

January 11, 2018

Re: ACEP Response to the PTAC Preliminary Review Team's Questions on the Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions Model

On behalf of more than 37,000 members of the American College of Emergency Physicians (ACEP), please find below the responses to the Preliminary Review Team's questions on the AUCM. Thank you for the opportunity to provide additional information and clarifications regarding this proposed Physician-Focused Payment Model (PFPM).

I. Payment and Clinical Model Components

1. Please describe how the clinical model and payment model work together to create an improved patient experience and a new payment model using illustrative examples that start with an index patient arriving at the doors of an ED and continues through all the steps you envision to the endpoint of the final financial reconciliation with CMS.
 - a. Please use a timeline of events which would illustrate the payment and clinical aspects of the model from the perspectives of a patient, the ED organization, and clinicians starting with the triggering ED event to completion of the model intervention.

Figure 1. Clinical Episode of Care Process

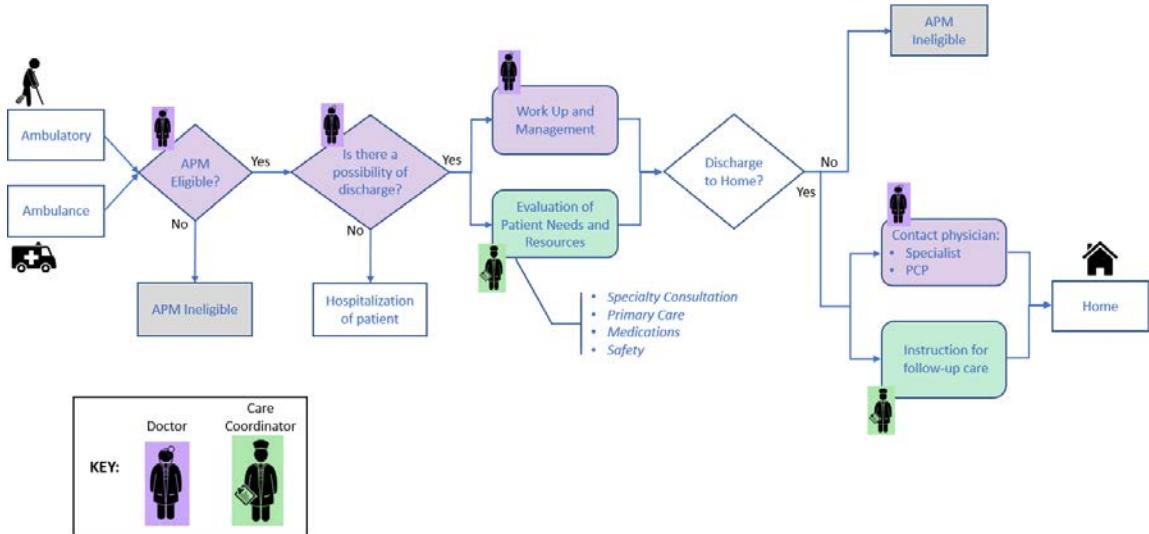
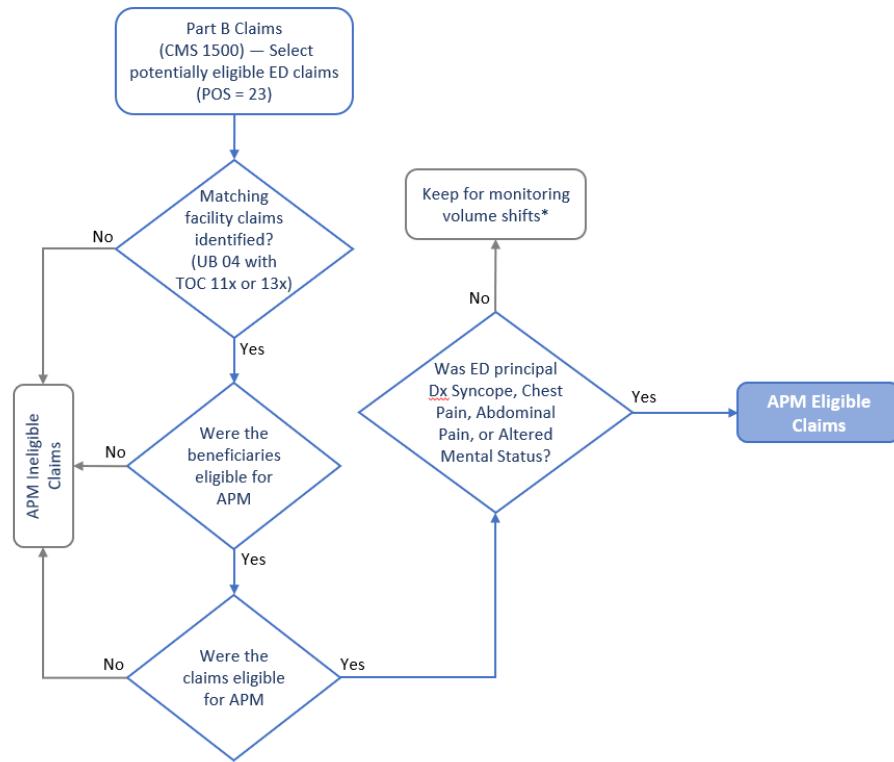
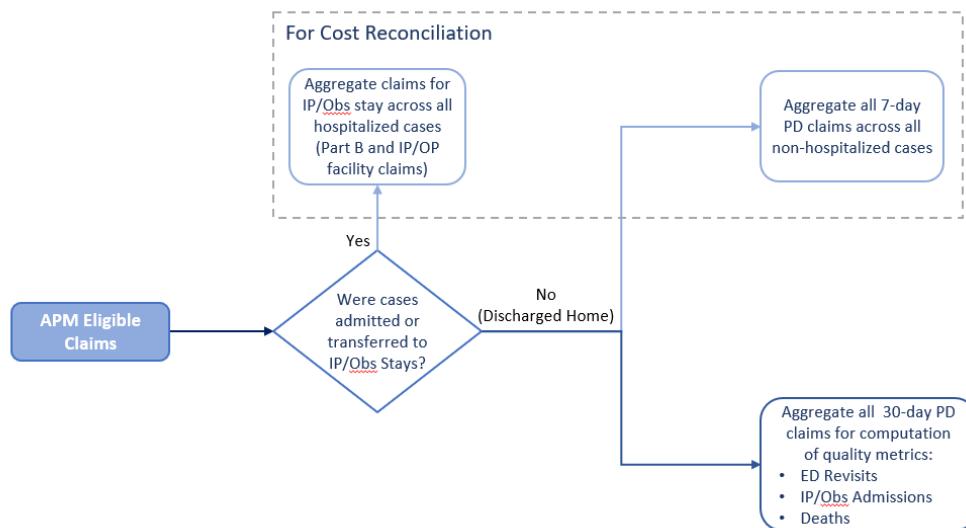


