

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the “Acute Unscheduled Care Model: Enhancing Appropriate Admissions” Payment Model

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee’s (PTAC’s) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions* (available on the ASPE PTAC [website](#)), physician-focused payment models (PFPMs) that contain the information requested by PTAC’s Proposal Submission Instructions will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

A. Proposal Information

- 1. Proposal Name:** The Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions
- 2. Submitting Organization or Individual:** American College of Emergency Physicians (ACEP)
- 3. Submitter’s Abstract:**

The Physician-Focused Payment Model (PFPM) model, *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions*, which has been proposed by the American College of Emergency Physicians (ACEP), will enable emergency physicians to participate in an Advanced Alternative Payment Model (AAPM) by accepting financial risk and quality-of-care risk that is directly attributable to the medical decision to discharge a patient from the emergency department, rather than admit them to the hospital.

Emergency department (ED) services for acute unscheduled care represent a segment of Medicare expenditures that has not yet received focused attention by the Centers for Medicare & Medicaid Services (CMS) as the agency attempts to drive payment models that reward physicians for providing value over volume. The model fills the gap as it

provides incentives to safely discharge Medicare beneficiaries from the ED by facilitating and rewarding post discharge care coordination. It represents the next step beyond the Hospital Readmission Reduction program as it seeks to reward appropriate admission to the hospital for Medicare beneficiaries who present to the emergency department for acute unscheduled care. The model ensures that emergency physicians who make the decision to provide safe, efficient outpatient care have the necessary tools to support this transformation and are rewarded for their decision making.

A thorough analysis of Medicare claims data revealed a significant opportunity to reduce hospital admission rates and costs associated with unscheduled post-ED return visits and admissions. In a review of 6.9 million Medicare fee-for-service (FFS) ED visits in 2014, 35.8% resulted in admission, 7.3% resulted in observation stays, and 54.7% resulted in discharges to home or the community. Significant variation seen in risk-adjusted admission rates across states, facilities, and clinical categories confirmed the opportunity. In cases discharged home to the community, there was a post discharge event (i.e. death, repeat ED visits, inpatient admission, observation stay) rate of 8.8% at 7 days, and 19.9% of 30 days. At the same time, as many as 45% of ED patients discharged home received no other Medicare services within 7 days of discharge; at 30 days, this rate remained as high as 17% for some categories of discharge diagnoses. This analysis has identified significant variation in post-discharge care patterns as well.

The model is focused on rewarding clinicians for reducing costs in three ways. The first is by reducing hospital inpatient admissions or observation stays. The second is by enhancing the ability of emergency physicians to coordinate, manage and avoid unnecessary post discharge services, when appropriate. The third is by avoiding post-ED visit patient safety events and their associated costs. The proposed monitoring of post discharge events (death, repeat ED visits, inpatient admissions and observation stays) protects Medicare beneficiaries and will ensure that attempts to decrease the cost of care do not result in decreased quality. The model will honor patient preference to avoid hospitalization and observation stays (when appropriate) through provision of transitional follow-up care in the home environment.

The proposed payment methodology is an episode-based, bundled-payment model like the Bundled Payments for Care Improvement Advanced Model (BPCI Advanced). In the model, however, a qualified episode is triggered by the submission of a Medicare claim for an eligible visit by an ED physician. Medicare FFS claims for all items and services furnished during that clinical episode will continue to be processed under the relevant Medicare payment system rules. On an annual basis, Medicare FFS expenditures for the Clinical Episode will be subsequently reconciled against the final target price.

The model also includes payment waivers for ED acute care transition services, telehealth services, and post discharge home visits, which will provide emergency physicians with the necessary flexibility and tools to better coordinate care for their patients, and which will be necessary to promote better outcomes and better patient

care quality and safety profiles. The model includes a robust set of outcome measures that can be calculated by CMS using claims and, electronic health record (EHR) data and a set of patient safety measures. When combined, these measures set a minimum (floor) for qualifying for reconciliation payments as well as to provide safeguards against inappropriate discharges that result in potential patient harm or additional cost.

