

The University of Massachusetts Medical School
PTAC PROPOSAL: Eye Care Emergency Department Avoidance (EyEDA) Model

PTAC Preliminary Review Team PRT
Responses to Questions from the PRT
10/16/2019

1. The proposed model is based on experience with the project operated by the Southern New England Practice Transformation Network (SNE-PTN) funded under the Transforming Clinical Practice Initiative (TCPI). The PRT would like to know more information about the activities and results in this project.
 - a) Please describe the changes in care delivery that were made by the participating practices and whether you believe the same types of changes would lead to success under the proposed model.

Response 1a): The changes in care delivery made by the participating practices included utilizing tools and coaching by Quality Improvement Advisors (QIAs) to expand patient access to accommodate an increased volume of urgent and after-hours care. Practices displayed posters describing urgent care visits, discussed availability of urgent care visits with patients and tracked requests for urgent visits and visits completed. Through our proprietary data portal, our organization is able to track and report on performance measures. We treated rate of urgent care visits as a new custom measure. Practices reported to us each month the number of urgent visits for the specified list of conditions (measure denominator), and the number of those requests that were accommodated via an urgent visit or after-hours triage (measure numerators).

We also asked practices to report to us each month, through the same portal, the type(s) of access they offer to their patients, selecting from the following options:

1. No system in place for after-hours triage or care.
2. Practice has an after-hours recording directing patients to the ED.
3. Practice has a live answering service that takes messages with no specific timeframe for response.
4. Practice has an after-hours clinician on call or triage service that does not have access to patient records.
5. Practice has a clinician on call who has access to patient records.

Our data showed a significant shift in self-reported clinical access over time as the number of practices that offered low levels of expanded access (no system in place, a phone message directing the patient to the hospital) decreased from 32% to 22%, and those who offer expanded access (clinician or qualified personnel available) increased from 66% to 75%.

If this model is scaled, there is every reason to believe that participating practices will make similar changes.

- b) What types of practices (e.g. size, geography, ownership or organizational structure) participated? How many Medicare FFS patients did each of these practices serve?

Response 1b): The types of practices that participated varied in size and geography from small and independent to multi-disciplinary managed care organizations. These practices are located in settings varying from rural to urban. Practice reporting on patient population and payer mix was voluntary. These practices average 1.8 optometrists per practice, and over 90% of our participating practices were below the MIPS reporting threshold, which suggests each practice served a relatively low number of Medicare FFS patients.

- c) The proposal states that SNE-PTN provided assistance to optometry practices. Were ophthalmology practices able to participate? If so, how many participated? If not, why not?

Response 1c): All eye care professionals were able to participate in the initiative. Our two enrolled ophthalmology practices did not contribute any data regarding ED avoidance (though they did contribute data on clinical quality measures, and other aspects of performance in TCPI). Practices recruited in our local area were assigned a staff member and worked on clinical measures that aligned with their individual practice goals. There were no clinical or administrative barriers preventing ophthalmologists from participating, and they would be fully eligible and able to participate in the proposed APM.

- d) What did it cost for the practices to make the changes in care delivery under the project? How did they support the costs of these changes without the payment model you are proposing? Did individual practices receive funding through the TCPI project to cover any of these costs, and if so, how much did they receive?

Response 1d): Practices did not report any significant incremental costs associated with implementing this model. Our organization provided the marketing materials, education, technical assistance and process for implementing a patient and provider education campaign. Practices that demonstrated sustained performance in the initiative (TCPI) were eligible to earn achievement payments ranging between \$80 - \$750 (per achievement) in 2019. These funds were not designed to defray practice costs and were not an element of the program until the third year of the project. It is noteworthy that practices that implemented the changes did so before the availability of achievement payments was announced.

- e) Please describe in more detail how the outcomes in the project were measured and any variations in performance across practice sites.

Response 1e): We provided practices with log sheets that allowed them to track the number of patients who contacted their practice for urgent care. The practices then submitted self-reported data on a monthly basis. This data included the number of patients with ambulatory sensitive eye conditions who were seen, the number of patients who had contacted them seeking urgent care, the number of clinicians in the practice that month and a selection of what type of access they offered to patients (listed in the response to question 1a.).

Practices reported the above items monthly over a 20-month period. In the aggregate, practices showed consistent growth in both the rate and number of patients seen:

- Patients who contacted the office and who also received office-based care increased from 94% (Q4 2017) to 97% (Q3 2019)
- Practices reporting on this urgent care measure (again, all reporting was voluntary) increased from 541 (Q4 2017) to 830 (Q3 2019)
- Total patients reported receiving in-office care (across all reporting practices) increased from 26,644 (Q4 2017) to 60,458 (Q3 2019)

There was a great deal of variation in performance across practice sites. Even after controlling for practices size (number of clinicians), the number of urgent visits for the selected conditions ranged from 0-1 to over 25 visits per eye care clinician per month. We were not able to investigate and measure the causes and correlates of variation. However, all participating practices were clinically qualified to care for these urgent conditions. Variation was likely related to a combination of differences in the local environment (such as presence of urgent care centers), specific patient population, practice enthusiasm and diligence in implementation of the patient outreach campaign, and others.

- f) For the results you cite on avoided ED visits (e.g., map on page 5), how did you define an “ED visit avoided” and how were the data collected?

Response 1f): We defined "ED visit avoided" as an office visit generated by a patient who contacted the practice requesting urgent care for one of the groups of conditions enumerated in Table D3 of our proposal, and who was seen within 24 hours of first contact. The data were self-reported by the practices who used our log sheets or were able to generate the same information from a query of their EHRs, and they reported their results monthly through our data collection portal.

- g) How did you determine that the ED visits were avoided “through same-day office-based appointments and after-hours triage” at the optometry practice?

Response 1g): Our model includes an assumption that most people who call an outpatient office seeking care for one of the selected conditions will, if they are not accommodated in the office, seek care somewhere else, most likely in an emergency department. We have confirmed (please see HCUP NEDS data presented in the proposal) that millions of patients are indeed treated in emergency departments each year for these specific conditions. Once a patient has self-identified their condition as urgent, we think that it is unlikely that they will stop seeking care and simply wait for their symptoms to subside. Similarly, if after contacting their optometrist requesting urgent care, they cannot be seen in that setting, it is unlikely that they will continue to call around to other offices trying to get an urgent/same day appointment. Virtually all patients are aware that they can get care by walking into an emergency department. For these six condition groups, treatment rendered during the initial office visit is almost always definitive. Thus, it would be exceedingly rare for a patient would need to seek emergency department care for the same condition after being treated in the optometry office.

Please see the “ED Avoidance Sheet” (Attachment 1 and 2) for the instructions and log sheet used by practices.

2. The proposal refers broadly to Medicare beneficiaries but does not distinguish how the model would work for fee-for-service (FFS) beneficiaries versus Medicare Advantage (MA) enrollees. Medicare’s advanced alternative payment models target FFS rather than MA enrollees.
 - a) Can you provide the PRT with a clearer understanding of the size of the proposed model’s target population of Medicare FFS beneficiaries?

Response 2a): This model benefits all patients. In Table 1 on page 7 of the proposal, we identify 226,000 ED visits by Medicare beneficiaries for ambulatory sensitive eye conditions in 2016. Our dataset does not distinguish between beneficiaries enrolled in FFS and Medicare Advantage. We have no basis to believe that Medicare FFS beneficiaries would participate in the program at a different rate from beneficiaries enrolled in a Medicare Advantage plan.

- b) To what extent would this population be of sufficient size to implement the model if other payers (e.g., commercial, Medicaid or MA) are not participating?

Response 2b): We believe the Medicare FFS population size would be of sufficient size to implement this model. It is worth noting that practices participating in the APM would implement the needed practice changes for all patients (regardless of payer) in their practices. While, in the scenario proposed in this question, practices would only receive upside financial benefit for their Medicare FFS patients, they would also only incur downside risk for the same group of patients. Since there are no significant investments required to

participate, the model remains attractive even if only Medicare FFS were participating.

3. The proposal describes the risk-bearing entity as the eye care private practice, corporate practice, multi-disciplinary practice or other non-physician-owned entity that employs an eligible eye care professional (p.4). However, the examples you cite in the Appendix are based on 1,000 participating eye care professionals. Could individual small practices participate, and if so, could you give an example of how the model would work for a small practice with the typical number of patients in such a practice?

Response 3: The care model worked in small practices during our project. We believe the payment model is one that is reasonable to assume by small practices because the financial risks are modest and proportionate to the fee for service payments.

Table F1, Step 4 and Table F2, Step 4 show how the model would work for a typical individual practitioner. A practice with two participating eye care practitioners could estimate its results by multiplying the example results by two. A practice with five participating eye care practitioners could estimate its results by multiplying the example results by five.

4. Please explain how you would determine whether a participating optometry practice would be held responsible for a specific patient who visited an ED for one of the avoidable conditions. Would the patient need to have enrolled with the practice in some way? Which practice would be held responsible if a patient had made visits to multiple optometry practices prior to the ED visit? Which practice would be responsible if a patient had visited both an ophthalmology practice and an optometry practice prior to the ED visit? How recently would the patient need to have visited the practice in order for the practice to be held responsible for the ED visit? Would there be any changes in patient residence, health issues, etc. that would exempt the practice from being held responsible for the visit?

Response 4: This model does not hold practices financially responsible for the cost of an ED visit. ED patients would be attributed to a practice only if the payer had also paid for an office visit for the same primary diagnosis within 7 days of the ED visit. The ED visit in this example would be considered an adverse event related to the quality of the treatment provided by the practice.

The model is built around a positive incentive of shared savings, with the downside risk taken upfront as a discount on fee for service reimbursement. Determination of ED utilization is based on claims held by the payer. The purpose of this lookback is not to hold the practice accountable for the cost of any ED visits. It is solely to ensure that no shared savings payments are made for office visits that failed to definitively treat the urgent problem. And of course, if this happened frequently for a particular practice, it might be an indication of a

quality concern. An ED visit for the same primary diagnosis within 7 days serves as a quality and patient safety check. The payers' medical review processes would identify adverse outcomes.

5. Please explain why you would require an increase in the number of office-based visits for ED-avoidable conditions as part of the model, and how the target level of utilization would be established. Is it correct that phone or email contacts with the patient would not be included in this measure?

Response 5: The assumption was that payers would not want to pay for the level of performance that pre-dated the model.

The model assumes that payers would work with participating practices to establish a utilization baseline. Increases above the baseline sufficient to meet or exceed target utilization levels would trigger shared savings payments.

An office visit representing ED avoidance needs to be documented through some billable event to the payer. If phone or email contact were reimbursed as a billable service (this area is evolving rapidly at this time) then these contacts could be included in the measure.

6. In the discussion of the adverse event rate on page 9 of the proposal, you state that “the adverse event rates could be adjusted for age, gender and/or other risk factors.” The PRT would like to know what other factors might be important to include in the adjustment. Do you have a risk adjustment model that could be used for this purpose?

Response 6: We do not have a data set to evaluate for this risk adjustment. We are not aware of an existing risk adjustment model for this purpose. Any risk adjustment would be payer specific and payers would develop any risk adjustment model based on their own data.