Figure 2. Advanced Payment Model (APM) Eligibility Assessment Process



Notes. TOC=Type of Claim. POS=Place of Service. Beneficiary APM ineligible criteria include: missing beneficiary information, lacking full Medicare coverage, Medicare not primary payor, HMO, or dual eligible. Claim ineligible criteria include: claims initiated in the last month of the reconciliation period, claims with inpatient or observation stays 90-days prior, claims with ED visits 30-days prior, or claims with ineligible discharge dispositions (e.g., SNF, Hospice, missing supporting claims etc.).

Figure 3. Claim Aggregation and Reconciliation Process



A patient will arrive at the emergency department (ED) by ambulance or by another mode of transportation. In all cases, the individual will undergo federally-mandated EMTALA screening and stabilization. The triage process for all Medicare-eligible patients will include questions regarding whether they are a hospice beneficiary, a dual-eligible beneficiary, have been hospitalized (inpatient or observation stay) in the prior 90 days, or had a treat and release ED visit within the prior 30 days. If the answer is yes to any of these questions, the visit is not APM-eligible. If a hospital is participating in another APM, a check of the patient's record for ACO attribution may also be done to avoid double attribution. A clinician then evaluates the patient to determine if his/her presenting symptoms are associated with one of the targeted diagnostic categories (Attachment 1). If the answer is yes, the case is then deemed eligible. Information regarding the alternative payment program will then be provided to the patient and family. Concurrent to clinical care, the patient will undergo a safe discharge assessment (SDA) to identify socio-economic barriers to safe discharge, potential needs related to care coordination, and to identify additional assistance that may be necessary. This interaction is designed to support patient and family engagement, and to lay the groundwork for shared decision making at the time of discharge. If the physician, in collaboration with the primary care physician or designated specialist, determines that the patient is a candidate for discharge, the information captured during the SDA will be used to generate unique patient discharge instructions including identifying symptoms that would require rapid reassessment and return to the emergency department. The physician will participate in providing discharge instructions to the patient and family. If a follow-up visit under the supervision of an ED physician is appropriate, these arrangements will be made prior to discharge when possible. The patient will then be discharged.

*The initial workflow for the **ED clinician** will be unchanged. If the preliminary diagnosis is AUCM eligible (abdominal pain, altered mental status, chest pain, or syncope), they will initiate the SDA. At the time of discharge disposition, the physician will coordinate with staff to ensure a safe discharge. As a part of the process, the clinician will speak with the primary care provider or specialist (or their designee) who will be assuming care and providing additional work-up or treatment as necessary. The clinician will participate in the final decision making with patients and their families. The **ED organization** (risk-bearing entity) will arrange telephonic, in person, or in the rare case, telehealth, follow-up. Claims for these services will be submitted within the agreed upon waivers included in the AUCM model.*

- b. Please use a timeline of events which would illustrate the payment and clinical aspects of the model from the perspectives of a patient, the ED organization, and clinicians starting with the triggering ED event to completion of the model intervention.

Please see the timeline above. The clinical and payment timelines follow the current model of care and claims process. The additional services for care coordination would be billed by the ED organization (risk-bearing entity) along with the ED Part B claim. Any other services provided as

allowed under agreed upon waivers for telehealth or post-discharge home visits would be submitted to CMS. The eligible patient will experience the enhanced services and be responsible for any Part B beneficiary charges related to such services.

2. A good number of ER physicians are part of independent groups contracted with the hospital or health system to provide staffing. Often these arrangements include incentives and service level agreements that may or may not conflict with this proposed model. How are these measures going to be reconciled with payments and or do they need to be?

ACEP does not believe that current contracting models between physician groups and hospitals are in conflict. ED groups and hospitals share the responsibility for appropriate care and risk for poor discharge decisions that might result in patient harm. The model enhances this shared-accountability as it focuses on improving patient hand-offs. It also adopts a similar process to the post-hospitalization care coordination that has been found to reduce readmissions. Hospitals and ED groups will need to work closely together to optimize efficiency and effectiveness in this move to embrace outpatient disposition. ACEP recognizes that the model may initially increase staffing needs in the department. We anticipate that successful implementation of the model will improve ED effectiveness by decreasing the volume of ED revisits and admissions, which will in turn improve ED efficiency as well. The Emergency Department Practice Management Association that represents both large and small ED groups found no potential conflict with current contracting processes and endorsed the model.

3. Also, given the common practice of signing off patients to the oncoming ER shift physician, how are individual physicians recognized in these circumstances?

The model is designed to incentivize the discharging physician to review the case, to focus on care coordination, to re-examine the patient and to discuss the plan of care with the patient and family. The AUCM model will attribute patients to the physician making the discharge decision. ACEP has received confirmation by staffing and billing entities that this is the standard practice.

4. Do the funds flow to the group and then the group is charged with determining individual physician payments?

Funds will flow to the staffing group, faculty practice plan, or hospital in the case of employed physicians. This will allow the group to be flexible in rewarding physicians who have not only met the target, but also have succeeded in managing unique populations where discharge home is more difficult, such as those receiving care in the late evening, weekends or at night.

II. Possible Incentives

1. Does the model place financial incentives on the ED physician not to admit? If yes, how do the incentives manifest in the mechanics of the model?

