Alternative Payment Models
Salvation From MIPS?

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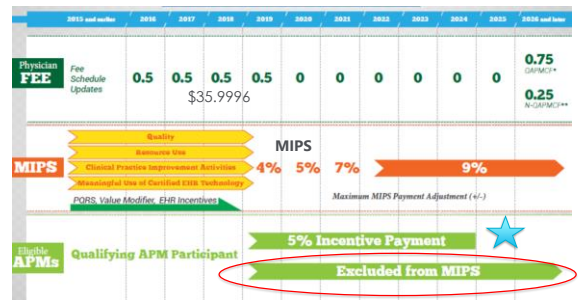
The Quality and Payment Timeline



What Is an APM?

- Alternative Payment Models are payment approaches, developed in partnership with the clinician community, that provide added incentives to deliver high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

What Is An Advanced APM?

Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes.

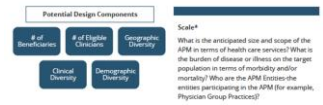
- Uses CEHR technology
- Requires "more than nominal" financial risk
- Applicable to specific care models, though expanding by year

Do APMs Matter to Emergency Medicine

- Yes- we need Emergency Medicine specific APMs
  - they take a while to develop
- Most ED physicians will satisfy MACRA requirements initially through MIPS
- Advanced APMs described in the MACRA proposed rule require very substantial infrastructure
- ACEP has a deeply resourced expert group working to design APMs for Emergency Medicine- challenging!

CMS APM Elements

- How will your Alternative Payment Model result in clinical practice transformation?
  - Change in delivery or payment methodology
- What is the rationale for your Alternative Payment Model?
  - Supporting data or payer experience
- What is the scale of your Alternative Payment Model?



CMS APM Elements

- How does your Alternative Payment Model align with other payers and CMS programs?
  - Are enough payers aligned to make the business case
- How is improved clinical quality or better patient experience of care measured under your Alternative Payment Model?

CMS APM Elements

- How easy would it be for participants to implement your Alternative Payment Model?
  - Are the systems and processes in place to operate the APM?
  - For Emergency Medicine the answer is currently No
  - We need an APM that will apply to a diverse patient population to hit required minimums
  - May need some regulatory waivers to be reimbursed for extra services

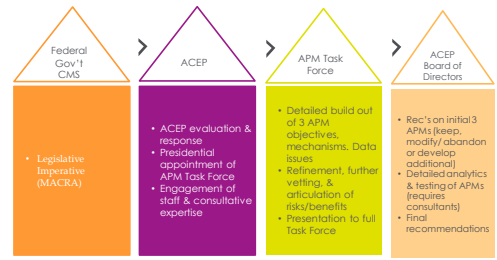
PTAC: Physician-Focused Payment Model Technical Advisor Committee

- Will assess the extent to which each submitted proposal meets criteria for PFPMs established by the Secretary of HHS in regulations at 42 CFR § 414.1465

Criteria

- Value over volume -Flexibility
- Quality and cost -Payment methodology
- Scope -Ability to be evaluated
- Integration and -Care Coordination
- Patient Choice -Patient Safety
- Health Information Technology

Alternative Payment Models: Project Flow



Ultimately Submit ED APMs to PTAC

ACEP APM Model 1- Discharge Planning

- ED physicians bear the cost of hiring DC planning FTEs in order to decrease preventable admissions
  - The economic risk component
- ED physicians bill using new CPT codes for DC planning services for appropriate patients
- If minimum regulatory thresholds hit could receive 5% lump sum bonus
- Result- Abandoned- the DC Planners were too expensive and no version of the model created adequate additional off setting revenue

APM WG 2 and 3

- (WG 2)Episodes of Care with the Hospital: An emergency physician group and hospital agree to jointly manage the total costs associated with ED visits within a pre-defined ED Case Rate
- (WG3) Population Health: Participants in this APM would agree to manage the costs of ambulatory acute care visits for a defined population of people, such as the residents of a nursing home, the employees of a self-insured business, etc.

