Alternative Payment Models
Salvation From MIPS?

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What Is an APM?

- Alternative Payment Models (APMs) are payment approaches, that provide risk/reward incentives to deliver high-quality and cost-efficient care. APMs can apply to:
  - Specific clinical condition (CHF)
  - Care episode (CABG)
  - Population (geographic-local SNF)
Do APMs Matter to Emergency Medicine?

- Yes- Most ED physicians will satisfy MACRA requirements through MIPs for now
- Many ED MIPS quality measures are topping out:
  - 2021+ potential problem (e.g.#91 & #255)
- APMs require infrastructure - need time to build
- ACEP has a deeply resourced expert group designing APMs for Emergency Medicine

Economic Benefits To ED Participating In Advanced APM

- Lump sum bonus payment 5% of Medicare Part B services
  - (2019-2024)
- Exempted: Merit-Based Incentive Payment System (MIPS)
- Reimbursement for new services to help coordinate and oversee patient care outside of the ED
- A portion of additional shared savings derived from the model itself
The ACEP Acute Unscheduled Care Model (AUCM)

- CMS requires a minimum 8% reduction in cost for APM
- Achieved increasing the rate of discharge for 3% of patients
  - 4 presentations: chest pain, abdominal pain, syncope, altered mental status
- However, need quality and safety infrastructure:
  - Coordinate outpatient care and check on the patient
- Currently not paid for - would need waivers for payment approval

Overview of Emergency Medicine APM Design

ED APM Revenue Detail

- The routine fee for service model stays in place- 99285
- 5% APM Bonus - $70,000 (40K visit group)
- 3 services currently not reimbursed for would be paid:
  - Transitional care Management codes – ($250)
    - Coordinate the complex discharge plan/process
  - Telehealth services - payment detail pending
    - To check on the patient
  - Home Visits - payment detail pending
    - Close follow up of the patient in the home
- Eligible for risk/reward $$$ from shared savings derived from the model itself
APM Financial Risk Model Detail

- **Target price:** Medicare calculates the 3 yr. prior cost of all services (part A and B) for the 4 presentations (baseline) extending out 30 days post ED visit.

- **Actual cost:** Medicare calculates true cost over 1 yr. for the 4 presentations extending out 30 days post ED visit.

- 10% Model: 10% X (target price minus your actual cost)
- 20% model: 20% X (target price minus your actual cost)

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APM Financial Risk Model Example

**100K Visit Group**

**Chest Pain: $5,000 Target Price and 2,000 Annual Patients**

<table>
<thead>
<tr>
<th>Target Price</th>
<th>Actual Cost</th>
<th>Change</th>
<th>Chest Pain Volume</th>
<th>Medicare Savings</th>
<th>10% Reward or Risk</th>
<th>20% Reward or Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>$5,000</td>
<td>0</td>
<td>2,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>$5,000</td>
<td>$4,000</td>
<td>$1,000</td>
<td>2,000</td>
<td>$2,000,000</td>
<td>+$200,000</td>
<td>+$400,000</td>
</tr>
<tr>
<td>$5,000</td>
<td>$6,000</td>
<td>-$1,000</td>
<td>2,000</td>
<td>-$2,000,000</td>
<td>-$200,000</td>
<td>-$400,000</td>
</tr>
</tbody>
</table>
Evolution: Types of Visits

- A limited number of conditions would be included for testing in the first two years.
- Proposed conditions high volume, high cost, identified as showing variation in risk-adjusted readmission rates.
  - Chest pain
  - Abdominal pain
  - Syncope
  - Altered mental status
- Year 3 possibly all conditions

Expansion of Safety Measures
### Proposed Medicare Waivers and Key ED Value Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telehealth</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Post discharge Home Visit</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Transitional Care Management</strong></td>
<td>Authorize emergency physicians to bill for a transitional care management code. This could be done utilizing the current CPT codes (99495 – 5.20 RVUs NF and 99496- 6.87 RVUs NF)</td>
</tr>
</tbody>
</table>

### Where Does the ACEP APM Stand In The Regulatory Process?
Physician Focused Payment Model Technical Advisory Committee (PTAC): Evaluation

ACEP Received a 10/10 Score

- 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

PTAC Approval!