For the first two to three years, the model focuses on episodes related to four high-volume ED conditions – abdominal pain, altered mental status, chest pain and syncope. Starting in year 3, the model will expand to include additional diagnoses (excluding those that result in greater than a 90% admission rates per condition) as well as qualifying visits by dual-eligible beneficiaries. To maximize participation from both large and small physician groups, the model will include three options for risk-sharing that enable emergency physicians to either take on downside risk immediately or ease into risk over time.

ACEP believes that the model has the opportunity to significantly reduce Medicare spending, while improving the quality of care that patients receive in the ED. The model guarantees savings for Medicare by building a discount into the target price for each episode and produces additional savings by reducing hospital admissions and other post-discharge costs associated with each episode. A conservative 3% decrease in admission rates for these conditions could reduce annual Medicare spending by \$314 million. Over time, a national 8% decrease in admission rates for just the four initial high-volume ED conditions could save Medicare over \$840 million annually.

ACEP anticipates that the evaluation of the model will demonstrate that when emergency physicians are rewarded for making the right disposition decisions for their patients in the ED and following up with them after the visit, not only will health care spending decrease, but patient outcomes will improve and both provider and patient satisfaction will increase as well.

B. Summary of the PRT Review

The ACEP proposal resubmission was received by PTAC on June 12, 2018. The PRT met in July 2018 on the proposal resubmission. A summary of the PRT's findings are provided in the table below.

PRT Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	PRT Rating	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets	Unanimous
2. Quality and Cost (High Priority)	Meets	Majority
3. Payment Methodology (High Priority)	Does Not Meet	Majority
4. Value over Volume	Meets	Unanimous
5. Flexibility	Meets	Unanimous
6. Ability to be Evaluated	Meets	Unanimous
7. Integration and Care Coordination	Does Not Meet	Majority
8. Patient Choice	Meets	Unanimous
9. Patient Safety	Meets	Unanimous
10. Health Information Technology	Meets	Unanimous

C. PRT Process

The ACEP proposal resubmission was received by PTAC on June 12, 2018. The PRT met in July 2018 on the proposal resubmission. The initial ACEP proposal was received by PTAC on October 25, 2017. The initial proposal received four letters of public support. The PRT met on the initial proposal between December 2017 and April 2018. The submitter participated in one phone call with the PRT. The proposal, questions and answers, and call transcripts are available on the ASPE PTAC [website](#).

1. Proposal Summary

The proposed model centers on incentivizing improved quality and decreased cost associated with the discharge disposition decisions made by ED physicians for defined episodes of care. The ACEP proposal uses an episode framework or bundled payment methodology with retrospective reconciliation, a target price based on historical controls, and a quality reporting or performance component for eligible participants. The model includes three options for participants to choose different tracks of quality reporting versus performance which correspond to different options for risk sharing, limits to gains or losses, applicable conditions for qualifying episodes, and the inclusion of Medicare fee-for-service (FFS) beneficiaries and dual eligible beneficiaries in a given performance year. The risk bearing entity is the physician group, the faculty practice plan in academic settings, or the hospital in the case of employed physicians. The proposed model includes five-performance years.

The model episode starts with a qualifying ED visit. All Medicare services that occur in the 30 days post-ED visit are included in the episode. The submitter proposes to use the same Medicare service inclusion and exclusion criterion for their model’s episode definition as used in the CMS BPCI Advanced model. The initial performance years of the

proposed model focuses on four high-volume ED conditions (abdominal pain, chest pain, altered mental status, and syncope) with additional conditions to be added that do not result in greater than 90% of inpatient admissions in subsequent performance years. The episode ends at the beneficiary's death or 30 days after the qualifying ED event. Savings in the model would be generated when the actual Medicare episode spending for selected conditions is below a facility-specific, historical cost for the episode. Areas for potential Medicare spending reductions and improved quality of care will focus on reducing avoidable hospital inpatient admissions and observation stays, financial incentives for ED physicians to coordinate and manage post-discharge services, avoiding return ED visits, and other patient safety events. The post-discharge events of interest in the 30 days following discharge home are return ED visits, non-ED observation stays, inpatient admissions, and deaths. Specific patient safety areas include repeat ED visit, inpatient or observation stay for injuries, adverse drug reaction, post-ED procedure complications, and unexpected post-ED deaths.