Current State of APM Design WG 1 and 2

- APM 1 & 2 combined and redefined
- The ACEP Acute Unscheduled Care Model (AUCM)
- Background- The future is being thrust upon us
- The expansion of ACOs and other global AAPMs will expand pressure to discharge elderly patients into a healthcare system where timely appropriate testing and follow-up are a challenge, instead of admitting them to inpatient or observation services.
- To minimize the risk of adverse outcomes, changes in practice patterns must be accompanied by changes in payment policy that support care coordination, care transition services and telehealth

Benefits To ED MD Participating In Advanced APM

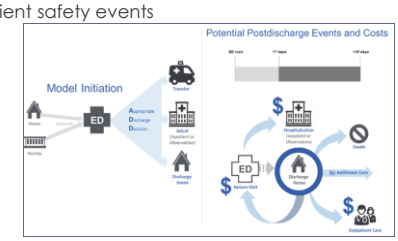
- Eligible for a lump sum bonus payment equal to 5% of all reimbursement for services rendered under Medicare Part B. (2019-2024)
- A portion of additional shared savings derived from the model itself
- Exempted from the Merit-based Incentive Payment System (MIPS)
- Reimbursement for waiver services: tele health, transitional care management, general supervision of post discharge home care visits
- Patient safety infrastructure enhanced with post DC care

Acute Unscheduled Care Model (AUCM)

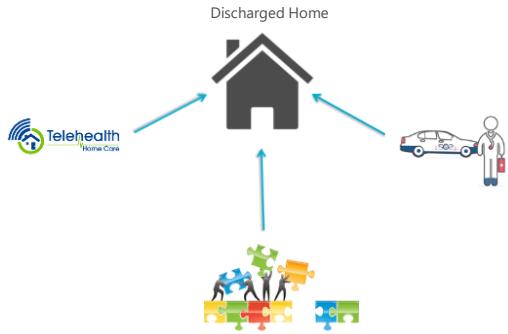
- AUCM enables ED physicians to improve the quality and cost effectiveness of acute, unscheduled care of Medicare beneficiaries.
- The AUCM will enable CMS to effectively engage emergency physicians:
  - **To avoid an initial admission while ensuring *safe* discharge of Medicare beneficiaries to a home environment**
  - **To foster effective care coordination**
  - **To reduce adverse post-ED patient safety events**
  - **To create overall cost savings**

The AUCM Model

- Increase the number of discharged patients while ensuring safe discharge of Medicare beneficiaries to the home environment, to foster care coordination regarding post-discharge workups and to reduce post-ED patient safety events



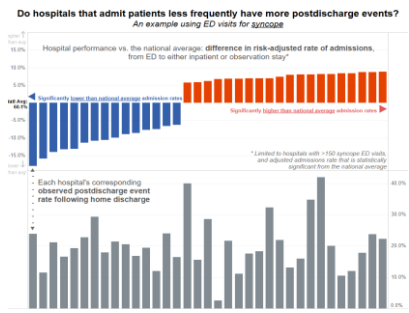
Expansion of ED Services and Value



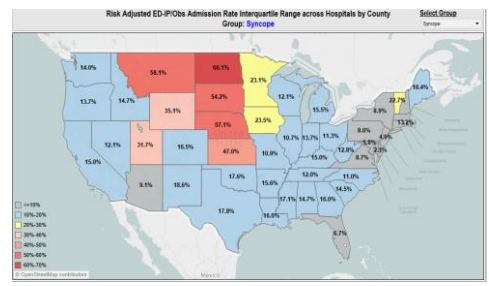
Key Findings- Data Analysis

- In the primary analysis of 6,995,818 ED visits, 54.7% resulted in discharge
  - Removed Hospice, no prior admission within 90 days, no prior ED visit in 30 days
- No relationship was found between rate of ED admissions and 30-day post-discharge event rates for ED visits discharged home.

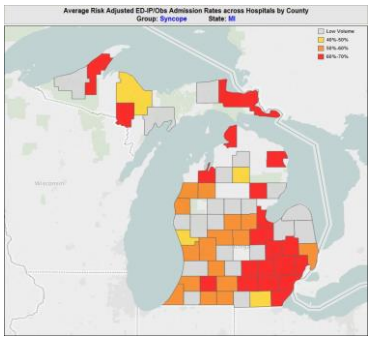
Did hospitals that admitted fewer patients have more post-discharge events?