Under the current model of care, there is a near-complete lack of incentives to discharge a patient. Hospitalization is generally perceived as a safer choice that facilitates continuous treatment, results in an expeditious work up for new clinical problems, and limits physician liability related to post-discharge adverse outcomes in high risk populations. The model is designed to increase the ED physician's and patient's comfort with a discharge disposition by including financial incentives that reward care coordination, enhance discharge planning, support patient and family engagement, and ensure follow-up care when barriers exist to rapid access to primary or specialty care. The model aligns the ED physician with the patient's financial interest in avoiding potential beneficiary costs associated with observation stays and non-covered SNF costs as identified by the Office of the Inspector General of the U.S. Department of Health and Human Service.¹

2. How does the model (or other factors) mitigate risk of inappropriate ED discharges given the change in incentives?

It is critical that any model providing financial incentives that are dependent on decreasing utilization of healthcare services includes the measurement of potential adverse outcomes. Such models should mitigate financially biased decision-making by rigorously measuring adverse outcomes that matter to patients and payers. There must also be a focus on measuring patient safety events. The choice of candidate measures in the proposed model was driven by the fact that emergency physicians have long been concerned about the risk of death, the frequency of hospitalization and the likelihood of return to the ED after discharge. Unfortunately, they have rarely had access to complete data about these events which may occur at other facilities. The model assumes that CMS-generated performance and cost data, like that provided to other APMs, will be made available on an ongoing basis. This will give emergency physicians an accurate picture of their recent performance and help to identify trends that should be addressed long before the reconciliation process. The patient safety measures will provide a new focus on ED-related events such as post-discharge falls, adverse drug events, and post-procedural complications that are in alignment with the Agency for Healthcare Research and Quality (AHRQ) goals and patient safety indicators.²

ACEP was deliberate in choosing the post-discharge events that will be measured and linked to payment. They are in alignment with the movement to measure what matters and to focus on outcomes instead of processes of care. They are also aligned with physician's professional, ethical,

¹ Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy. Report in Brief. Office of the Inspector General, U.S. Department of Health & Human Services. <https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf>. Accessed on January 5, 2018.

² AHRQ Patient Safety Indicators. http://www.qualityindicators.ahrq.gov/modules/PSI_TechSpec.aspx

and medico-legal obligations to insure appropriate patient care decision-making. For example, a recent study by Obermeyer et al. exposed the continued risk of post-discharge death within 7 days of an ED visit.³ This justifies the inclusion of a 30-day Post-Discharge Mortality Measure in the model. ACEP also chose to align measurement efforts with other CMS programs and priorities. The inclusion of 30-day measures for return ED visits, inpatient admission or observation are components of the Hospital-Level 30-Day Risk-Standardized Excess Days in Acute Care Measurement methodology. ACEP is committed to work with CMS to further develop a cadre of ED-specific measures that build upon CMS priorities and that are included in other models such as the Medicare Readmission Reduction Program. This will ensure that these events are tracked and linked to quality requirements that impact eligibility for bonus payments and shared savings. These robust measures will allow CMS to define a minimum quality score metric that will be used to set eligibility for the APM financial incentives. Capping the shared savings available to physicians (Stop-gain) to a percentage of savings generated by the 3% reduction in admissions will help to limit inappropriate behavior that might occur without a cap.

3. What happens in the model if we assume avoidable inpatient admissions have been fully avoided over time and participants are left with financial pressure not to admit patients who should be admitted?

This is a challenge in all APMs especially those built on an episode of care framework. The research cited in the submission identified significant variations in admission rates across the nation, regions, and hospitals at the diagnosis level (Attachment 2). The breadth of opportunity makes it unlikely that all facilities will reach this ideal state within the first few years of the program. Additionally, the model is designed to retire or exclude “topped out” diagnoses for which the admission rates at the national level exceed 90% (Attachment 3). In the very rare event where avoidable inpatient admissions have been fully avoided, the physician group will have the option to elect not to participate in the APM which is voluntary by nature.