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

PTAC recommends the ACEP proposal to the Secretary for implementation. The Committee finds that the proposal meets all 10 of the Secretary’s criteria.
I am pleased to respond to the comments and recommendations of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

The AUCM is a creative proposal to address ED payment policy that focuses on the safe discharge of patients, follow-up care for 30 days post-ED visit, and hospitalizations or other avoidable post-ED visit events and their associated costs. We have further discussed care transitions with ACEP, and I have asked the CMS Innovation Center to assess how this model could operate as a component in a larger model dedicated to improving population health. I am encouraged by submitters like ACEP who continue to help drive transformative innovation.

ED APM Model Summary

- The admission from the ED presentation is recognized as a major cost driver
- ACEP AUCM Model has multiple revenue impacts
  - MIPS exclusion
  - 5% APM bonus
  - Billing for post-discharge care
    - Transitional Care Management, Telehealth, and home visits
    - Shared savings upside if cost reduction achieved
- PTAC has approved the model & Secretary Azar is enthusiastic
Contact Information

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Educational Appendix
Glossary

- **APM Entity** - An entity that participates in an APM or payment arrangement with a non-Medicare payer through a direct agreement or through Federal or State law or regulation.

- **Advanced APM** – A payment approach that gives added incentive payments to provide high-quality and cost efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- **Affiliated Practitioner** - An eligible clinician identified by a unique APM participant identifier on a CMS maintained list who has a contractual relationship with the Advanced APM Entity for the purposes of supporting the Advanced APM Entity's quality or cost goals under the Advanced APM.

**Glossary**

- **Affiliated Practitioner List** - The list of Affiliated Practitioners of an APM Entity that is compiled from a CMS maintained list.

- **MIPS APM** – Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard. The APM scoring standard is designed to account for activities already required by the APM.
Glossary

- **Participation List** - The list of participants in an APM Entity that is compiled from a CMS-maintained list.

- **Qualifying APM Participant (QP)** - An eligible clinician determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity.

Am I In an APM?
APM Qualification Look Up Tool

https://qpp.cms.gov/participation-lookup

QPP Participation Status

Enter your 10-digit National Provider Identifier (NPI) number to view your QPP participation status by performance year (PY).
APM Thresholds and Eligibility Requirements

To qualify as an APM: 2019 at least 25% of Medicare part B payments via an advanced APM. Then steps up to 50 percent of your Medicare Part B payments or at least 35 percent of Medicare patients through an Advanced APM entity and ultimately goes up to 75% by 2023

Determination Period - A 24-month eligibility assessment period in which CMS reviews past and current Medicare Part B Claims and PECOS data for clinicians, practices, and MIPS APMs. Each determination period consists of two 12-month segments.

MIPS Segment Details

<table>
<thead>
<tr>
<th>Segment</th>
<th>Initial Eligibility</th>
<th>Final Eligibility*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Segment 1</td>
<td>Covers October 1, 2017 – September 30, 2018</td>
<td>May 2019</td>
</tr>
<tr>
<td>Segment 2</td>
<td>Covers October 1, 2018 – September 30, 2019</td>
<td>November 2019</td>
</tr>
</tbody>
</table>

*Segment 2 data released with final (renamed) data.

Hospital-Level Variation in Admission Rates
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?

![Graph showing hospital performance vs. national average difference in risk-adjusted rate of admissions, from ED to either inpatient or observation stay.](image)
Intra State Variability
Admission of Syncope

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

Target Price Detail

- Target price calculated for each individual ED facility
- Uses a 3-year historical baseline cost
- Includes all Medicare costs during ED visit through 30 days post discharge
  - Part A and Part B Medicare costs, beginning at ED presentation and ending 30 days post ED discharge
  - Cost of ED visit and newly waived services
  - Cost of inpatient hospitalization or observation care
  - Post-ED office visits, lab, x-ray, etc.
The Basic Payment Math

- Historical target price compared to achieved Target price calculation for current year
- Achieved target price < historic target price:
  - ED group receives 10% to 20% of Medicare savings
- Achieved target price > historic target price
  - ED group penalized 10% to 20% of Medicare increased costs

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