Other factors that might be important to include in a risk adjustment model are co-morbidities, e.g., diabetes, cardiovascular diseases, and episodic conditions such as herpes simplex. Clinically, one might consider adjusting for a number of systemic and ocular conditions.

7. On page 8, the proposal states “the proposed model will measure patient safety by monitoring the occurrence of adverse events within seven days of the office visit with the eye care professional and incorporate a patient survey to measure the patient’s experience of the office visit.”

- a) Why is a seven-day window for adverse events appropriate for the proposed diagnoses? Could a 30-day or 90-day window be used instead?

Response 7a): The seven-day window is appropriate because the ocular conditions considered in the model typically respond to treatment and resolve within a seven-day period. Therefore, a reoccurrence of the same condition after seven days is reasonably considered to be a separate and discrete event albeit of the same condition. A 30- or 90-day window would therefore be too broad and if included in the model this length of time would potentially incorporate multiple instances of recurring visits that were appropriately treated and resolved during a 30- or 90-day timespan.

- b) Please explain more precisely how you would define an ED visit that is “related to same ICD 10 Dx as original office visit.”

Response 7b): An ED visit within the seven-day time period is “related to the same ICD 10 diagnosis” if the ED visit produces a billable event using the same primary diagnosis code as the immediately preceding office visit. It is important to include this limitation on *primary* diagnosis. For instance, if five days after an optometry visit to treat a corneal abrasion, a patient is treated in an emergency department for a motor vehicle accident with broken ribs, that emergency physician is likely to note and code the corneal abrasion. But it will not be the primary diagnosis, and will not be the primary reason for the ED visit.

- c) Who would conduct the patient survey and how would responses be collected?

Response 7c): An independent survey administrator will create customized survey links for practices who will then provide that link to patients. The administrator will collect, collate, and share survey results with practices and payers.

- d) Will patient volume be sufficiently high to enable statistical reliability of the measures for individual practices, especially small practices?

Response 7d): Most of the practices contributing data to the TCPi project are individual or small practices, and they reported an average of approximately 22 patients per reporting month over the course of the project. Payers can evaluate the statistical reliability of survey results for any small practice using aggregate data for all practices enrolled in the model. The model includes an appeal process so providers can contest statistical anomalies.

Small numbers are entirely typical of patient experience surveys conducted in small practice settings.

8. How would the patient survey (described on page 10 and in Appendix E) be scored? Which are the “core survey questions?” What answers would result in a score of 3 points or more?

Response 8: The core survey questions in the EyEDA proposal's patient survey in Appendix E are questions 8, 9 and 10. These core questions each have four answer choices, and the answers would be assigned points (1, 2, 3 or 4). The answers that would result in a score of 3 points or more are as follows:

Q.8: Agree Completely (4 pts), Agree Somewhat (3 pts.);

Q.9: Very Satisfied (4 pts.), Somewhat Satisfied (3 pts.);

Q.10: Very Likely (4 pts), Somewhat Likely (3 pts).

9. The proposal states (p. 2) that “providers will bear financial risk in the form of a discount of at least 8% applied to all FFS rates for urgent visits.” Page 14 indicates that the discounted rates would apply to evaluation and management services, comprehensive eye exams and diagnosis/treatment procedures for ED-avoidable eye conditions. Page 15 indicates that “eligible visits do not include follow-up visits for the same condition.” The PRT would appreciate clarification on several points.

- a) Would payments for all visits to the practice be reduced by 8%, or only “urgent” visits?

Response 9a): Only the billable services (identified by CPT codes for E&M services, eye procedures and comprehensive eye exams) related to the initial “urgent” visit and any treatments or procedures performed within (for conditions as defined by the discrete set of ICD10 codes in the model) would be subject to the 8% reduction.

- b) Please indicate whether urgent visit codes are the same as ED-avoidable codes (e.g., that the proposal uses them interchangeably). If not, please indicate how urgent visits are identified.

Response 9b): We regret the ambiguity of the language in the proposal. “ED-avoidable codes” refers to the discrete set of ICD10 codes in the model. “Urgent codes” refers to a set of CPT codes (9905X) that may be billed for unscheduled visits. Unfortunately, these codes are rarely used in practice. Providers typically bill the E&M code for the office visit, regardless of whether or not it was scheduled (9921X). These urgent codes would have been helpful in distinguishing “urgent” visits, but because they are rarely used, they cannot be relied upon. However, *any* office visit for one of the defined conditions can and should be considered in the model for the following reason. Symptoms from the five diagnosis groups represented by the list of ICD10 codes almost always have abrupt onset. Patients would be very unlikely to schedule visits for these conditions in advance. For this reason, all visits for these conditions may be safely assumed to be unscheduled visits.

- c) Please clarify whether the discount would apply to all FFS payments pertaining to the urgent/ED-avoidable condition. If not, how would it be determined which follow-up visits or other services would not be included.

Response 9c): Follow up services would not be discounted.

10. The PRT is interested in understanding how the proposed model would work from the provider perspective. Please describe or provide examples of how your PFPM might work in the following settings or identify differences in how the model would operate in different settings.

- a) hospital-based practice with employed physicians
- b) community-based setting with large (>10) number of doctors
- c) community-based settings with small (<3) number of doctors or solo practitioners
- d) practices with optometrists only vs. practices with both ophthalmologists and optometrists
- e) retail eye clinics

Response 10a-e): The model will function in the same way in all of the above settings. The model is not sensitive to the size of the practice. As we have indicated in responses to earlier questions, the majority of practices participating in the TCPi demonstration model were small. While the modeling was done in optometry practices, it would function in the same way in practices that include both eye care professions. We note that almost all practices participating in the demonstration were private practices, owned by the optometrist(s). However, we did also work with an academic practice, as well as some larger clinics. In clinics where the providers are employed (e.g. hospital-based, retail), in order for the incentive to function properly, there would need to be some sort of variable compensation arrangement in place. But this is no different from any other financial incentive.

11. Table 5 presents a methodology of shared savings by using changes in payments for both the ED and eligible providers for the performance year relative to the base year.

- a) This methodology seems to assume that the population remains fixed. How would the shared savings methodology adjust for changes in the service area population over time, either due to movement by the patient population or expansion/retraction of the providers' service areas?

Table 5. Calculation of Savings Amount for Distribution

1.	Change in payments to EDs	Performance Year ED payments less Base Year ED payments
2.	Change in payments to eligible providers	Performance Year payments to eligible providers less Base Year payments to eligible providers
3.	Program costs	Administrative costs for monitoring and evaluation of quality performance
4.	Net Shared Savings for Distribution	$(-1 \times (L.1 + L.2)) - L.3$ (if positive)

Response 11a): Payers have the latitude to make adjustments to the incentive. By creating a baseline from a 2 to 3 year rolling average of utilization, practices and payers could smooth out variances in patient population and account for expansion.

- b) The table indicates that program costs for monitoring and evaluation of quality performance would be subtracted from shared savings. To what extent would these costs initially be covered by the practices versus the payers? Are other costs to the practice of doing the model expected to be adequately covered by the shared savings?

Response 11b): As discussed in the response to Q1d above – the model does not anticipate any additional direct costs to practices. The practices will incur financial risk through the 8% FFS reduction for applicable visits when they occur. Payers would incur administrative costs, but these incremental costs are substantially lower than the savings produced by the shift from emergency department to office-based care.

12. The PRT would like a better understanding of how this model would work from a patient's perspective.

- a) Please describe in more detail how you would expect practices to encourage patients to seek care at an optometrist's office.

Response 12a): In our TPCi experience the practice staff and providers have encouraged patients and families in person, through flyers, notices on the practice website and newsletters. The typical message used is "Do you know that we treat eye conditions?". (It is important to recognize that many optometry patients know the practice only as a place to get eyeglasses and contact lenses, not care for eye injuries and illnesses. The message is part of a campaign to expand patients' understanding of the services offered by the practices). By utilizing education, marketing materials, interoperability, and changes to workflows, the model aims to improve care by utilizing lower cost and more appropriate care settings. Interventions have included and should include:

1. Increased access to clinicians via open scheduling, after-hours care, triage telephone lines, and tele-health.
2. Collaboration with the eye care provider's existing medical neighborhood for same-day direct referrals to and from primary care physicians and ophthalmologists as needed.
3. Staff engagement and education of patients - telephonically and in-person
4. Marketing materials at the eye clinic, referring providers offices, and in some cases, businesses
5. Inclusion of urgent care discussion while taking a patient's history: 'Have you or an acquaintance sought care for an eye condition in an emergency room in the past?'

6. Improved utilization of existing web pages, newsletters and social media presence.

- b) One graphic on page 21 shows the patient being referred by the primary care physician (PCP) to the ED (e.g., for a patient who deems their condition to be urgent after-hours). The letter from the American Academy of Optometry (p. 27) notes that “up to 44% of the patients who access EDs for eye-related conditions have a diagnosis of conjunctivitis.” Since conjunctivitis or other conditions could be treated in either a PCP or optometrist’s office, how would the model distinguish between situations in which the ED visit was avoided by a visit to their PCP rather than by a visit to the optometrist?

Response 12b): Payers will identify the clinician responsible for avoiding the ED visit through claims. If the code for one of the diagnosis groups was billed by the eye care professional, it will be credited to that practice. If the same code is billed by a PCP, they may get credit for avoiding the ED visit. The model does not contemplate inclusion of PCPs only because we have no pilot data or experience with that group. There is no structural reason why they could not be included in the future. If a patient is seen by both an eye care professional and a PCP for the same diagnosis within a short period of time, the payer’s medical review would need to reach a determination of whether to credit the eye care professional for that visit.

13. Page 23 of the proposal states that the EyEDA model would be able to incorporate HIT and telehealth advancements, with a short example of how a participating eye care provider could collaborate with a PCP. The PRT would like to understand if and how telehealth would be used more broadly in the model, particularly in relation to avoiding ED visits.

Response 13): The key element requiring an office visit to the eye care professional is a visual examination of the eye. When this can be done remotely using a camera, telehealth visits will be able to effectively substitute for in-person visits. Telehealth could be used more broadly in the model, once the technology is fully approved by regulatory bodies, and accepted for reimbursement by payers. In this scenario, a telehealth solution in lieu of an ED visit accomplishes the same goal of delivering care using the most cost-efficient method. The cost difference between a reimbursable telehealth visit and an ED visit may differ by payer and may require adjustment to the shared savings model.

14. The proposal states that the set of ICD-10 codes identifying ED-avoidable visits was developed at the Southern New England Practice Transformation Network with input from subject matter experts and an independent review panel.

- a) Please describe in more detail the process for identifying ED-avoidable eye-related diagnoses codes and describe which eye-related condition codes were not included as avoidable.

Response 14a): We convened an expert panel with representation from optometrists from different licensing jurisdictions and practice modes who have significant clinical and administrative experience as well as other professional credentials. They reviewed the complete list of ICD-10 codes related to ocular conditions and eliminated any that were deemed to be true emergencies that required immediate medical evaluation and intervention, e.g., sudden onset of visual field defects that might be indicative of a stroke.

