simplification of the enrollment process; payment of active-duty military physicians who moonlight in civilian settings; and hospitals’ ability to provide continuing medical education free to their staff.

Agenda Item J — Stark Update

Donald Romano, Director of the Division of Technical Payment Policy for the Center for Medicare Management, said the regulations under phase III of the Stark laws go into effect December 4, 2007 (Presentation 5). The new regulations clarify existing exemptions and relax some restrictions. For example, anti-markup provisions now apply to the technical and professional components of diagnostic tests if the billing supplier ordered the test and if the technical and professional components were either purchased or performed outside of the billing supplier's office. Mr. Romano noted that CMS has a formal process for providing advice and opinions on how Stark laws affect physician relationships and may issue guidance on areas of particular confusion.

Recommendations

62-J-1: PPAC urges CMS not to issue additional rules that further complicate the Stark self-referral rules by adding more layers of confusion and regulation that discourage efficient and innovative quality health care.

62-J-2: PPAC recommends that CMS delay implementation of the anti-markup provisions to evaluate the substantial impact of these changes on health care providers, especially those in group practice.

Agenda Item K — Ninth Scope of Work/Quality Improvement Organizations (QIOs)

Paul McGann, M.D., Deputy Chief Medical Officer for CMS in the Office of Clinical Standards and Quality, described the evolution of the role of QIOs in quality improvement (Presentation 6). The ninth contract cycle (or scope of work) for QIOs begins August 2008, pending funding approval by the Office of Management and Budget. The ninth scope of work incorporates the themes of value-driven health care, adoption of health information technology, and reduction of health disparities in all of its components. Dr. McGann noted that in addition to the CMS website, www.medqic.org is a good source of technical assistance for QIO matters.

Agenda Item M — Testimony

William A. Dolan, M.D., of the AMA said its survey of physicians indicates that 60 percent would limit the number of new Medicare patients they see if the 2008 fee schedule includes a 10.1-percent negative update (Presentations 7a, 7b). He also pointed out the potential problems caused by other CMS rule changes, such as eliminating the fax option for e-prescribing and rigidly enforcing the use of National Provider Identifier (NPI) numbers.

Recommendations

62-M-1: PPAC recommends that CMS reinstate the fax exception for e-prescribing and work with Congress to provide financial incentives to facilitate wider adoption of e-prescribing.

62-M-2: PPAC recommends that CMS report to PPAC its plan of action to correct patient access cuts forecast by the AMA resulting from unsustainable cuts to physician Medicare reimbursement.

62-M-3: PPAC recommends that CMS allow carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections, especially given the untold numbers of practitioners who are being asked to reenroll.

62-M-4: PPAC recommends that CMS carefully monitor the industry's overall ability to use only NPI numbers by May 23, 2008, particularly the readiness of Medicare and those billing Medicare.

Agenda Item P — Wrap Up and Recommendations

Dr. Ouzonian asked for additional recommendations from the Council. He then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

Recommendations

62-P-1: PPAC recommends that CMS report the analyzed results of data from the 2007 PQRI at the May 2008 PPAC meeting and additional data at the August 2008 PPAC meeting.

62-P-2: PPAC recommends that CMS implement a rapid and direct NPI outreach plan with emphasis on small and rural providers and reconsider the revalidation process that began in October 2007 until the enrollment problems associated with NPI-Medicare matching are thoroughly resolved.

62-P-3: PPAC recommends that CMS work with Congress to 1) ensure immediate action to produce at least 2 years of positive updates and avert the 15-percent cut to the physician fee schedule over 2008 and 2009 and 2) repeal the Sustainable Growth Rate altogether and replace it with a system that produces positive physician payment updates that accurately reflect increases in medical practice costs as indicated by the Medicare Economic Index.

62-P-4: PPAC recommends that CMS apply the budget neutrality adjustment to the conversion factor for 2008 and subsequent years.

62-P-5: PPAC recommends that CMS be aware of areas of concern with proposed durable medical equipment, prosthetics, and orthotics supplies (DMEPOS) regulations, including competitive bidding and requirements to provide surety bonds to provide DMEPOS service. It is impossible for health care providers to compete against larger businesses whose sole purpose is to supply medical equipment. Therefore, providers should be exempt from the accreditation process on the basis of their training and from the competitive bidding process. PPAC urges CMS to remedy this situation by amending the Final Rule.

62-P-6: PPAC recommends that CMS reevaluate and reduce the 1.4-percent productivity adjustment to the 2008 Medicare Economic Index and the reduction for future years.