III. Baseline and Benchmark Standards

1. What is the evolving baseline and benchmark standard (how is it calculated?) under which financial performance would be judged in the first years of the model? Would there be a need to change the model over time as variance in admissions and post-ED events decreased?

The baseline admission rates for the targeted diagnoses will be set at the hospital level and is calculated using the facility admission rates for each diagnosis over a three-year period to set the baseline target for the 3% reduction. For example, if the program is rolled out in 2019, targets would be based upon historical performance in 2015-2017. The rate would be recalculated on an

³ Obermeyer Z, Cohn B, Wilson M, Jena AB, Cutler DM. Early death after discharge from emergency departments: analysis of national US insurance claims data. BMJ. 2017;356:j239.

annual basis. If the national rate of admission for a given diagnosis exceeds 90% in the final of the three years, that diagnosis would be retired from the program.

2. What are the relative roles of specific ED groups historical claims experience, regional benchmarks, and national benchmarks in setting the evolving target spending amount over time?

The program does not include a national or regional spending target as it is not a traditional bundled payment model. The hospital will be benchmarked against its own historical performance. This closely mirrors the methodology and intent of the Medicare Readmission Reduction Program. Shared savings will be calculated as net savings to the Medicare program based upon the difference between all Part A and Part B services associated with the inpatient stay minus the ED-visit claims and all claims within 7 days of the index ED visit for patients who were discharged home.

IV. Risk Bearing Entity

Please specify the risk bearing entity(s). If the physician group and hospital are not linked financially, who is the risk bearing entity, or do they share risk? If they share risk, how are the funds flows managed from providers and CMS perspective?

As this is a Physician-Focused Payment Model, the risk bearing entity is the physician group, the faculty practice plan in academic settings, or the hospital in the case of employed physicians. Successful participation is based upon the entity's ability to meet quality requirements and to achieve the targeted rate of reductions in admissions for qualifying ED visits. The funds will thus flow between CMS and the entity. In developing the model, ACEP adopted a model like that in physician-led ACO models where credit for the avoidance of admissions and a portion of subsequent savings are directed to the physician-led entity. It would be possible to add provisions that allow sharing arrangements with the hospital such as those in the newly announced BPCI-Advance program. Such a provision might better align the hospital and ED group financial incentives as reducing admissions will directly impact hospital revenue.

V. Post-Discharge Events

1. The post discharge events are defined as return to ED visit, observation stay, inpatient admission, or death in the 7 (30) days following discharge home.
 - a. How do all post-discharge events effect net payment?

All claims that occur with the 7 days post-ED visit are included in calculating the expenditures that are attributed to the episode. The potential shared savings are calculated based upon the difference between the inpatient care for eligible cases minus aggregate expenditures for services provided to patients discharged with the same diagnoses. The 30 post-discharge events are utilized for quality measurement and thus expenditures for services that occur between day 8-30 are not

included in the calculation of net savings. This has been proposed as the attribution of costs and services to an ED visit beyond a 7-day window would likely capture unrelated expenditures for diagnostic and therapeutic services not associated with the ED visit. This also avoids the need to develop an extensive exclusion list and the research necessary to validate it.

- b. Does the model solely include patients who are discharged home to the community (i.e., model would exclude a patient returning to a skilled nursing facility or discharged home to receive Medicare home health)?

The exclusion of patients who have had a hospitalization in the 90 days prior to the ED, hospice beneficiaries or who were Medicare-Medicaid dual eligible beneficiaries effectively eliminated those presenting to the ED who would be likely to be receiving home health services or residing in an LTAC or skilled nursing facility. The intent of the model is to only include patients discharged home to the community. Patients discharged to a skilled nursing facility were excluded from the analysis reported in our proposal. In addition, only a very small number of ED cases included in our originally analysis were discharged home to receive Medicare home health (0.08% of the total population), providing evidence supporting that the exclusions we implemented effectively removed this population.

VI. Episode Definition

1. Your model appears to be based on episodes of care or “bundle”, though you do not use these terms. Please describe the episode definition in terms of the timeline and Medicare services which could be subject to spending and quality targets in the model. What event triggers the episode? What services are included in the episode?