The five broad conditions whose management was identified as being within the purview of optometric licensure were initially broken down into the appropriate ICD-9 codes (we were initially working with HCUP data from 2014, which was coded in ICD-9). When we acquired subsequent years' data which were coded in ICD-10 these were then cross-walked into the ICD-10 codes. We convened an expert panel of optometrists to review the code list that had been generated. The panel was composed of five nationally recognized and clinically active optometrists. We limited panel membership to optometrists because we were focused on confirming that the codes on the list were within the scope of practice and licensure of outpatient optometry. The list was given to the members of the expert panel, and the panel members reviewed and scored each code. The scoring options were patient education, urgent (one-day) office visit to the practitioner, referral to an ophthalmologist, referral to an ER, or referral to a PCP. The codes that are included on the list attached to the proposal were unanimously accepted by the expert panel as being appropriate for outpatient management by optometry.

- b) Some of the codes in Appendix B seem more limited than might be appropriate for identifying all avoidable ED visits. For example, Appendix B includes "C44119" in the "Other" category on page 36. This ICD-10 code represents "Basal cell carcinoma of skin of left eyelid, including canthus." However, it was not clear to the PRT why similar codes for the eyelid (C44.11), unspecified eyelid (C44.111) right eyelid (C44.112) were not also included in your list. Can you please confirm for this example whether the additional codes were intentionally excluded and if so, why?

Response 14b): C44.111 are descriptors rather than a diagnosis. In order to apply a conservative standard for inclusion on the list, we excluded any code where there appeared to be the possibility that the ocular symptoms might be the result of systemic disease. Also, only eye conditions presenting in the first diagnosis position were included. As explained above, the first position or primary diagnosis is the primary reason for the current visit or service. Diagnoses in the second or later position are identified by the clinician as present but are not the primary reason for the current visit. We recognize that this resulted in the omission of some codes from the list that might be suitable, in some circumstances, to treatment in the outpatient setting. We opted for

conservatism because we did not want to create an incentive to keep patients away from higher intensity settings who really needed those settings.

The codes in the appendix are ICD10 eye/vision-related codes and will need to be reviewed further for practical implementation. Typically, clinicians attempt to match the findings of their exam and treatment plan to the most appropriate code(s) on the list they are provided by payers. These lists are exhaustive and highly detailed, e.g., each type of conjunctivitis is usually broken down into four codes: a) right eye; b) left eye; c) both eyes; d) unspecified eye. Being overly specific may make it difficult to track the impact of this project. For example: an outpatient office visit with an adverse outcome that generates a subsequent ED visit may be coded differently at each of these visits:

H1031 Unspecified acute conjunctivitis right eye at the initial visit and

H10011 Acute follicular conjunctivitis right eye at an ED visit two days later

Simply tracking by code would make these appear to be separate events when in actuality, the second is a different manifestation of the original presenting condition.

Reducing Unnecessary Hospitalizations: Avoiding Patient Visits to ED and Urgent Care Centers

SNEPTN wants to assist optometry's increased integration within the medical neighborhood. Patients often self-refer to emergency departments for problems that can be treated or managed in the optometry office at a lower cost and with better outcomes for patients and providers.

By establishing a trackable metric, we will demonstrate the high level of performance and value optometrists deliver as first line eye care providers.

Metric Definition:

- Numerator:**
Number of patients contacting the office for urgent care who are seen within an appropriate time (as defined by clinical guidelines).
- Denominator:**
Number of patients contacting the office for urgent care.
- Exclusions:**
Patients seeking urgent care for conditions that are outside the scope of practice.

This process can be used by the practice to document how well it serves patients seeking urgent care. Sample target: > 85%.

Impactful Questions to Consider:

Is there a system or understanding in place between your office and your local ambulatory care office to refer urgent cases?

By building out your connections within the medical neighborhood you provide greater opportunity to provide timely cost efficient care for in-scope issues.

Is your practice able to see patients for urgent or same-day appointments if needed?

When patients require an appointment for an urgent issue, are you able to see them or refer them to another ambulatory provider on the same day or as appropriate?

Performance:

By highlighting the value that optometrists add within the medical neighborhood as first-line ambulatory providers as well as a source of direct referrals, we aim to accelerate their integration into current and future healthcare delivery models.



IDENTIFYING BARRIERS TO REDUCING UNNECESSARY HOSPITALIZATION AND URGENT CARE UTILIZATION

www.sneptn.org

We are asking that you log the number of individuals who contact your office, who would otherwise seek care within the next 24 hours at an ER or urgent care center, for whom the office provided definitive care. If patients are unable to obtain care, please indicate the barrier on the sheet. In the final column, tally the number of patients who received care and place the total **over** the number of patients seeking urgent care.

<u>Examples=></u>	No Access/ No Clinician Available	No transportation				A	B	Ratio of A/B
						# of patients who receive care	# of patients seeking urgent care	
<i>Week of:</i>								
<i>Week of:</i>								
<i>Week of:</i>								
<i>Week of:</i>								
<i>Week of:</i>								

This is a tool is to track patient volume and identify areas for improvement.
Enter the Ratio in the last column at Portal.SNEPTN.org every month.

Please keep the sheet for your records

**University of Massachusetts Medical School Responses to
Preliminary Review Team Report to the Physician-Focused Payment Model
Technical Advisory Committee on the**

Eye Care Emergency Department Avoidance (EyEDA) Model

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March 4, 2020

We have reviewed the detailed analysis of our proposal provided to us in the Preliminary Review Team Report, dated November 8th, 2019, as well as the thoughtful and insightful comments and questions posed to our team in a teleconference with PRT held a few days earlier. We recognize that the EyEDA model is a bit unusual in several ways. We have endeavored to develop a physician focused alternative payment model for a specialty that currently has no access to participation in value-based care. We also developed a model in which the financial incentives are aimed to drive higher efficiency care, while preserving or enhancing patient choice, patient safety and care integration. This was certainly a steep challenge, and we appreciate the deep consideration that the PRT has given to our proposal.

In this document, we respond to the items that the PRT has described as weaknesses, and we have offered an outline for potential modification of the payment model that aim to address many of the PRT's most pointed concerns. Our responses are tagged to the criteria, and then to the sequential comments provided in the PRT report under those criteria.

Criterion 1. Scope (High Priority)

Weaknesses, 1st comment

We agree that this model focuses on changing the site of treatment for a particular set of health problems. However, we believe that it does indeed take a holistic approach to the patient's needs. By encouraging patients to seek and receive urgent care from a professional with whom they have an existing primary care (for the eyes) relationship, the model also encourages more comprehensive and coordinated care. Widespread implementation of the model would also encourage greater coordination and communication between the eye care professional, and the primary care clinician. We note that ED overuse is currently a high priority challenge for payors and self-insured employers. This concern is being widely discussed in health policy circles, and it is a significant irritant to many patients, who are experiencing rapidly rising co-pays and other cost-sharing in response to the perceived problem. This model

could be adapted and applied to other conditions for which the emergency department is thought to be over-used.

Weaknesses, 2nd comment

The health conditions included in the model were carefully reviewed and validated by an independent clinical advisory panel. These conditions are an ordinary part of outpatient practice. These conditions are routinely seen on an urgent care or walk-in basis in optometric and ophthalmologic practice. A very small percent of patients do have an urgent condition that cannot be definitively treated in an optometric office, and they are referred, most often to an ophthalmology office, but if needed, to an ED. But this is a very, very small percentage of patients, and none of the conditions in question are critically harmed by the small delay of referral. In other words, this model simply encourages the best triage and referral practices that are already in wide-spread use across the health care system.

Weaknesses, 3rd comment

This model would function optimally in practices that are able to implement it on an all-payer basis. (We note that this is generally true of most payment models. Payment models that require providers to provide care in different ways depending upon payer create complexity and confusion in the practice setting). The issue raised by this comment would be mitigated if the model were modified to eliminate the threshold, baseline measurement, and requirement for an increase above baseline. This is discussed in further detail elsewhere in this response.

Summary

“One PRT member believes that the scope criterion is specifically intended to encourage participation of more types of physicians in APMs, and that the proposed model would provide such an opportunity for two types of physicians that do not have other APM opportunities. In addition, specialty-specific models can help improve coordination and reduce fragmentation of care by allowing each specialty to be compensated appropriately for the specific types of conditions it is best qualified to treat.”

We note that the quote above accurately captures the intent underlying the development, design and testing of the model, which occurred in the context of the CMS-funded TCPI program. Transitioning physicians of all specialties into APM models was an explicit goal of the program, and this model was more successful in doing so on a larger scale than any other test of change in TCPI.

Criterion 3. Payment Methodology (High Priority)

Weaknesses, 1st comment

This critique accurately and insightfully captures one of the dilemmas faced by the authors who developed this model. Some practices are already highly effective in this type of urgent eye care, and they might find it difficult to increase their volume sufficiently to meet the required threshold. While we believe that there are ways to mitigate this concern (e.g. increased referrals from primary care clinicians who prefer not to see urgent eye care themselves, and currently routinely refer such calls to emergency departments), this remains a weak point in the model. The variability in such visits over time, particularly in small practices, is also a real concern. We also agree that some of challenging features of the model were added explicitly in order to meet criteria for an advanced APM. Certain design changes could be made (and we are amenable to doing so) that would both simplify the model, and address some of these concerns.

One way to achieve such simplification would be to eliminate the baseline measurement, the requirement to increase urgent visits, and the threshold for payment of shared savings. Shared savings would accrue to the practice for *every* eligible urgent care visit, albeit likely at a lower percentage of savings shared. We had contemplated the possibility of such a change when we developed the original model. The spreadsheet contained in the appendix, which calculates the shared savings for various practice scenarios, allows for adjustment of all variables, including setting the required increase at 0%, and the shared savings percentage at any desired level. By adjusting these parameters, it can be shown that the model can be effective for both payer and provider without a required increase in volume.

Weaknesses, 2nd comment

This note in essence raises the concern that this payment system could be subject to “gaming” by practices coding routine or non-urgent visits for one of the five covered conditions as urgent. As a general matter, we agree that all coding and reimbursement mechanisms are subject to potential gaming, and that is true in this instance. However, we also note that there are several factors that mitigate the likelihood this would occur on a large scale. First, clinical notes in the medical record should document the urgency of the visit. Second, it is, in all payment systems and mechanisms, the responsibility of the payer to monitor claims patterns, and audit detected outliers. This occurs routinely, and would allow payers to monitor the performance of the APM, and the practices using it. There are also code modifiers intended to identify urgent care cases. These are not currently used widely, but payers adopting this APM could require them as a condition of participation. Finally, it is really the patient’s perception of urgency (not the physician’s post-hoc determination) that drives utilization. Patients seek care in emergency departments when their perception of the urgency of their symptoms exceeds their understanding of the availability of care in the office or clinic setting. One of the explicit goals

of this model is to help patients gain a better understanding of the availability of office-based care, prior to self-referral to the emergency department.