The submitter defines a qualifying ED case/anchor event as an ED visit that results in (1) discharge home to the community, (2) ED observation stay followed by discharge home to the community, (3) non-ED observation followed by discharge (any location), or (4) inpatient admission followed by discharge including stays where patients admitted to non-ED observation are ultimately discharged from inpatient status. The proposal makes a distinction between observation stays that are under the care of an ED physician in the location of the ED (i.e., ED Obs) as compared to observation stays that take place in hospital locations other than the ED under the care of non-ED physicians (i.e., non-ED Obs). The parameters of the model define non-ED observation stays that take place in hospital locations other than the ED as equivalent to inpatient admissions in the calculation of the target price for the episode. Both non-ED observation stays and inpatient stay cases are not participants in the model and the quality metrics that would determine eligibility for reconciliation payments do not apply to them. The model intervention is focused on the discharge disposition decisions made by ED physicians for patients who receive ED services or ED-observation stays in the location of the ED and are discharged home to the community. A qualified ED case does not include a patient who presents at the ED from hospice or an ESRD beneficiary, had a prior hospitalization 1-90 days prior to the index ED visit, or died in ED.

A facility-specific target price for each qualifying condition would be calculated by CMS based on three years of historical claims data for the initial ED visit plus all costs incurred for 30 days post discharge including new services associated with proposed waivers in the model. To ensure cost savings, the model proposes that the cost target for each condition be reduced by 1.5% to 3%. The participant's performance on quality determines the target cost reduction. The model includes different options for eligibility for a reconciliation payment based on categories of performance and corresponding discount rates. Participants whose performance falls within higher quality performance categories such as excellent (e.g., meeting the minimum threshold in all three measure categories and having a combined rate of clean cases of at least 90% or meeting or

surpassing a threshold rate of clean cases that is calibrated to each facility's historical performance) have a lower discount to the episode target price or the potential to receive higher reconciliation payments. A clean case is defined as no post-discharge events of interest occurring within 30 days of discharge during a clinical episode. Lower quality performing participants such as acceptable (e.g., meeting the minimum threshold in all three measure categories) have a higher discount or the potential to receive lower reconciliation payments. If participants have an unacceptable quality score, they are not eligible for any reconciliation payment.

The target prices would be updated by CMS annually and risk adjusted using the CMS – Hierarchical Condition Category (HCC) or other methodology determined by CMS. On an annual performance year basis, CMS would determine whether the actual spending is below the target price (savings/gain) or above the target price (loss). If a participant's spending is below the episode target price and meets the specified quality thresholds, then it would be eligible for a reconciliation payment. If a participant's spending is above the target price, then it would be required to reimburse CMS as part of downside risk (e.g., option one does not start downside risk until performance year three, options two and three start downside risk in performance year one). The model also includes stop gain and stop loss thresholds which would vary with the quality reporting or performance option chosen by a participant.

There are three options for participants to choose different tracks of quality reporting versus performance which correspond to different options for downside risk, stop gain/loss thresholds, applicable conditions, and the inclusion of Medicare fee-for-service (FFS) beneficiaries and additional dual eligible beneficiaries in a given performance year. The three options are: 1) pay for reporting transition to pay for performance with downside risk starting in performance year three; 2) pay for performance with stop gain/loss of 10% with downside risk starting in performance year one; and 3) pay for performance with a progressive stop gain/stop loss capped at 20%/20% with downside risk starting in performance year one.

The proposal includes three performance measures with specified minimum thresholds in the domains of patient engagement/experience (% of eligible cases in which shared decision making about discharge plan occurred is reported – minimum threshold 40%), process/care coordination (% of eligible cases in which a shared discharge assessment was completed and reviewed by physician is reported- minimum threshold 40%), and outcomes (% of eligible cases where an unscheduled ED revisit, hospitalization, or death did not occur within 30 days compared to the prior reference period (event-free post discharge period)-calculated at the facility level). The model defines observation stays that take place in hospital locations other than the ED to be considered equivalent to an inpatient admission for purposes of calculating the episode target price. However, those stays (i.e., inpatient admissions and observation stays that take place in locations other than the ED) do not appear to qualify for participation in the model intervention in terms of the cases or the physicians who would be accountable for those cases since the

quality metrics that determine eligibility for reconciliation payments do not apply to them. The proposal language states that ACEP would be open to aligning performance measurement related to this population to support CMS in implementing policies and/or models targeted at hospitalists.