Report prepared and submitted by
Dana Trevas, Rapporteur
Magnificent Publications, Inc.

PPAC Members at the December 3, 2007, Meeting

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John E. Arradondo, M.D.
Family Physician
Hermitage, Tennessee

Vincent J. Bufalino, M.D.
Cardiologist
Naperville, Illinois

Peter Grimm
Radiation Oncologist
Seattle, Washington

Roger L. Jordan, O.D.
Optometrist
Gillette, Wyoming

Geraldine O'Shea, D.O.
Internal Medicine
Jackson, California

Gregory J. Przybylski, M.D.
Neurosurgeon

Edison, New Jersey

Helena Wachslicht Rodbard, M.D.
Endocrinologist
Rockville, Maryland

Jeffrey A. Ross, D.P.M., M.D.
Podiatrist
Houston, Texas

Jonathan E. Siff, M.D.
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Cleveland, Ohio

Arthur D. Snow, M.D.
Family Physician
Shawnee Mission, Kansas

M. LeRoy Sprang, M.D.
Obstetrics/Gynecology
Evanston, Illinois

Karen S. Williams, M.D.
Anesthesiologist
Washington, DC

CMS Staff Present

Stephanie Kaminsky, J.D., Deputy Director
Division of Outpatient Care
Center for Medicare Management

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services

Linda Magno, Director
Medicare Demonstrations Program Group
Office of Research, Development, and
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Whitney May Deputy Director
Division of Practitioner Services
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Paul McGann, M.D., Deputy Chief Medical
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Elizabeth Richter, Acting Director
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William Rogers, M.D., Director
Physicians Regulatory Issues Team
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Donald Romano, Director
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Ken Simon, M.D., M.B.A., Executive Director
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Public Witnesses:
William Dolan, M.D.
American Medical Association

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the December 3, 2007, meeting

The following documents were presented at the PPAC meeting on December 3, 2007, and are appended here for the record:

- Presentation 1: 2008 Physician Fee Schedule Final Rule
- Presentation 2: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Centers Final Rule
- Presentation 3: Overview of Medicare Demonstration Projects
- Presentation 4: PRIT Update
- Presentation 5: Stark Update
- Presentation 6: Ninth Scope of Work/Quality Improvement Organizations
- Presentation 7a: Statement of the American Medical Association to the Practicing Physicians Advisory Council
- Presentation 7b: Correspondence from the American Medical Association and the Medical Group Management Association to CMS

Appendix A

**Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 705A
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
December 3, 2007**

08:30-08:40	A. Open Meeting	Anthony Senagore, M.D., M.B.A., Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Herb Kuhn, Deputy Administrator, Centers for Medicare & Medicaid Services Elizabeth Richter, Acting Director, Center for Medicare Management
08:50-09:10	C. PPAC Update	Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council
09:10-09:40	D. Physician Fee Schedule Final Rule	Whitney May, Deputy Director, Division of Practitioner Services, Center for Medicare Management
09:40-10:15	E. Outpatient/ASC Final Rule	Stephanie Kaminsky J.D., Deputy Director, Division of Outpatient Care, Center for Medicare Management
10:15-10:30	F. Break (Chair Discretion)	

10:30-11:15	G. Overview of Medicare Demonstration Projects	Linda Magno, Director, Medicare Demonstrations Program Group, Office of Research, Development and Information
11:15-11:45	H. PRIT Update	William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Affairs
11:45-1:00	I. Lunch	
1:00-1:45	J. Stark Update	Donald Romano, Director, Division of Technical Payment Policy, Center for Medicare Management
1:45-2:30	K. 9th Scope of Work/ Quality Improvement Organization (QIO)	Paul McGann, M.D., Deputy Chief Medical Officer for CMS, Office of Clinical Standards and Quality
2:30-2:45	L. Break (Chair discretion)	
2:45-3:00	M. Testimony— William A. Dolan, M.D. American Medical Association	
3:00-3:30	N. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS December 3, 2007

Agenda Item D — Physician Fee Schedule Final Rule

62-D-1: PPAC recommends that CMS use the Physician Assistance and Quality Initiative Fund to partially offset the planned negative update for 2008 and allow all physicians to benefit from the fund.

Agenda Item E — Outpatient Prospective Payment System and Ambulatory Surgical Centers (ASCs) Final Rule

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Agenda Item J —Stark Update

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ACTION ITEMS