Weaknesses, 3rd comment

In our experience implementing this model of care in over 1,600 optometry practices across the nation, upfront costs of implementation were nominal, at most. Many practices reported no investments whatsoever. Most practices already have an answering service, and simply needed to change the instructions to the service regarding which calls to put through or page to a provider. We are not aware of any practice that was forced to purchase or upgrade a telephone system in order to support this model. Most practices also already had the capacity to schedule same day appointments. The principal change was simply to better understand the system value embedded in those appointments, and encourage the office scheduler to accommodate them. The volume in any given office was not sufficient to require them to change or extend their office hours. On occasion, the physician might “stay late” to accommodate a same day patient, but in physician-owned small town practices (the majority of the 1600), this represents their normal business operations, and this accommodation was not a change requiring an investment.

Weaknesses, 4th comment

The model does not attempt to attribute visits between emergency departments and optometry/ophthalmology offices. It also does not attempt to calculate the savings achieved based on a reduction in aggregate numbers of ED visits. Rather, it assumes that urgent visits not seen in an office setting would have ultimately resulted in a visit to an ED. While this assumption might not be 100% true, it is much closer than not. Once a patient decides that their eye symptoms are of sufficient severity to request urgent care from a physician, if they are not able to receive that care in the office on a timely basis, they are very highly likely to next go to an ED. Thus, we calculate the savings based on the difference in costs between the two settings. The savings to be paid to practices is therefore not based on their share of a pool, it is based on the specific patients they treated, and helped to avoid a visit to an ED.

However, this issue will be further mitigated if we make the changes described above, and eliminate the baseline, threshold and increase in volume features of the model.

Weaknesses, 5th comment

As noted above, this model does not rely upon comparison to other practices or to benchmarks. As discussed above, elimination of the baseline, threshold and requirement for increased volume would effectively nullify this issue. Shared savings would simply inure to the practice for each urgent office visit that replaces an ED visit.

Criterion 7. Integration and Care Coordination

Weaknesses, 1st comment

It is the standard of practice in optometry practices to refer patients to an ophthalmologist, to a hospital, or in rare cases to another medical specialist (eg rheumatologist or immunologist) when the patient's needs are not within optometry's scope of practice, or the specific office's scope of services. A very common scenario is that all optometrists, as a routine part of the examination, measure intraocular pressure to screen for glaucoma. But in most states, scope of practice does not include all modalities of treatment of glaucoma. All patients who are diagnosed with glaucoma are referred to ophthalmology. No payment mechanism could incentivize them to operate outside of their scope of practice. Professional training, licensure and medical liability all act as restraints against such inappropriate practice.

Because optometrists follow large panels of patients, it is not uncommon for patients to contact them by phone, or as walk-ins, for symptoms that are outside of the optometrist's scope of practice. They routinely refer patients whose symptoms require quick evaluation and treatment to an ED. Like other specialists, when doing so, they phone ahead to the ED, provide history and any initial evaluation data, and in so doing, shorten the time until the patient receives definitive treatment.

Weaknesses, 2nd comment

We believe that the model does encourage care integration, and that this was demonstrated in our experience of pilot implementation through the TCPI program. Optometry offices routinely coordinate care with the patient's PCP through shared EHR systems (when in ACO or developed systems of care), through CCDs, or when none of these are available, through letters to the referring provider. This effectively "closes the referral loop." When our care and payment model is implemented, one of the steps taken by the optometry office is to outreach to the community of referring PCPs to inform them that the optometrist accepts and treats urgent eye visits. This communication of course encourages referrals, as the PCP office is often the first point of contact for patients with eye symptoms that they perceive to be urgent. However, since many PCPs prefer not to examine and treat ocular disorders, they refer many such calls to the ED. These outreach calls serve to enhance the effectiveness of the model. However the outreach from optometrist to PCP also encourages communication among providers, and thus more coordinated care.

Finally, we would note that we considered embedding performance on the HEDIS measure related to Closing the Referral Loop in our payment model. However, we ultimately determined that this was not directly on point, and added further complexity to the model.

Criterion 9. Patient Safety

Weaknesses, 1st comment

While the conditions selected for inclusion by our clinical advisory panel may be clinically serious, evaluation and diagnosis of these conditions is entirely within the training and scope of practice of the disciplines of both optometry and ophthalmology. Optometry offices typically have advanced and sophisticated diagnostic equipment, which often exceeds that present in emergency departments, particularly smaller EDs. Smaller EDs may also not have an eye care professional onsite at all times, and need to call in an on-call optometrist or ophthalmologist to see the patient. As noted earlier, because optometry scope of practice is very broad for examination and diagnosis, but somewhat more limited for invasive treatment, optometrists routinely diagnose and refer patients to ophthalmologists. This is a routine part of practice, and the modest financial incentives in this model would not be sufficient to induce an optometrist to violate their scope of practice, and risk their licensure or litigation. On the other hand, the less common patient who might present to an optometrist, but be determined to need ED care, is likely to have that care accelerated by presenting to the ED with a referral from an eye care professional, a call-ahead, a diagnosis, and where appropriate, ocular imaging already performed.

We believe based on professional opinion, and considerable experience, that this model poses virtually no risk to patient safety, and in many instances, is likely to enhance it.

Weaknesses, 2nd comment

It is important to recognize that this model does not encourage patients to walk-in to the optometry office for urgent conditions. While that might happen on occasion (and does today outside of this model), the model encourages established eye care patients to call their optometrist if they have symptoms that they perceive as urgent. The optometrist, who knows the patient, has a medical record for them, and understands their co-morbid conditions, then makes a triage decision regarding whether to ask the patient to come in for an urgent visit, or direct the patient to go the ED. While, like any clinician, the optometrist could conceivably make an error in that triage decision, they are far more likely to make an accurate and appropriate decision than the patient acting alone without any medical advice. Thus, if anything, this model reduces, rather than increases that likelihood that participating patients will receive care in the most appropriate setting.

This model provides modest financial incentives for skilled specialists to offer care in the most appropriate setting of care. We know from HCUP NEDS data that approximately 3 million patients receive care in emergency departments for this group of non-emergent eye conditions. Our analysis eliminated all cases that resulted in admission or where the patient was not discharged alive from the ED, and all cases where the eye condition was not the primary diagnosis.

We also note that the broad range of conditions was driven by the structure of the ICD10 classification system. We began this work using ICD9 diagnoses, and with approximately an order of magnitude fewer conditions. The crosswalk from ICD9 to ICD10 resulted in a vast expansion of the number *codes* to capture the same set of conditions. It is the symptom or presenting complaint that drives the patient to seek care. But in order to perform an objective analysis, and develop a payment model, one must rely upon the established coding system.

Finally, the quality measures are included for purposes of ongoing monitoring of patient safety. They are obviously retrospective in nature, and can help to ensure patient safety in the aggregate, but not individually. Prospective patient safety is protected by the fact that it is patients who seek care based on symptoms and ultimately decide where they wish to receive that care. This model does not in any way create barriers that obstruct patients from exercising those choices. However, nowhere in our health care system do we believe that encouraging patients to seek advice from a trained specialist with whom they have an established doctor-patient relationship as they make care decisions adds danger or risk. When distilled to its essence, that's all this model does – encourage patients to seek the advice of their eye doctor before visiting an ED for eye symptoms.

Contributions to the development and submission of the EyEDA model and this response were made by the following individuals:

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PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL
ADVISORY COMMITTEE (PTAC)

+ + + + +

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH THE UNIVERSITY OF
MASSACHUSETTS MEDICAL SCHOOL (UMASS)
SUBMITTER

+ + + + +

WEDNESDAY, OCTOBER 30, 2019

4:00 p.m.

PRESENT:

PAUL N. CASALE, MD, MPH, Lead, PTAC Committee
Member

KAVITA PATEL, MD, MSHS, PTAC Committee Member

HAROLD D. MILLER, PTAC Committee Member

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P-R-O-C-E-E-D-I-N-G-S

4:02 p.m.

DR. CASALE: So thank you, everyone, for getting on the call. I guess I'll have the PTAC members introduce ourselves, and then we'd like to hear from everyone on the phone.

So Paul Casale, I'm a cardiologist, and I lead the accountable care organization at New York-Presbyterian, Weill Cornell and Columbia. Harold, why don't you go ahead and introduce yourself?

MR. MILLER: Sure. Hi, this is Harold Miller. I'm the CEO of the Center for Healthcare Quality and Payment Reform, and I'm a member of PTAC.

DR. CASALE: Great, thanks, and Kavita?

DR. PATEL: Hi, there, Kavita Patel. I'm an internist at Johns Hopkins and a fellow at the Brookings Institution and a member of PTAC.

DR. CASALE: Thanks. So, Sally, how do you want to do this?

1 MS. STEARNS: So sure, and by the way,
2 just to repeat the announcements that this call
3 is being recorded and will be transcribed. When
4 people speak, if they can identify themselves.
5 And, Dr. Polakoff, do you want to introduce
6 yourself?

7 And then we do have this sheet with
8 the information for everybody on your team, so I
9 don't know. I think introduce yourself, and then
10 perhaps others can introduce themselves as they
11 speak, if that makes sense.

12 DR. POLAKOFF: Sure, I think that
13 works. So good afternoon, everybody. I'm David
14 Polakoff. I'm an internist and geriatrician. I'm
15 a member of the faculty here at UMass Medical
16 School in population and quantitative health
17 sciences.

18 I direct our Center for Health
19 Innovation and Quality, and I'm the PI of our
20 TCPI¹ award, so I'm kind of the team leader for
21 this effort.

¹ Transforming Clinical Practice Initiative

1 DR. CASALE: Great, great, thank you.
2 So I'm not sure how we wanted to structure this.
3 I know we had sent some questions ahead of time
4 on some topics to review. So I'm wondering, do
5 you want to start there and then the discussion
6 can expand off of those?

7 DR. POLAKOFF: We're open to whatever
8 structure works best for PTAC, but we'd be happy
9 to start with the four questions that were sent
10 in advance, but we're not stuck on any formal
11 kind of structure. If questions arise along the
12 way, please just ask them, and we'll do our best
13 to respond.

14 DR. CASALE: Okay.

15 MS. STEARNS: Sure, so I think
16 everybody should have a copy, but I can just read
17 the first one if that would be helpful, and that
18 is how the target levels of ED-avoidable office
19 visits would be established for an individual
20 provider and whether the target increases would
21 differ for providers who already have a high
22 level of such visits.

1 DR. POLAKOFF: So I'll take the first
2 part of answering that question, and then I'm
3 going to ask Amy Hoskins to share some thoughts
4 she has on it as well, and then others may join
5 in.

6 I wanted to first say that the reason
7 we set target levels here was based on the
8 assumption that payers would not want to pay
9 additional incentives for performance that pre-
10 existed and pre-dated the existence of the APM.

11 And so therefore, we thought that from
12 the payer perspective, if they're going to
13 incentivize these urgent visits, they would want
14 to incentivize an increase, not just pay more for
15 what they were already getting previously.