The ED physician is responsible for the final assessment of the patient for safe discharge home. ACEP included examples of safe discharge assessment (SDA) tools that could be used such as Identification of Seniors at Risk (ISAR) tool or the Triage Risk Stratification Tool (TRST) submitted via certified electronic health record technology (CEHRT). ACEP also proposes the possible use of ACEP's clinical emergency data registry (CEDR) or other registries to provide benchmarks and enable ED group participation in the model that could be submitted via CEHRT.

At the time of ED discharge, the model requires the ED physician to communicate with a follow-up care provider (primary care physician, specialist physician or designee). The proposal suggests an ED-based care coordinator will assist scheduling follow-up care to facilitate the handoff of the patient at ED discharge.

The model also includes proposed Medicare program policy waivers: 1) authorize emergency physicians to bill for transitional care management codes, 2) allow emergency physicians to provide telehealth services, and 3) allow licensed clinical staff to provide home visits under the general supervision of an emergency physician to eligible Medicare beneficiaries. Payments for ED acute care transition services, telehealth services, and post-discharge home visits would be included in the overall spending calculations. In other words, if these additional payments resulted in increased costs, the participant would need to pay CMS the difference between target cost and actual cost.

2. Additional Information Reviewed by the PRT

a) Literature Review and Environmental Scan

The submitter cited relevant literature in the proposal. ASPE, through its PTAC support contractor, conducted an abbreviated environmental scan that included a review of peer-reviewed literature as well as a search for relevant grey literature, such as research reports, white papers, conference proceedings, and government documents. Results of the scan are located on the ASPE PTAC [website](#).

None of the documents identified through this search provided information that was sufficiently specific to the proposal to significantly affect the PRT's evaluations of whether the proposal met the criteria for a PFPM.

b) Data Analyses

This proposal addresses data analysis to support the initial conditions to be included in the model (syncope, chest pain, abdominal pain, and altered mental status). The submitter plans to include additional conditions that do not result in greater than a 90% inpatient admission rate. The PRT asked for additional descriptive statistics to inform its evaluation of the initial proposal. This data analysis was provided to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) by the ASPE PTAC support contractor.

c) Public Comments

The PRT reviewed four public comment letters on the proposal. The public comment letters are available on the ASPE PTAC [website](#).

d) Other Information

The PRT also met with an ED physician consultant who was provided by the ASPE PTAC support contractor.

D. Evaluation of Proposal Against Criteria

Criterion 1. Scope of Proposed PFPM (High Priority Criterion). The proposal aims to broaden or expand the CMS APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

PRT Qualitative Rating:	Meets Criterion
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The PRT members concluded that the ACEP proposal meets the criterion because the proposal aims to provide a Medicare payment model whereby ED physicians currently not able to participate in APMs could do so through an episode framework in alignment with other CMS initiatives. The model both approaches ED payment policy in a new way and provides an opportunity for a new group of physicians, ED physicians, to participate in an APM. The patient-centered approach would identify qualifying ED patients at potential risk for post-discharge events and provide financial incentives that enhance discharge planning and support patient and family engagement. The current measured variation in treatment of these types of patients supports the finding that this type of payment model is a potential candidate to advance the progression of best practices of care for patients in this care trajectory. Of note, a strength the proposed model is that it could be adopted by commercial payers, states, and even ACOs could use a similar approach internal to their organization.

Criterion 2. Quality and Cost (High Priority Criterion). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Qualitative Rating:	Meets Criterion
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A majority of the PRT members concluded that the ACEP proposal meets the criterion. The proposed methodology would use an episode for purposes of monitoring quality and costs post-discharge from a qualifying ED visit. An episodic approach to care delivery in the model shifts the focus from a volume of individual services to a more patient-centered approach focused on the value of care delivered. The proposal is anticipated to improve quality by supporting appropriate discharge from the ED while ensuring beneficiaries are safe from harm by relying on both the professionalism of the care team and through monitoring of post-discharge events including hospital admission, death, and return to the ED within 30 days of the qualifying ED visit.