Intra State Variability Admission of Syncope



Risk-Adjusted Admissions of Syncope Patients: Differences by County in Michigan



Hospital-Level Variation in Admission Rates

Hospital Variation in % ED Index Cases Admitted to IP or Observation Stays

Group Name	Total # ED Cases	Total % Admitted to IP or Obs	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile	Interquartile Range
Syncope	175,281	58.8%	16.7%	36.4%	53.8%	68.1%	80.0%	31.7%
Chest Pain	436,264	58.4%	20.4%	37.9%	54.7%	69.1%	80.7%	31.1%
Abdominal Pain	313,267	31.2%	0.0%	14.3%	25.4%	39.7%	47.0%	21.4%
Altered Mental Status	87,024	73.8%	25.0%	63.1%	72.7%	85.1%	100.0%	22.0%

Variations in Risk Adjusted ED-IP/Obs Admission Rates Across Hospitals

Group Name	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile	Interquartile Range
Syncope	31.4%	49.0%	58.5%	64.2%	67.8%	15.2%
Chest Pain	36.1%	50.2%	59.3%	64.7%	68.0%	14.5%
Abdominal Pain	0.0%	17.9%	28.1%	36.4%	42.2%	17.9%
Altered Mental Status	55.4%	71.6%	77.0%	79.4%	81.3%	7.9%

AUCM Model Specifications

Population	**MEDICARE FFS BENEFICIARIES WHO WERE NOT ADMITTED FOR AN ACUTE CARE STAY WITHIN 90 DAYS, NOT IN HOSPICE. (DUAL ELIGIBLE BENEFICIARIES WILL BE ROLLED INTO THE AUCM IN YEAR TWO.)**
Post discharge Events	In the 7 & 30 days following discharge home: • Return ED visit • Observation stay • Inpatient admission • Death
Patient Safety Metrics	Repeat ED visit, inpatient or observation stay within 7 days for: • Injuries • Adverse drug reaction • Post-ED procedure complications

AUCM Model Specifications

Cost Metrics	**AVOIDED ADMISSIONS AND POSTDISCHARGE COSTS AT 7 (30) DAYS**
Included Visits	All live ED discharges where the ED diagnosis does not result in admission over 90% of the time. • Program Limited Test Years (One-Two): A select group of episodes for a basket of targeted symptoms or diagnoses • Program Implementation Years (Three): **All episodes of acute unscheduled care rolled into program**
Waivers and Incentives	Participating ED physicians become eligible to provide telehealth services, transitional care payments and post discharge visits (non-home health)
Potential Exclusions	Patient transfers, deaths in ED, hospice cases, Medicare beneficiaries with an inpatient admission 1-90 days prior to the index ED visit.

Opportunity For Quality Impact: Post ED Discharge Acute Unscheduled Care

- An analysis of 6.9 million FFS Medicare ED visits in 2014 revealed a significant opportunity to impact quality of care and reduce expenditures:
- 35.8% of the visits resulted in admission, 7.3% in observation stays, and 54.7% of beneficiaries were discharged to home.
- Aggregate post-discharge event rates (adverse event rates) were 8.8% at 7 days, and 19.9% of 30 days.
- We will now have infrastructure to perform and be reimbursed for post DC care

Opportunity For Economic Impact

- Analysis of the 6,246,743 ED visits for conditions with a historical admissions rate of less than 90% found they represent $20.8 billion dollars in inpatient costs.
- A 3% reduction in the admission rate for four high-volume diagnoses (abdominal pain, syncope, chest pain, and altered mental status) would lead to approximately **$315 million dollars in savings**

Types of Visits

- A limited number of conditions should be included for testing in the first two years. Proposed conditions are high volume, high cost, symptom-driven diagnoses that were identified as showing marked variation in risk-adjusted readmission rates
  - Chest pain 33.0% of FFS ED visits in data sample
  - Abdominal pain 23.7%
  - Syncope 13.2%
  - Altered mental status 6.6%

Performance Metrics (Lower Is Better)

- Death
- Repeat ED visits with discharge
- Observation stays
- Inpatient admissions