16 And thusly, we suggested that a
17 baseline be set with a look-back, a claims-based
18 look-back, and the duration of the look-back
19 could be set by each participating payer. It
20 could be, we would suggest a minimum of a year,
21 but it could be as long as a three year rolling
22 average, to try to get each individual provider's

1 baseline performance.

2 And then a payer could also choose to
3 either offer the incentive for every single case
4 above the baseline level, or some threshold such
5 as 10 percent increase or 20 percent increase
6 above the baseline.

7 So we deliberately offer some
8 flexibility here to different payers that might
9 adopt this APM because market conditions and
10 policy preferences might vary from payer to payer
11 and market to market.

12 Amy, did you want to offer some of
13 your thoughts as well?

14 MS. HOSKINS: Yes, this is Amy
15 Hoskins. I'm a consultant for the development of
16 the APM, working for University of Massachusetts
17 Medical School Health Law and Policy Department.

18 So addressing the second part of the
19 question, whether the target increases would
20 differ for providers who already had a high level
21 of such visits, and we think that certainly could
22 be a good idea if there is a lot of variation,

1 and there are some providers that have already a
2 high level of office-based ED-avoidable visits.

3 And it certainly could be done in a
4 variety of ways, and it's possible that payers
5 might decide that practices starting with a lower
6 baseline level of visits per clinician per month
7 could have a higher target increase over baseline
8 levels of visits.

9 So it could be as much as 30 to 50
10 percent if they are starting with, you know, zero
11 to five visits per clinician per month, or if
12 they have a moderate level of visits in their
13 baseline, it could be between 10 and 20 percent,
14 and a practice starting with a very high level of
15 visits could even have a target of less than 10
16 percent or maybe just anything above their
17 baseline level of visits.

18 DR. CASALE: Great, that's helpful.
19 Could I just ask, while we're on the topic of ED-
20 avoidable visits, there were some letters that
21 were sent in, one from the emergency room
22 physician, the American College of Emergency

1 Physicians and the Optometry Association, which
2 suggested that maybe this list was sort of a
3 little too broad and suggested narrowing the
4 list, and I don't know if you saw those letters
5 or had comments about the...

6 DR. POLAKOFF: So not only did we see
7 the letters, but we had direct outreach from both
8 of those organizations. We've had discussions
9 with them about their concerns.

10 And I think to some extent, there was
11 ...well, particularly on the part of the AOA (the
12 American Optometry Association), there was a
13 little bit of a misunderstanding on how the list
14 was generated, which we were able to explain to
15 them, and I think has satisfied the concerns of
16 their leadership.

17 The American College of Emergency
18 Physicians actually wasn't that dissimilar. We
19 spoke with their leadership, including their
20 president and some of their government relations
21 folks.

22 I think their concern was a little bit

1 different in that they were worried that we might
2 be incentivizing too many patients not to go to
3 the ED and that that could have a volume impact
4 for them, was essentially what they said.

5 But what we did talk about was helping
6 both groups to understand that the way we
7 generated this list, which I think we explained
8 in our responses, written responses to earlier
9 questions to PTAC, was that we started with half
10 a dozen broadly stated conditions, for instance,
11 conjunctivitis being one of them.

12 And at the time we started looking at
13 claims data, the claims data were still coded in
14 ICD-9, so we developed a list of ICD-9 codes that
15 mapped to conjunctivitis.

16 About a year later, the claims data
17 that were available had transitioned over to ICD-
18 10, so we had to cross-walk the ICD-9 codes to
19 ICD-10 codes. That resulted in a 10 to 20x
20 multiplication of the number of codes simply
21 because of the changes from ICD-9 to ICD-10.

22 And then we took that list and put it

1 through an expert review panel of optometrists
2 and asked a group of five optometrists led by Dr.
3 Scott, who is here with us, to review the list
4 and scratch off any diagnosis code on which there
5 wasn't unanimous agreement that it was suitable
6 to be treated in an outpatient setting and was
7 within the scope of practice of both optometry
8 and ophthalmology.

9 If it's within optometry's scope, it's
10 also within ophthalmology's scope, but, so that
11 was the process we used to generate that list,
12 and I think Dr. Scott wants to add something.

13 DR. SCOTT: Sure, thanks, Dr. Casale.
14 What we also did was look at the practicality of
15 the situation where someone who has an eye
16 condition or a vision condition that they were
17 concerned about and would just call whoever would
18 answer a phone or however we were going to handle
19 using the mechanism.

20 And the conditions that we included
21 were ones that can easily be managed legally by
22 an optometrist, but we also included several of

1 the conditions that would be better triaged by
2 someone who had an extensive background in eye
3 care and was able to titrate the severity and
4 probably the most expeditious management scheme
5 to benefit the patient.

6 For example, if someone called and had
7 symptoms of a retinal detachment, many times,
8 that's difficult to differentiate from someone
9 who has a field loss from, say, a medical
10 condition, and the management of those two
11 entities is different.

12 One, if it's, for example, a stroke
13 with visual associated signs or symptoms, it
14 really does need to go to the emergency room
15 directly. And someone who has a retinal
16 detachment in the middle of the night needs to
17 see an ophthalmologist with retina specialization
18 first thing in the morning, but not necessarily
19 that night, and so we felt that that was in the
20 patient's best interest, to have access to that
21 type of practitioner who could inform the patient
22 appropriately.

1 MR. MILLER: This is Harold Miller.

2 DR. CASALE: Well, go ahead.

3 MR. MILLER: Go ahead, Paul.

4 DR. CASALE: Oh, no, I just wanted to
5 finish up. So it sounds like at least in your
6 conversations with the ED physicians and the
7 Optometry Association, they were ultimately
8 comfortable with the list that you generated. At
9 least that's what it sounds like.

10 DR. POLAKOFF: The optometrists for
11 sure were ultimately...

12 DR. CASALE: Okay.

13 DR. POLAKOFF: ...comfortable. As I said,
14 I think the ED physicians, there remains some
15 discomfort that more relates to the sheer volume
16 of these cases that are seen in EDs and there is
17 some worry.

18 And I'll be very candid. You know,
19 I've had these same discussions with the local
20 chair of the ED department at our own
21 institution, and so the concerns about the length
22 of the list and the volume get mixed up a little

1 bit.

2 DR. CASALE: Okay, thanks. Harold, go
3 ahead.

4 MR. MILLER: Hi, it's Harold Miller. I
5 want to get back ultimately to the issue of the
6 target rates, but while we're on the issue of the
7 diagnosis codes, I mean, I think there's two
8 different kinds of issues associated with the
9 diagnosis codes.

10 One is, do you have codes that are
11 inappropriate to be seen by an optometrist or an
12 ophthalmologist? I didn't add that concern.

13 I think the issue that I'm sort of
14 struggling with is that you're labeling these all
15 as urgent visits and as ED-avoidable visits, and
16 you're using diagnosis codes for them,
17 particularly this category of other that you have
18 in here, which is about seven million lines long,
19 and has things like chronic open-angle glaucoma
20 in it, macular degeneration, et cetera, which
21 might well be the diagnosis that results from,
22 you know, an urgent complaint, but also

1 represents a condition that could be diagnosed
2 for something that wasn't urgent at all, but was
3 simply, you know, diagnosed in the normal course
4 of a visit.

5 And I guess I'd like to understand
6 better why you have the other category in there
7 at all? Why not just focus on the smaller subset
8 of more likely to be clear urgent care visits
9 that somebody would have gone to the ED for?

10 And if the answer is well, but there's
11 a lot of other things that don't fall in those
12 categories, I guess I'm wondering if you gave any
13 thought to how to exclude the possibility that,
14 you know, every new case of macular degeneration
15 or glaucoma would suddenly be counted as an
16 urgent visit?

17 DR. POLAKOFF: Thanks for the
18 question, Dr. Miller; David Polakoff speaking,
19 and then I'm going to turn it over to Dr. Scott.

20 So, yes, we did think quite a bit
21 about that. One of the things that we needed in
22 our project is we asked the participating

1 practices to report to us only cases that came to
2 them urgently, were not scheduled visits, right,
3 and so where a patient called in and asked to be
4 seen on an urgent basis, generally the same day.

5 And so that tended to exclude a lot of
6 the new diagnoses. Those patients tend to be
7 scheduled patients who were in their schedule,
8 you know, well in advance, so that was the
9 mechanism we used to try to exclude those.

10 Now another concern that was raised by
11 the emergency physicians was that most patients
12 don't call up with a diagnosis attached to them.
13 They call up with a symptom, right, or they
14 appear in the ED with a symptom.

15 MR. MILLER: Sure, well, and that's
16 part of my question. I mean, I can imagine
17 somebody came in with some, "I can't see," and
18 somebody said, "Guess what? You have macular
19 degeneration," you know, although you'd say, "Why
20 did they not discover that earlier?"

21 But, so, but I guess I understand the
22 first answer, but the problem is in the model,

1 you're suddenly creating a target level for
2 people to reach for these things that are called
3 urgent visits.

4 So all of a sudden, if somebody is
5 falling short of their target level, there
6 becomes a strong incentive to say, "Gee, you
7 know, every new glaucoma case, I, you know, count
8 there because I need to get my urgent care visits
9 up," and it doesn't seem that you have any
10 mechanism for trying to distinguish whether it
11 really was an urgent symptom or not. It's based
12 on what the ultimate diagnosis was.

13 I mean, the ACEP concern in general
14 about all of these models is that you can't
15 necessarily determine, once it becomes a minor
16 diagnosis, you don't know that it might have been
17 a symptom that could have been something else,
18 but I'm asking a different question here.

19 I'm asking why is it that something
20 that seems to me to be unlikely to have been an
21 urgent case, couldn't that have easily be coded
22 in your diagnosis code list in a way that would

1 count as an urgent care visit?

2 DR. SCOTT: So this is Cliff Scott.
3 When we developed the list, we did it from the
4 patient's standpoint, and we also looked at it
5 from experienced practitioners, experienced
6 optometrists who were working in large
7 interdisciplinary, multidisciplinary practices,
8 what their experience was.

9 And a significant number of them took
10 calls related to open-angle glaucoma,
11 specifically when somebody ran out of medication,
12 and what we looked at was how do we keep people
13 out of the emergency room?

14 And if it was a concern enough to pick
15 up the phone, we extrapolated to say it might
16 have been urgent enough that they would have used
17 the emergency room to try and get a refill off-
18 hours or on a weekend. They considered it urgent.
19 We wouldn't, and probably payers wouldn't
20 consider it.

21 And what triggers it is a visit to an
22 eye care practitioner within one day, I believe,

1 and for a refill on a prescription, that code
2 doesn't - it actually solves the problem of
3 someone who would have gone to the emergency
4 room.

5 MR. MILLER: Well, let me ask, I
6 guess, maybe a follow-up question, because I'm,
7 it was a little, I was reading through your
8 answers. So, first of all, it said-this is at the
9 bottom of page eight of your answers.

10 You said, "Symptoms from the five
11 diagnosis groups." I think there are six or seven
12 that you actually have there, but it says,
13 "almost always have abrupt onset. Patients would
14 be very unlikely to schedule visits for these
15 conditions in advance."