The model includes three different participation options that are designed to encourage participation. Two-sided risk is an option in performance year one or three based on the readiness of the participants to accept downside risk and quality performance measurement. Cost savings would be realized if actual spending is below a historical episode target price. The target price would be based on three years of historical claims data with a required discount percentage ranging from 1.5% to 3%. The participant's performance on quality impacts the discount rate to the episode target price. Participants in higher quality performance categories such as excellent have a lower discount rate to the episode target price or the potential to receive higher reconciliation payments. Lower quality performing participants have a higher discount rate or the potential to receive lower reconciliation payments. If participants have an unacceptable quality score, they are not eligible for a reconciliation payment. The model also includes stop gain and stop loss thresholds which would vary with the quality reporting or performance option chosen by a participant.

The most important quality concern related to changing payment for ED services is the possibility that patients who should be admitted will not be. The PRT found that the proposed payment model addresses this concern in three ways. First, the payment model's inclusion criteria focus on diagnoses where evidence suggests there is considerable opportunity to reduce hospitalizations. Second, it uses historical controls. Third, it proposes to measure post-discharge mortality and include performance on this metric in assessment of the program.

Nonetheless, the PRT raised concerns with the lack of available quality measures. The proposal includes the following measures: 1) patient engagement/experience: % of eligible cases in which shared decision making about discharge plan occurred is reported; 2) process/care coordination: % of eligible cases in which a Shared Discharge Assessment was completed and reviewed by physician is reported; 3) outcomes: % of eligible cases where an

unscheduled ED revisit, hospitalization, or death did not occur within 30 days compared to the prior reference period. The proposal included specific minimum thresholds.

The PRT believed the measures included in the proposal could be understood as a proxy for quality. Even recognizing the need to minimize measurement burden, the proposed measures were viewed by some PRT members as minimally sufficient. The PRT thought more work on quality metrics was indicated. While the PRT was not able to examine the merit of different approaches, it wanted to be judicious in balancing additional requirements that could introduce both patient and provider burden.

Criterion 3. Payment Methodology (High Priority Criterion). 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 PFPM cannot be tested under current payment methodologies.

PRT Qualitative Rating:

Does Not Meet Criterion

A majority of the PRT found the ACEP proposal does not meet the payment methodology criterion. The PRT finds that the proposal meets the provider where they are in their readiness for risk tolerance and quality performance. The ACEP proposal uses an episode framework with retrospective reconciliation, a target price, and a quality performance component for eligible participants.

The ACEP model includes three options for participants to choose different tracks of quality reporting versus performance which correspond to different options for downside risk, stop gain/loss thresholds, eligible patient conditions, and the inclusion of Medicare FFS beneficiaries and additional dual eligible beneficiaries in a given performance year. The PRT was concerned with option one which permits pay for reporting with upside only for two years. Given the rapid cycle time for interventions and measurement in this model (approximately 60 days), the PRT believes pay for reporting (upside only) would only be appropriate for one year of the model. This is not a critique of the model per se but instead a judgement about the proposed implementation plan.

The PRT raised additional concerns with the payment methodology, including: 1) the artificial distinction made between observation stays with oversight by ED physicians (ED-observation) and oversight of observation patients within the hospital (non-ED observation) by non-ED physicians, and 2) the exclusive use of a facility specific target price for the episodes which does not include a regional, national, or blended target.

The distinction between patients cared for in ED observation and those cared for under observation by other departments is a result of the submitters desire to constrain accountability to only the providers practicing within the risk accountability unit (ED physicians). This model feature is imposed in an identical way to all potential risk-bearing entities which are defined as including independent physician groups, the faculty practice plan in academic settings, or the hospital in the case of employed physicians. ED observation patients and non-ED observation patients would have different attendings of record, who may or may not be in the same risk group. Nonetheless, these distinctions are unimportant from the patient or payer's perspective.

However, the PRT was concerned about different financial incentives for the type and scope of services provided to a beneficiary in an observation stay either in an ED or another bed location in a hospital. Since the proposed model has not been proven to be superior, an argument can be made that two different financial incentives for comparable patients might not result in measurably different care. On the other hand, the submitter asserts that the proposed model would improve care and the PRT considers this assertion at least credible, so proposing that two different standards exist side-by-side is problematic. This could potentially be handled as an implementation issue by mandating movement to a single model once superiority was established.