Proposed Medicare Waivers and Key ED Value Services

Telehealth	Emergency physicians will be allowed to provide telehealth services into the beneficiary's home or residence and to bill one of the in-home visits under the same waiver that was put in place in the CJR and other APMs.
Post discharge Home Visit	Licensed clinical staff may provide home visits under the general supervision of an emergency physician to eligible Medicare beneficiaries. The providers may bill these services utilizing the same G-codes utilized in other APMs.
Transitional Care Management	Authorize emergency physicians to bill for a transitional care management code. This could be done utilizing the current CPT codes (99494 and 99496) or the ED specific Acute Care Transition codes submitted to the CPT Editorial panel in 2016. (Appendix B)

AUCM Model Summary

- The cost of admission from the ED presentation is the major cost driver
- Great variability at the State, County, and hospital level regarding admissions for several (test case) conditions.
  - Year 3 would be expanded to **all conditions**
- Hospitals with low rates of admissions using risk-adjusted prediction models have no increase in post-discharge adverse outcomes
- Utilizing telehealth , post discharge home visits, and transitional care services allows ED physicians to coordinate post ED discharge care and build infrastructure to decrease adverse events

AUCM Timelines

Review and approval of Final PTAC submission						
Letter of Intent to PTAC	completed					dated 9/7/17
Submit model for Task Force workgroup approval	completed	X	X	X	MPA	
Approval by ACEP reimbursement committee	completed	X	X			based on changes made by MPA from 9/11/17 call
Appproval of PTAC submission by task force chairs	completed	X		X		based on changes above
ACEP Board aproval of PTAC submission	completed	X	X			based on changes above
Submission to PTAC	completed	X	X	X		
outside agencies - talking points and outreach	10/20/2017					Laura, Randy and Sue and Jeff - talking points completed
PTAC Review and Recommendation	2/15/2018	X	X	X		
Approval by Board for HHS submission	2/20/2018	X	X	X		PTAC recommendation not binding
submission to HHS	2/18/2018	X				goal is for decision at first board meeting in 2018
HHS Decision	3/25/2018					
Physicans paid under APM model	FY 2019					should coincide with CMS schedule for CMMI awards.

Alternative Acute Care Model (AACM)

Work Group #3 has identified for further study the population of nursing facility patients who are transported to the emergency department (ED), treated, and discharged back to the nursing facility. These patients require rapid assessment and coordination of care when they develop an acute illness or injury based upon likelihood of multiple underlying comorbid medical conditions. The work group believes that an alternative model of "care in place" with shared risk between emergency physicians, nursing facility medical directors, and facility operators can be implemented that would provide improved quality of care, improved patient experience, and more cost-effective care.

AACM Construct

Medicare Care in Place Construct

The Care in Place Physician Focused Payment Model (PFPM) episode is a sequence of events initiated by a qualifying index visit by a nursing home patient to an ED, in which an eligible professional orders, provides or significantly influences cost and quality. The physician and payer define the period of responsibility for which the physician is accountable for driving effective and efficient care

Figure 1. Model for the "Acute Care in Place" Alternative Payment Model

AACM Timelines

	Task	due date	Co-Chairs	ACEP	Tony	Consultants
1	Phase I – Approvals to begin project					
	Conversation with CMMI re general interest	completed				
	Identified SNF as industry partner	completed				
	Schedule call with MPA	completed				
	Proposal from MPA based on 8/15/call	completed				MPA
	Budget approval from ACEP	completed		x		
	PTAC Submission					
	initial data produced by MPA	10/19/2017				MPA
	Call to discuss initial data	10/20/2017	x	x	x	x
	Final analysis	11/10/2017				
	call to discuss	11/13/2017				
	PTAC DRAFT	12/8/2017				
	Review and comment by workgroup members on MPA draft	12/10/2017				
	Complete PTAC submission	12/22/2017				
	Reach out to external parties if needed	12/27/2017				
4	Review and approval of FINAL PTAC submission					
	review by ACEP reimbursement committee	12/10/2017				
	Review and Approval of PTAC submission by task force members	12/15/2017				
	Review and Approval of PTAC submission by ACEP Board	12/15/2017				
	Letter of Intent to PTAC	12/8/2017				
	Submission to PTAC	1/10/2018				
	PTAC Review and Recommendation	3/10/2018				
	Approval by Board for HHS submission	3/15/2018				
	submission to HHS	3/25/2018				
	HHS Decision	4/25/2018				
	Physicians paid under APM model	FY 2020				