16 So, I mean, it's clearly not
17 necessarily the case for all of these things that
18 that's true, and then you said that follow-up
19 visits would not be included. Follow-up services
20 would not be discounted, which presumably means
21 that they would not be counted as urgent care
22 visits.

1 So I'm sort of curious, so, I mean,
2 what you just described as, "I ran out of
3 medications for my glaucoma," would be a case
4 where the patient had already been diagnosed in
5 the past with glaucoma, right, and now is coming
6 in again, which I thought when I was reading
7 this, that you were only really talking about new
8 conditions, not a chronic condition that would be
9 coded for a follow-up visit.

10 DR. SCOTT: So from my point of view,
11 that scenario we just talked about, the patient
12 who ran out of medication, say, on a long
13 weekend, and needed a refill on the prescription
14 and wasn't able to get it through their current
15 practitioner, online, or however they were
16 getting it, that would not be covered under the
17 urgent, the urgency that describes this APM. That
18 would be simply one of the calls that a
19 practitioner took and gave them advice.

20 MR. MILLER: Yeah, but tell me why it
21 is that you think, in the model, it wouldn't be
22 covered, because the person had already had that

1 diagnosis?

2 DR. SCOTT: Yes, that, it's not a
3 true, these are for truly urgent conditions. In
4 that...

5 MR. MILLER: Well, yes, I understand,
6 but I'm asking, are you saying that you would see
7 the model as only applying to a new diagnosis
8 that the patient had not ever had before?

9 DR. SCOTT: No, not not ever had. It
10 could be a resurgence of, for example, herpes
11 simplex.

12 MR. MILLER: Okay, but it wouldn't be
13 a chronic condition diagnosis, in other words?

14 DR. POLAKOFF: If somebody calls in
15 for a refill for their glaucoma medication, for
16 instance, the diagnosis that would be coded is
17 glaucoma, and if they already had glaucoma and
18 that was an established diagnosis, they wouldn't
19 be eligible...

20 DR. SCOTT: Correct.

21 DR. POLAKOFF: ...in this model.

22 MR. MILLER: But why do you say that

1 they wouldn't be eligible? Because you're saying
2 here, I mean, chronic-angle closure glaucoma, for
3 example, is one of the diagnoses in your other
4 category.

5 DR. SCOTT: Well, it's in the category
6 that would be considered manageable by an
7 optometrist. What we were looking to say is from
8 the practical standpoint, if someone – who would
9 call in? We're trying to get the universe of
10 people who have typically used emergency
11 departments for their eye care, and in their
12 mind, it was urgent.

13 We're offering a safety valve as part
14 of that, and this was somewhat to assuage the
15 emergency room doctors that we are not planning
16 to, you know, I think we're...

17 MR. MILLER: I understand. I understand
18 that part. I'm asking about the other side. I'm
19 asking what would be the, how would the patient
20 with a chronic condition, who is simply coming in
21 for a medication refill or whatever, be excluded
22 under your model?

1 I'm not sure I understand how they
2 would be excluded because you're saying any visit
3 with a diagnosis code in that list would be
4 included.

5 DR. POLAKOFF: Well, I think there are
6 a couple of ways. One, the first way is that the
7 patient who has an established diagnosis of
8 glaucoma, runs out of meds and calls in, will
9 probably not even ask to be seen.

10 A refill will be phoned in for them,
11 and they won't come in. There's no visit to code,
12 so that's the majority of cases of patients who
13 run out of, who have an established relationship
14 with the practice and run out of meds. They won't
15 be seen at all, so I think that's the most
16 important mechanism.

17 MR. MILLER: Well, let's just pretend
18 for the moment that they did come in for a visit.
19 Tell me what it is, if anything, that would
20 preclude their visit, to come in and get a refill
21 of their medication for their chronic glaucoma,
22 be excluded?

1 DR. POLAKOFF: I think that's a fair
2 question and a, and in some ways a more, sort of
3 a more incisive one, because I think it's the
4 majority of patients who need, a minority of
5 patients, excuse me, who need a medication refill
6 who would actually show up.

7 But in that case, you are actually
8 keeping that patient out of the ED because they
9 might just as well walk into an ED and get the
10 same thing and that visit billed at 10 times the
11 rate.

12 Now I do want to make one other point
13 here about the list of diagnosis codes. So, in
14 part, we approached this from the other side.
15 When we were establishing the list, one of the
16 things we did was look at several years of HCUP
17 NEDS² data and look at eye care visits, and then
18 analyze the volume of all of these different
19 codes that were being paid as ED visits.

20 And so one of the ways we got to our
21 starting list was, okay, are these cases being

² Healthcare Cost and Utilization Project Nationwide Emergency Department Sample

1 seen today in EDs and which of them can be
2 accommodated in an outpatient setting?

3 DR. CASALE: So...

4 DR. POLAKOFF: In other words, they're
5 not hypothetical scenarios that patients with
6 these conditions are going to EDs. That's fact.

7 DR. CASALE: Yes, thank you for that
8 discussion. I'm going to, I know Kavita hasn't
9 had a chance to ask a question, so let me just
10 turn to Kavita next, and then we can turn back to
11 the questions.

12 DR. PATEL: Thanks, Paul, and thanks,
13 everyone, and I'm actually going to kind of cover
14 some of the other areas because you've hit on
15 that kind of domain area around methodology for,
16 you know, what's appropriate, kind of
17 appropriateness. Can I take, just a very, without
18 too long of an answer, because I want to get to
19 your points in your written responses?

20 I went back to the TCPI kind of
21 original intent, and then I just happened to kind
22 of look at the results of the PTN in your region,

1 which I believe David and others have actually
2 been leading for several years.

3 It feels like what has been the crux
4 of the model to date has been this robust
5 practice support by helping optometrists. And
6 then I did want to ask because it sounded like
7 there were no ophthalmologists that participated,
8 but it doesn't seem like there's a reason you
9 couldn't extend it to an ophthalmology practice,
10 how to do after hours, how to be more responsive
11 maybe at the staff level. Is a lot of the
12 discussion we're having around these lists of
13 diagnoses codes and having, to your point on the
14 top, David or Amy, the point about the payment
15 model?

16 Is the real heart, if we were to step
17 back as a preliminary review team and think about
18 what really is the value added for a Medicare
19 beneficiary or any beneficiary, it's how any
20 savings or differential payment would really
21 support the practice transformation, and then the
22 avoidable visits.

1 One concern I had is kind of to
2 Harold's point, these lists of codes. In the
3 feedback from the American Academy of
4 Ophthalmology, I think they brought up - I'm an
5 internist, so this corneal ulcer kind of comment
6 really resonated.

7 So, to me, is the issue that you'd be
8 willing as a submitter to think about, you know,
9 the framework, whether, it's not these lists of
10 codes in and of itself, but it's some boundaries
11 of appropriateness, a methodology for that, but
12 then also some payment model.

13 To your point, David, that you didn't
14 think payers were just going to give more money
15 hoping it would reduce ED costs, but the truth of
16 the matter is that what you're really trying to
17 do is support this infrastructure quality
18 improvement mechanism that has been proven to
19 avoid ED costs.

20 So I do kind of want to wrap in a
21 couple of the other points if that is true, what
22 I just stated, and then think through because you

1 are doing really a transformation network, what
2 are you, how would you take an optometrist in
3 Wichita, Kansas who doesn't have the UMass PTN,
4 how would you take someone that raises their
5 hand, if this were to become a PFPM, and kind of
6 help to recreate some of what I think is probably
7 the most valuable aspects of this, including how
8 to deal with the most serious eye conditions and
9 having a network?

10 DR. POLAKOFF: So thank you for that
11 question. There were actually, I think, two or
12 three questions in there, but I'll try to touch
13 very, be brief and still touch on all of them.

14 First, yes, ophthalmologists certainly
15 could participate. We did have one or two
16 ophthalmology practices. They weren't included in
17 our data because even though they were working
18 with us, they chose to work on other measures,
19 not the ED avoidance measures.

20 So, you know, they worked on diabetic
21 eye exam and a number of other measures. So we
22 did work with some, but they weren't included in

1 these data, but they'd certainly be eligible to
2 participate and could effectively.

3 Yes, you're right. What we're trying
4 to get at is a way to include optometry
5 specifically, and ophthalmology more broadly, in
6 practice transformation. Frankly, the biggest
7 impact on this for a Medicare beneficiary is that
8 it has represented an expansion of access to
9 care.

10 A lot of the ways in which the
11 participating practices implemented it was
12 essentially educating their patient base. It's
13 starting to interact with their patients to tell
14 the patients, "I know you come here for your eye
15 exams and your eyeglasses and your contact
16 lenses, but did you know that we provide urgent
17 eye care? If you have a symptom, call us."

18 That's a little bit oversimplified,
19 but not by that much. It was teaching patients
20 that if they have an urgent eye issue, if they
21 have a corneal abrasion, or they have eye pain,
22 or they have a visual field problem, that before

1 they get themselves hopefully driven, not
2 driving, to an ED, they should call the eye
3 doctor's office, and what they have may be
4 treatable, and if not, the eye doctor will triage
5 them, will give them advice to go somewhere else,
6 and that simple intervention actually resulted in
7 pretty dramatic scaled results.

8 And so, yes, that is exactly what this
9 effort overall is trying to get at, and trying to
10 find a way both to, yes, to fund those efforts,
11 but even more importantly, to try to find a way
12 to link eye care into the world of value-based
13 payment, which...

14 DR. PATEL: Okay.

15 DR. POLAKOFF: ...frankly, this
16 discipline, this profession prior to this was
17 pretty disconnected from the switch to value-
18 based care.

19 DR. PATEL: Okay, so, and kind of
20 buried in my lengthy question/commentary was, so,
21 thank you, because I think what you're stating,
22 if I can ask, was that that really, that

1 intervention so to speak, the transformation and
2 even that simple engagement with the patient
3 translated to these avoidable ED costs.

4 However, it probably also translates
5 to other benefits that might not be accurately
6 reflected in your current list of diagnoses or in
7 the metrics with just avoidable ER conditions, or
8 avoidable ER visits. Is that fair?

9 DR. POLAKOFF: Yes, it is fair, and
10 specifically, it translated to other benefits in
11 the area of quality improvement. Most of the
12 practices also worked on their diabetic eye exam
13 measure and improved it rather dramatically.

14 Most of the practices participating
15 with us learned a lot about their EHRs and how to
16 get and manage data from their EHRs. And the
17 practices that were most active in the ED
18 avoidance realm also improved their relationships
19 with referring PCPs.

20 It served as a vehicle for improving
21 the relationship with the PCP because in many
22 instances, while the eye care office was detached

1 from value-based care, the PCPs, the referring
2 PCPs had entered into value-based contracts, were
3 accountable for some measure of total cost of
4 care, and actually reaped benefits from this
5 reduction of ED use, so...

6 DR. PATEL: Okay, thank you.

7 DR. POLAKOFF: ...it improved the
8 relationship between specialists and primary
9 care.

10 DR. PATEL: Thank you.

11 DR. CASALE: Given that last point,
12 just - so if the primary care physicians are in a
13 value-based contract, rather than having a
14 separate payment model for this specific, is
15 there thought about creating incentives within
16 the primary care payment model for the eye
17 physicians to, you know, benefit from this kind
18 of work as opposed to having a separate model?
19 I'm sure you've probably thought about this.