In addition, a hospital or group is reimbursed for an observation stay by Medicare under the outpatient prospective payment system in a similar manner for similarly situated patients whether the patient was in an ED-observation bed or a non-ED observation bed and discharged home. The submitter views ED observation as observation, but views non-ED observation as equivalent to an inpatient stay for purposes of calculating a target price for the episode. The PRT viewed observation services as equivalent whether provided in a bed in the ED or a bed location other than the ED for a patient who is ultimately discharged home. The PRT was therefore concerned that, where ED observation and non-ED observation co-exist in the same hospital, changes in the types of patients going to each could confound estimates of performance or potentially be used to game the assessment.

The model defines observation stays that take place in hospital locations other than the ED to be considered equivalent to an inpatient admission for purposes of calculating the episode target price. However, those stays (i.e., inpatient admissions and observation stays that take place in locations other than the ED) do not appear to qualify for participation in the model intervention in terms of the cases or the physicians who would be accountable for those cases since the quality metrics that determine eligibility for reconciliation payments do not apply to them. The proposal language states that ACEP would be open to aligning performance measurement related to this population to support CMS in implementing policies and/or models targeted at hospitalists. The PRT thought that ED physicians influence the care of the patient regardless of the location of the observation stay, and that the ultimate location of the patient could be driven by multiple factors including available space in a given hospital unit. If the rationale for the exclusion of non-ED observation patients from the bundles is the lack of alignment between the at-risk

physicians and the control of the discharge of the included patients, then the PRT thought this exclusion should be applied to only independent physician association (IPA) participants. The PRT viewed the other two types of risk bearing entities (i.e., the faculty practice plan in academic settings and the hospital in the case of employed physicians) as having institution/hospital-wide responsibility for handoffs and discharges. In these cases all observation patients, regardless of the type of physician managing the patient in the observation unit, should be handled similarly by the model.

The PRT also had concerns on the sole reliance on a historical, facility-specific target price without consideration of a process to include a regional, national, or blended approach. The PRT was concerned that the reliance on a historical, facility-specific target may end up rewarding improvements based on relatively poor starting performance. For example, participant A performs well by decreasing admissions and otherwise performing well. Participant B with high baseline performance may see little or no improvements in performance (so not get any shared savings) and yet have a higher baseline performance than participant A. If we are correct this characterization, this situation would likely be considered unfair. Again, this observation does not implicate the soundness of the model which would still provide all participants with an incentive to improve. The fact that the ease with which that incentive can be earned is not equally distributed among potential participants could undermine the long-term viability of the model.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Qualitative Rating:	Meets Criterion
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The PRT found the proposal meets this criterion because the focus of this model is to incorporate an episode of care triggered by an ED event. The current Medicare fee-for-service structure focuses on individual service delivery. This model would improve value because it provides incentives to inform the ED physician’s decision making on the included patient populations. The design of the model focuses on diagnoses with high variability in admissions and returns to the ED. This shift toward incentivizing decisions in the ED focuses on opportunities to obtain value in the purchase and delivery of health care to beneficiaries.

Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.

PRT Qualitative Rating:	Meets Criterion
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The PRT found the proposal meets this criterion. The proposed model is designed to include nearly all practice types found in the ED. The model does not specify how the target

price can be achieved and therefor provides adequate flexibility to providers to deliver care they consider appropriate and innovative. The proposed model provides a platform that could be extended to more diagnoses in the ED (i.e., those that do not result in inpatient admission rates over 90% in the previous year) which by definition provides flexibility. In addition, it provides flexibility in options for quality performance strategies as well as paths towards two-sided risk based on the readiness of participants.

Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Qualitative Rating:	Meets Criterion
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The PRT concluded that the proposal meets this criterion because an evaluation could be performed by comparing changes in spending under the model for participating vs. non-participating practices. Patient, provider and geographic characteristics of participants vs. non-participants could be constructed using CMS administrative data sets.

Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

PRT Qualitative Rating:	Does Not Meet Criterion
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A majority of the PRT concluded the proposal does not meet this criterion. Some PRT members had concerns with the proposal's approach to coordination. On one hand, the model clearly incentivizes greater communication and coordination between the ED and all ambulatory physicians who are planned to follow up with the patient. On the other hand, as stated above, the ACEP distinction between ED visits with observation stays as compared to observation stays that take place in hospital locations other than the ED with physicians who are not ED physicians seems artificial and could be viewed as a barrier to communication and coordination among these different parts of a hospital that should be providing the same level of care. The decision of an ED physician to hand-off the patient from the ED to another physician who is attending in an observation unit in another location within the same hospital is handled differently within the organizational structure of a given hospital. When a patient is determined to need observation status, the Medicare covered observation services could be provided in the ED or in a separate observation unit depending on the organizational design of a hospital. The PRT raised concerns that this proposal draws a distinction between observation services provided by an ED physician versus a different physician of record in the hospital (e.g., a hospitalist) which does not support internal care coordination within the hospital.

The model includes a mandated physician-physician communication at the time of disposition for patients discharged from the ED or from ED-observation to the community to determine when follow-up will occur to identify consultants who will assume care for the patient. For patients who receive non-ED observation, ED physicians contact a hospitalist or other physician who assumes responsibility when the patient is placed in observation status. The proposal includes the potential for Medicare payment waivers to provide home visits, telehealth, and transitional care payments.

The PRT found that the model did not adequately address the feedback loop of patient information that would likely be necessary during the 30-day post discharge period to perform post-discharge coordination beyond the initial hand-off at ED discharge home. The proposal defines the first hand-off by the participant at the time of initial ED discharge home by requiring a physician-physician communication with the primary care physician (PCP), physician or designee who will provide follow-up care upon discharge and includes an ED-based coordinator who will assist in scheduling any necessary specialist follow-up as directed by the PCP. The model includes Medicare waivers to authorize physicians to bill for transitional management codes, allow emergency physicians to provide telehealth services, and allow licensed clinical staff to provide home visits. The PRT raised concerns about the lack of specificity on these features and how the patient information will be provided to the accountable entity to ensure care coordination during the 30-day post-ED discharge episode.

Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Qualitative Rating:	Meets Criterion
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The PRT found the proposal meets the criterion because protecting patient choices in the ED is in an ED physician’s rubric in which patient’s interests are being considered. The payment incentives included in this model are unlikely to negatively impact patient choices. In theory there may be some concern that individual financial incentives on participating ED doctors could provide an incentive for the doctor to advise patients to pursue a course that was not in the patient’s best interests. The PRT thought the checks and balances included in the proposal were sufficient to negate this potential concern.

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

PRT Qualitative Rating:	Meets Criterion
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The PRT found the proposal meets the criterion because the model incentives will hold ED physicians accountable for post-discharge complications in the scoring of quality and costs in the post-discharge 30-day episode period. The submitter includes measures such as patient engagement/experience defined as % of eligible cases in which shared decision making about discharge plan occurred is reported, process/care coordination defined as % of eligible cases in which a shared discharge assessment was completed and reviewed by a physician is reported, and outcomes defined as % of eligible cases where an unscheduled ED revisit, hospitalization or death did not occur within 30 days compared to the prior reference period.

Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.

PRT Qualitative Rating:	Meets Criterion
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The PRT found that the proposal meets the criterion because the model does not restrict current health information integration efforts and may incentivize use of technology such as registries to provide information on model discharges. The shared discharge assessment and shared decision making measures could be submitted through the use of certified electronic health record technology (CEHRT). The model also includes the possible use of ACEP’s clinical emergency data registry (CEDR) or other registries to provide benchmarks and enable ED group participation in the model using CEHRT.

E. PRT Comments

The PRT finds that the ACEP proposal meets 8 out of 10 of the criteria. In both cases where the PRT thought the proposal did not meet the criteria the PRT was not unanimous. The model both approaches ED payment policy in a new way and provides an opportunity for a new group of physicians, ED physicians, to participate in an APM. However, the PRT has concerns with the model in terms of the exclusion of non-ED physicians caring for observation patients admitted through the ED, the quality metrics, use of a facility-specific approach without including a regional or national benchmark, and the identified challenges with the feedback loop of communication among participating providers.

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