Next Steps

- The AUCM model has been posted to the PTAC website at https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee
- PTAC will review the model, score it against their criteria
- Provide feedback and additional requirements
- Model will be updated

Contact Information

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Educational Appendix

MACRA: Alternative Payment Model Thresholds

2019 – 2025 potential 5% lump sum bonus

- 2019-2020: 25% of Medicare revenues furnished as part of an eligible APM
- 2021-2022: 50% of Medicare revenues from APMs
  - *Or* 25% of Medicare revenues from APMs
  - *AND* 50% of all payer revenues from APMs
- 2023+- 75% of Medicare revenues from APMs or 25% of Medicare revenues from APMs and 75% of all payer revenues from APMs

Example Alternative Payment Models

- Certain clinicians participating in Advanced APMs are exempt from MIPS
- Current potential Advanced APMs
  - Next Generation ACO Model
    - 18 nationwide
  - Shared Savings Program - Track 2 and 3
  - Oncology Care Model (OCM) - Two-Sided Risk
  - Comprehensive ESRD Care (CEC) - Two-Sided Risk
    - 13 nationwide
  - Comprehensive Primary Care Plus (CPC+)

AMA APMs Under Development

- Angina (Stable)
  - Help patients quickly and accurately determine the causes of chest pain and their risk of a heart attack
- Asthma
  - Reduce emergency visits and hospitalizations due to asthma exacerbations
- Cancer
  - Improve cancer outcomes through accurate diagnosis and staging, as well as appropriate use of treatments

AMA APMs Under Development

- Chronic Kidney Disease
  - Slow progression to end stage renal disease
- Diabetes
  - Improve patient understanding and self-management of their condition
- Epilepsy
  - Reduce frequency and severity of seizures
- Pregnancy
  - Deliver babies in lower-cost settings

Almost All of them have as a goal: reduce emergency department visits

Evaluation Criteria

- Addressing an issue in payment policy in a new way
- Including APM Entities whose opportunities to participate in APMs have been limited
- Improve health care quality at no additional cost
- Maintain health care quality while decreasing cost
- Both improve health care quality and decrease cost

Evaluation Criteria

- Pays APM Entities with a payment methodology designed to achieve the goals
- Payment methodology differs from current payment methodologies
- How the model is intended to affect practitioners' behavior to achieve higher value care through the use of payment and other incentives
- How the proposed payment model could accommodate different types of practice settings and different patient populations
- Have evaluable goals for quality of care and cost

Supporting Information: Health Information Technology

- Encourage use of health information technology to inform care
- Describe how information technology will be utilized to accomplish the model's objectives with an emphasis on any innovations that improve outcomes, improve the consumer experience and enhance the efficiency of the care delivery process
- Describe goals for better data sharing, reduced information blocking and overall improved interoperability

Evaluation Criteria: Integration and Care Coordination

- Encourage greater integration and care coordination among practitioners and across setting where multiple practitioners or settings are relevant to delivering care to the population
- Improve care coordination for patients

Supporting Information: Patient Safety

- Aims to maintain or improve standards of patient safety
- How patients would be protected from potential disruption in health care delivery brought about by the changes in payment methodology and provider incentives
- Describe how disruptions in care transitions and care continuity will be addressed

Detail of PTAC Criteria

- ***Value over volume***: Provide incentives to practitioners to deliver high-quality health care.
- ***Flexibility***: Provide the flexibility needed for practitioners to deliver high quality healthcare.
- ***Quality and Cost***: PFPMs are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Detail of PTAC Criteria

- ***Payment methodology***: Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
- ***Scope***: Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

Detail of PTAC Criteria

- ***Ability to be evaluated***: Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- ***Integration and Care Coordination***: Encourage greater integration and care coordination among practitioners and across settings
- ***Patient Choice***: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- ***Patient Safety***: Aim to maintain or improve standards of patient safety.
- ***Health Information Technology***: Encourage use of health information technology to inform care.

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