20 DR. POLAKOFF: We did think a little
21 bit about it. I'll say something about an area
22 that I know only a little about. I'm not the

1 expert, but it seemed to have a lot of flashing
2 red lights related to Stark concerns, for one
3 thing, so that was one major concern we had about
4 trying to go down that road. Amy and Katharine
5 may have additional thoughts.

6 DR. CASALE: Or not. Okay, that's
7 fine.

8 MS. LONDON: Yeah, I mean, not really
9 except that they haven't had them, you know, that
10 there are APMs for a lot of physicians out there
11 and none for this group, and so we were thinking
12 that we needed to do something specifically for
13 them in order to shine a light.

14 But you're right that a plan that
15 decides to do this might have a way of folding it
16 into something else that they're already doing,
17 but we don't know of any opportunity anywhere in
18 the country for optometrists to participate in an
19 APM, and so we felt like we needed to build
20 something out that plans could go with.

21 DR. CASALE: Okay, great. Sally,
22 should we move on to the next? Is there, let's

1 see.

2 MS. STEARNS: Yes, I will say I'm not
3 positive that the issues about the target was
4 addressed, but I would also point out that there
5 is...

6 MR. MILLER: I do have some more
7 questions about that, Paul.

8 MS. LONDON: Okay.

9 MR. MILLER: About the targets.

10 DR. CASALE: Oh, I'm sorry. Yes,
11 thanks, okay.

12 MS. STEARNS: Okay, but then...

13 DR. CASALE: Go ahead.

14 MS. STEARNS: ...fast because there are
15 three other, a few other areas then.

16 MR. MILLER: Well, let me just, I want
17 to jump back to the target, briefly at least. I
18 was looking, this is Harold Miller again. And by
19 the way, I like what you're trying to do here, so
20 don't misinterpret my interrogation in terms of
21 trying to find fault with it, but I guess I'm, I
22 went back and looked to try to see in the

1 material that you submitted any information
2 indicating what the actual increase in these
3 kinds of urgent visits was for the TCPI
4 practices, and I couldn't find that.

5 You talked about how many avoided
6 visits there were, but presumably some of those
7 avoided visits were already being made by these
8 practices. What was the increase that you
9 experienced? Or that the practices?

10 DR. POLAKOFF: I can give you a high
11 level answer. There was a very wide range. There
12 were practices that were doing very little, and
13 sort of took the incentive and ran with it, and
14 increased by as much as 100 percent or more, or
15 increased even more than that because if they
16 were at zero visits a month and they went to
17 five, that's, you know, so that's an infinity
18 increase, but on average, it was in the range of,
19 in aggregate across all of the practices, in the
20 range of 10 to 20 percent increase.

21 MR. MILLER: And...

22 DR. POLAKOFF: It also varies by

1 practice size, practice location, urban/rural.
2 Rural practices seem to do better with this than
3 urban practices, so.

4 MR. MILLER: I'm curious also though
5 then, I guess part two of the question is to what
6 extent, you talked about, in your proposal about
7 the percentage of practices that added additional
8 kinds of services, 24/7 lines, et cetera, and I'm
9 kind of curious.

10 Did you actually tie the 10 to 20
11 percent increases to any of those practice
12 changes in any fashion, or how much of it was
13 just the education to the patient?

14 Because one of the issues in all of
15 these models is to what extent is there a cost to
16 the practice to be able to do what is necessary
17 to be able to get the bigger impact. And if they
18 actually have to have, you know, longer office
19 hours, or open access scheduling, and they lose
20 money in other fashions to be able to provide
21 that kind of access, that is a cost to them. But
22 if it's merely a matter of, you know, we never

1 thought of it before, but now we'll educate the
2 patients, and that results in the 10 to 20
3 percent increase, it's a very different thing. So
4 did you tie those things together in any fashion?

5 DR. POLAKOFF: We attempted to. I
6 will, you know, preface this by saying that TCPI
7 was explicitly not a research study, and so we
8 were discouraged from doing research by the
9 funder.

10 We did gather some information along
11 the way, and we tried to analyze it as best we
12 could. One of the things we did was survey the
13 practices each month when they reported their
14 data to us. There was a question and answer
15 about, and I think this was in our written
16 responses to the questions.

17 We asked them to tell us what type of
18 off-hours access they were providing to their
19 patients, you know, if they had a dedicated line
20 and so on. We didn't see any particular pattern
21 that would correlate those answers with the
22 degree of increase.

1 MR. MILLER: Yeah, because, I mean,
2 what I remember of the number that you cited was
3 that there was an increase in the number who did
4 it, but it was not a dramatic increase, and
5 that's partly why I'm asking as to whether this
6 is simply something where the incentive to try to
7 do something differently would be a relatively
8 easy thing to do, to implement if they actually
9 had that.

10 And I guess that's kind of what led to
11 the question, though, of, if you've already got a
12 practice that's doing this, and this has been a
13 problem in other APMs, is that the people who
14 were in the pilot that led to the idea of the APM
15 were already doing well and didn't get any credit
16 for the fact that they were already doing well
17 because of the pilot, as opposed to the new
18 people who got added in would then all of a
19 sudden, you know, would have an opportunity to,
20 you know, show a big increase.

21 MS. STEARNS: So, Harold,

22 DR. POLAKOFF: On that latter point,

1 if I may, just very quickly on that last point,
2 that's one of the reasons we would recommend a
3 longer look-back for the baseline for practices
4 that participated in the pilot. I think that's a
5 very fair point. Those that were in the pilot
6 have probably already seen a good part of the
7 increase that they're capable of based on their
8 patient population.

9 MR. MILLER: Okay.

10 MS. STEARNS: By the way, I was going
11 to say it may make sense with the time to go on
12 to the second question, which is to assess the
13 method by which payers would determine which ED
14 visits for eye-related conditions would be
15 associated with the providers participating in
16 their model, but that is an aspect that I think
17 was not clear to the PRT from the proposal. In
18 other words, what's the service area for the ED,
19 and how is all of that determined?

20 DR. POLAKOFF: So the only way in
21 which these visits need to be associated with the
22 eye care provider is as an adverse event. In

1 other words, if the patient – if a participating
2 provider has seen a particular patient in the
3 office and coded it as an ED-avoidable visit, and
4 is essentially claiming it as performance, and
5 within seven days, that same patient goes to an
6 ED for the same condition, we term that an
7 adverse event in the sense that it's a failure to
8 keep them out of the ED, right?

9 MR. MILLER: That's not the question.

10 (Simultaneous speaking.)

11 MR. MILLER: That's not the question
12 we're asking, David. That's not the question
13 we're asking about, though.

14 The question we're asking about is
15 you're trying to have the payer calculate how
16 much they saved on ED visits, how much there was
17 a reduction in ED visits, and the question is how
18 do they determine which, what set of ED visits
19 they're seeing a reduction in that they associate
20 with these practices, right?

21 So you're in some area and there are
22 ED visits, but not all of the optometrists are

1 participating, so you can't associate all ED
2 visits. You know, there might only be a subset of
3 optometrists, and you wouldn't want to say, "We
4 didn't see many reductions in ED visits across
5 the whole region." Well, guess what? Not
6 everybody was participating.

7 So we don't see how it is you're
8 connecting the measure of ED visits, the
9 reduction in ED visits at the payer level to how
10 many and which practices are participating.

11 DR. POLAKOFF: I think we would agree
12 with you. Correct, I don't think there is a
13 direct connection. I'm not sure that we are aware
14 of a way to do that.

15 I think what the payer can do is look
16 at the EDs that are within the service area, a
17 particular service area, and the participating
18 optometrists in that service area, and track over
19 time whether the ED visits for the selected code
20 set drops time period over prior time period, but
21 I don't know that they can tie an individual
22 visit back to a particular provider.

1 I'm not, I don't see a, we didn't see
2 a way to do that. If we could have made a
3 stronger connection, or if we could have thought
4 of a way to make a stronger connection, we would
5 have.

6 MS. LONDON: And this is Katharine
7 London. I would just add that, you know, we
8 talked about whether this should be taken on as a
9 regional kind of thing.

10 You know, that if this works, if you
11 can get a group of providers to participate, and
12 it doesn't really work if you have one individual
13 optometrist trying to do it on their own, and,
14 you know, if you had a group of optometrists or
15 ophthalmologists working together and they could,
16 you know, have public service announcements, and,
17 you know, they could do a lot to educate patients
18 in a region, but it's not really a one provider
19 kind of thing.

20 MR. MILLER: Well, I guess I'm just
21 curious. I have just one quick follow-up on this.
22 I guess you're trying to turn it into a shared

1 savings based on ED visits, but if, in fact, one
2 believes that an increase in urgent care visits
3 to the optometrists actually did or was likely to
4 have reduced ED visits, then why not just pay
5 some predetermined higher amount to the
6 optometrist who does the urgent care visit,
7 rather than trying to figure out how to determine
8 some savings from ED visits?

9 Because it would seem to me to be
10 unfortunate to say I have an optometrist that
11 wants to do this, but they can't do it because
12 none of the other optometrists want to do it.

13 DR. POLAKOFF: So, candidly, I think
14 one of the reasons we went this route is that we
15 wanted the APM to qualify as a higher level APM,
16 which meant that the participating practitioners
17 needed to take on some level of risk.

18 And so we were trying to develop a
19 mechanism that imposed demonstrable risk on the
20 participating practitioners but also then
21 rewarded them for performance.

22 MR. MILLER: But you seem to have

1 given them their risk by giving them the eight
2 percent reduction that they have to find a way to
3 earn back, right?

4 DR. POLAKOFF: Correct.

5 MR. MILLER: So you could reward them
6 without having to try to calculate an ED savings.
7 You could calculate whether or not they increased
8 their urgent care visits and then give them some
9 dollar amount based on the sort of imputed value
10 of that in terms of ED savings, and they would
11 still be taking the risk that if they didn't
12 figure out how to increase their urgent care
13 visits, then they would be losing money.

14 DR. POLAKOFF: I don't think we would
15 have any argument with that method. It's simpler.
16 I think in our minds, we weren't clear that that
17 would qualify...

18 MR. MILLER: Okay.

19 DR. POLAKOFF: ...under the HCP LAN
20 framework as an advanced APM.

21 MR. MILLER: Okay.

22 MS. STEARNS: Okay, then just for the

1 time, I'm going to read the third question.
2 That's the methods by which a payer could verify
3 that appropriate ICD-10 diagnosis codes were
4 being assigned if the providers had financial
5 incentives based on which codes were assigned, in
6 other words, a problem of coding.

7 DR. POLAKOFF: I'm going to ask Dr.
8 Scott to take the lead on that one.

9 DR. SCOTT: So if I understand what
10 you're asking, it's that there would be people
11 who could game the system? I mean, to be frank
12 about it, is that the question you're asking?

13 MS. STEARNS: Well, certainly there
14 have been other payment situations where there
15 has been increased diagnosis coding because of
16 the incentives embedded, so essentially, yes, I
17 think, although, I don't know, Harold or Paul, if
18 either of you want to..

19 (Simultaneous speaking.)

20 MR. MILLER: Can somebody game it?
21 Yes, that's the question.

22 DR. SCOTT: Okay, and I think that

1 that's a great question to ask because, you know,
2 we all know that there are even business seminars
3 that try to figure out ways that you can maximize
4 your income by coding in maybe inappropriate
5 methods.

6 What limits this is that the payer has
7 the determination of whether or not it met. It's
8 not the practitioner who determines it. It's the
9 payer, and the urgent visit follow-up is what
10 triggers the shared savings.

11 So if it's one of the conditions that
12 the payer recognizes as an urgent, not just
13 because of the visit itself and the coding on
14 that visit, but the follow-up for that visit, the
15 management plan for that visit, the payer could
16 have the option of saying that it didn't fit
17 within the APM.

18 MR. MILLER: I don't understand what
19 you said. What do you mean about the management,
20 that the payer would have, what does that mean?

21 DR. SCOTT: Okay, so each visit that
22 that patient has would trigger a payment from the

1 insurer, and each of those is predicated on
2 billing an office and a diagnostic code.

3 MR. MILLER: Right.

4 DR. SCOTT: And if the review panel at
5 the payer looks at it and determines that it is
6 an upcoding, for example, above what this is
7 designed to do, they could reject the shared
8 savings component of it.

9 DR. POLAKOFF: In fact, they could
10 reject the entire payment.

11 DR. SCOTT: Right.

12 (Simultaneous speaking.)

13 MR. MILLER: Okay, so your answer to
14 the question is that you would then say that the
15 payer would need to review the individual claims
16 to determine whether or not they felt that the
17 diagnosis coding was...

18 DR. CASALE: Well, they have a lot of
19 skin in the game on this.

20 DR. POLAKOFF: Well, I guess, let me
21 add something here. I would back this up.
22 Speaking from the perspective of one of my prior

1 hats as the CMO of a Medicaid health plan, you
2 know, almost any coding scheme and any
3 reimbursement mechanism can be gamed.

4 And ultimately, all of them need to
5 have both claims edits built into the claims
6 engine to look for the more common errors or
7 abuses, and then some spot auditing programs to
8 look a little bit more deeply.

9 I don't, I guess we didn't see this as
10 any different from any other payment mechanism.
11 Almost every one of, somebody tries to game
12 almost every one of them. I know that may not be
13 a very satisfactory answer.

14 DR. CASALE: Yeah, no, we understand.
15 I mean, there's certainly gaming in any, we're
16 just trying to get a sense of the degree given
17 the current model structure.

18 DR. SCOTT: Yeah, I don't think this
19 is any more gameable than the routine care that
20 would transpire if we didn't have this APM in
21 place.

22 MR. MILLER: Right, but just to be

1 clear, so you're not envisioning that there would
2 be any kind of additional coding or documentation
3 that this, in fact, was an urgent visit, because
4 it sounds from the way you've described this that
5 it's simply triggered by the presence of the
6 diagnosis code.

7 That's kind of why we were asking is
8 because then if it's that, then one could
9 potentially put the wrong diagnosis code down,
10 and then the only solution would be, you know,
11 periodic random audits, as opposed to saying that
12 there needs to be some other, you know, symptom
13 documentation or something like that to verify
14 that this was actually something that was urgent,
15 but it sounds like you're not proposing to do
16 that, so that's the answer to my...

17 DR. POLAKOFF: We're not proposing to
18 do that. I would just describe what we did in the
19 pilot, which is in the pilot where there was no
20 payments and we weren't working with payers, we
21 were tracking it based on practice records.

22 We asked the practice to maintain

1 monthly logs of all urgent visits to distinguish
2 them from regularly scheduled visits, and
3 specifically those that fell within these
4 diagnostic groupings, and so we asked the
5 practice to maintain those logs.

6 MR. MILLER: Yeah.

7 DR. POLAKOFF: It's entirely
8 reasonable that a payer, once they contract with
9 a provider for this APM, could insist on the
10 maintenance of such logs, which are then backed
11 up by the EHR because the EHR knows the type of
12 scheduling system and knows when the visit was
13 scheduled, so there are auditable logs that are
14 maintained within the practices' systems.

15 MS. STEARNS: Okay, so this is Sally,
16 and I'm just going to read the last question so
17 that there's also a little open time at the end.
18 The last question was how optometrists and
19 ophthalmologists who are practicing in the same
20 organization or community would deal with more
21 serious eye conditions.

22 DR. SCOTT: Hi, this is Cliff Scott

1 again. That exists already. I mean, patient care
2 trumps everything else. So when a patient has a
3 condition that requires the skills of an
4 ophthalmologist, there is a mechanism in place.

5 Usually it's done on a personal basis,
6 but sometimes it's done organization to
7 organization, where those patients have quick
8 access to the services of that ophthalmologist. I
9 don't see this as being any different. I think
10 there are just, it's activating those networks.

11 In fact, it's probably more efficient
12 that a patient who has one of those conditions is
13 managed by an optometrist simply because it's
14 more expedient to use that network rather than
15 the organization from the ED trying to find one
16 of their ophthalmologists within their system who
17 has that specialty.

18 DR. POLAKOFF: Except within tertiary
19 care medical centers.

20 DR. SCOTT: Right.

21 DR. POLAKOFF: Where, you know, there
22 is...

1 DR. SCOTT: Right, there.

2 DR. POLAKOFF: ...there's a retinal
3 surgeon in the building at all times.

4 DR. SCOTT: Right.

5 MR. MILLER: Well, the prompt for the
6 question, though, is that if you start having
7 target visit levels for individual providers and
8 somebody is falling short of their target, then
9 there would be some incentive potentially, you
10 know, for, say, the optometrist to see a
11 condition that would be better referred to the
12 ophthalmologist, but the optometrist wants to see
13 that patient to be able to hit the target, so
14 that was kind of at least one of the things that
15 prompted that question.

16 DR. POLAKOFF: In the pilot, we didn't
17 encounter that. What we encountered much more
18 often was that practices that wanted to increase
19 their, we didn't set targets, but practices that
20 wanted to increase their urgent visit levels did
21 it primarily by not turning down calls for urgent
22 visits because they were busy.

1 The real change in behavior that we
2 saw was primarily practices that previously, when
3 they had a fully booked day, told those patients
4 to go to the ER, started telling them, "No, we'll
5 squeeze you in. Come in."

6 MR. MILLER: See, and all of that is
7 good, back to Kavita's point. I mean, the idea of
8 helping the practices transform to be able to do
9 this makes a lot of sense. The problem is we're
10 trying to just struggle through the question of
11 what kinds of undesirable incentives does this
12 payment model potentially create in addition to
13 the things that you're trying to encourage to
14 happen.

15 You know, we need to think through
16 both those things as well as whether it supports
17 what you're trying to do, so that's the prompt
18 for the question.

19 DR. POLAKOFF: All fair questions.

20 DR. SCOTT: Right, and I think that we
21 have to accept the fact that there needs to be an
22 auditing mechanism, but we're not the ones who do

1 the auditing. I think it's the payers who need to
2 be in charge of that.

3 MS. STEARNS: Okay, so with that,
4 we've gotten through the questions that were
5 provided. So, Paul, I don't know if you want to
6 open it up for, if you or Harold or Kavita have
7 any additional...

8 DR. CASALE: Yeah.

9 MS. STEARNS: ...questions that you
10 thought of?

11 DR. CASALE: Yeah, I know we only have
12 a few minutes, or, I guess, you may be able to go
13 over a little bit, but, Kavita or Harold, are
14 there any - I know we sent those questions, but
15 you may have had others that you wanted to bring
16 up.

17 DR. PATEL: No, I'm good, Paul. Thank
18 you.

19 DR. CASALE: Okay.

20 MR. MILLER: I would just say, first
21 of all, just thank you for doing all of the work
22 on this because I think that this is a really,

1 you know, desirable kind of care delivery
2 approach.

3 And I speak for myself as I
4 understand, you know, that you're trying to sort
5 of squeeze this into a payment structure that
6 qualifies as an APM, which doesn't necessarily
7 mean that it's the right payment model to be
8 able, the ideal payment model to be able to use.

9 So, anyway, you know, many of the
10 questions were really trying to get at some of
11 those kinds of issues. They weren't necessarily
12 in any fashion, you know, being negative about
13 the concept that you're trying to promote, so
14 thank you for spending the time to answer all of
15 the questions.

16 DR. CASALE: Yeah, I would second
17 that. I appreciate you taking the time and, yes,
18 so don't misconstrue our questions as, you know,
19 certainly not being supportive of what you're
20 trying to do. It's really just trying to make
21 sure we understand, and particularly around the
22 payment part, the payment model that you're trying

1 to the clinical model.

2 DR. POLAKOFF: From our end, I would
3 just say thank you for the opportunity to discuss
4 this with you, and we do clearly appreciate that
5 the questions you've asked, they are challenging,
6 but they're very important.

7 And, yes, we have, you know, we know
8 that we have done something very important in
9 terms of patient care and patient access in the
10 clinical model. And we've tried, within a
11 framework, to try to fit this clinical model into
12 a payment framework that would bring this
13 specialty into the value-based payment world.

14 And it's not perfect, but a lot of
15 thought went into it, and this is the best one we
16 could come up with. And we're very open to
17 further input and suggestions for improvement.

18 DR. CASALE: Great, well, thank you.
19 Sally, I think, if there isn't anything else, we
20 can...

21 MS. STEARNS: Yes, I think.

22 (Simultaneous speaking.)

1 MS. STEARNS: You know, we'll just
2 thank everybody for participating, and we'll
3 adjourn this call. Obviously, the PRT will be
4 discussing what they've heard today, and they'll
5 proceed in their review and assessment, so we
6 really appreciate everybody's time.

7 DR. SCOTT: Okay, and if they have any
8 more questions, I think, you know, we all are
9 anxious to discuss with them, you know, any
10 nuances about the answers that we gave today
11 because some of this was on the fly. I mean, we
12 don't have a script that we follow.

13 And we have a very effective team
14 here. We have people with different backgrounds
15 and a lot of strength. I'm a consultant, but I see
16 the strength of the UMass Commonwealth practice
17 team here, and the data that they have is solid.

18 The way we're approaching this is
19 creative, and when you have that, you don't always
20 anticipate all of the issues that you can run
21 into, so thank you for bringing up some of the
22 ones that we might have just assumed were in

1 evidence, but obviously they weren't because you
2 asked the questions very concisely.

3 MS. STEARNS: All right, thank you
4 very much, and yes, the PRT will contact you if
5 they've got more questions, so, and we'll be, ASPE
6 will be in touch also as the review proceeds, so
7 we thank everybody for their time.

8 (Whereupon, the above-entitled matter
9 went off the record at 5:01 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: UMASS Conference Call

Before: PTAC

Date: 10-30-19

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.



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