The proposal is an episode of care model. It is similar to current bundle models being tested by CMS and is in alignment with the BPCI Advanced voluntary program announced on January 9, 2018.⁴ It also mirrors characteristics of the Medicare Readmission Reduction program in which an inpatient event triggers a defined episode in which an entity is rewarded or penalized for managing post-event hospitalization. The targets are set based upon historical admission rates and the goal is to achieve a 3% decrease in the admission rates for the selected diagnoses. The services included in the model include the ED and other professional and facility claims attributable to the qualifying ED index visit, and all Part A and Part B claims (excluding DME) that occur in the subsequent 7 days after discharge.

Claims for Part A and Part B services that occur within the 30-days after the qualifying ED visit are included in calculations of the post-discharge quality measures. Death rates are utilized to calculate the 30-day post-ED mortality rates.

⁴ BPCI Advanced. <https://innovation.cms.gov/initiatives/bpci-advanced>

2. Does the episode start with the ED visit, observation stay, and/or unscheduled acute stays followed by all Medicare Part A and B services during the post-discharge period of 7 or 30 days? [Anchor (ED, ED-Observation or ED- unscheduled inpatient stay) + Post discharge period of Medicare Part A and B for 7 or 30 days]]

a. What ED initiating, or anchor event is associated with the start date of the episode?

A qualified ED visit triggers the episode.

b. What Medicare services are included in the planned episode (i.e., post-discharge period)?

All Part A and Part B claims (excluding DME) that occur in the 7 days post-ED discharge are included in the episode.

c. What is the definition of the end of the episode for purposes of the model intervention?

The episode effectively ends at the beneficiary's death or 30 days post-qualifying ED event.

d. How would the episode definition differ across the planned years of the model (i.e., is unscheduled inpatient included as an initiating or anchor event in year 3)?

In year 3, the model expands to include additional diagnoses (excluding those that result in greater than a 90% admission rate) and the addition of qualifying visits by dual-eligible beneficiaries. All unscheduled hospitalizations that result from a qualifying ED visit will be included in the calculation of admission rates beginning in year 3. The unscheduled inpatient stay will not become the anchor event in the model.

VII. Patient Assessment

Does the proposal envision a patient assessment at discharge to inform coordination in the post-discharge period of 7 or 30 days?

The physician is responsible for the final assessment of the safety and appropriateness of discharge of the patient at the time of disposition. This assessment will include information derived from the clinical care episode and the safe discharge assessment (SDA) that is done in parallel to the clinical evaluation and management.

VIII. Coordination with a Patient's Primary Care Physician

How does the model envision coordination between the role of the ED physician in the model and a patient's primary care physician?

The model is designed to facilitate the handoff of the patient to the patient's primary care physician, the specialist they request, or to another physician when the primary care physician or his designee is not available. This latter scenario may occur when Medicare beneficiaries are domiciled in

another state for part of the year or when they seek acute care while traveling. In our review of ED visits by Medicare patients in 2014, 7.5% of Medicare beneficiaries with ED visits had at least one out-of-state visit. Nationally, 5.8% of ED revisits occurred outside of the patient's home state.⁵ If the primary care physician or their designee is not available, the ED physician will coordinate care with physicians providing services through the Medicare Conditions of Participation required hospital on-call list.

IX. Payment Waivers

The proposal includes waivers for participating ED physicians who would become eligible to provide telehealth services, transitional care payments, and post-discharge visits (non-home health).

1. Please specify what licensed clinical staff would be providing the home visits under the general supervision of an ED physician.

The licensed clinical staff would include Part B eligible providers consisting of physician assistants, nurse practitioners, clinical nurse specialist, and clinical social workers. Post-discharge home visits furnished under this waiver would not be furnished to a beneficiary that is receiving home health services.

2. Please clarify how the telehealth waiver would be implemented to allow ED physicians to provide telehealth in a patient's home (e.g., what is the equipment envisioned in the ED and patient's home, estimated cost if the equipment is currently unavailable etc.).

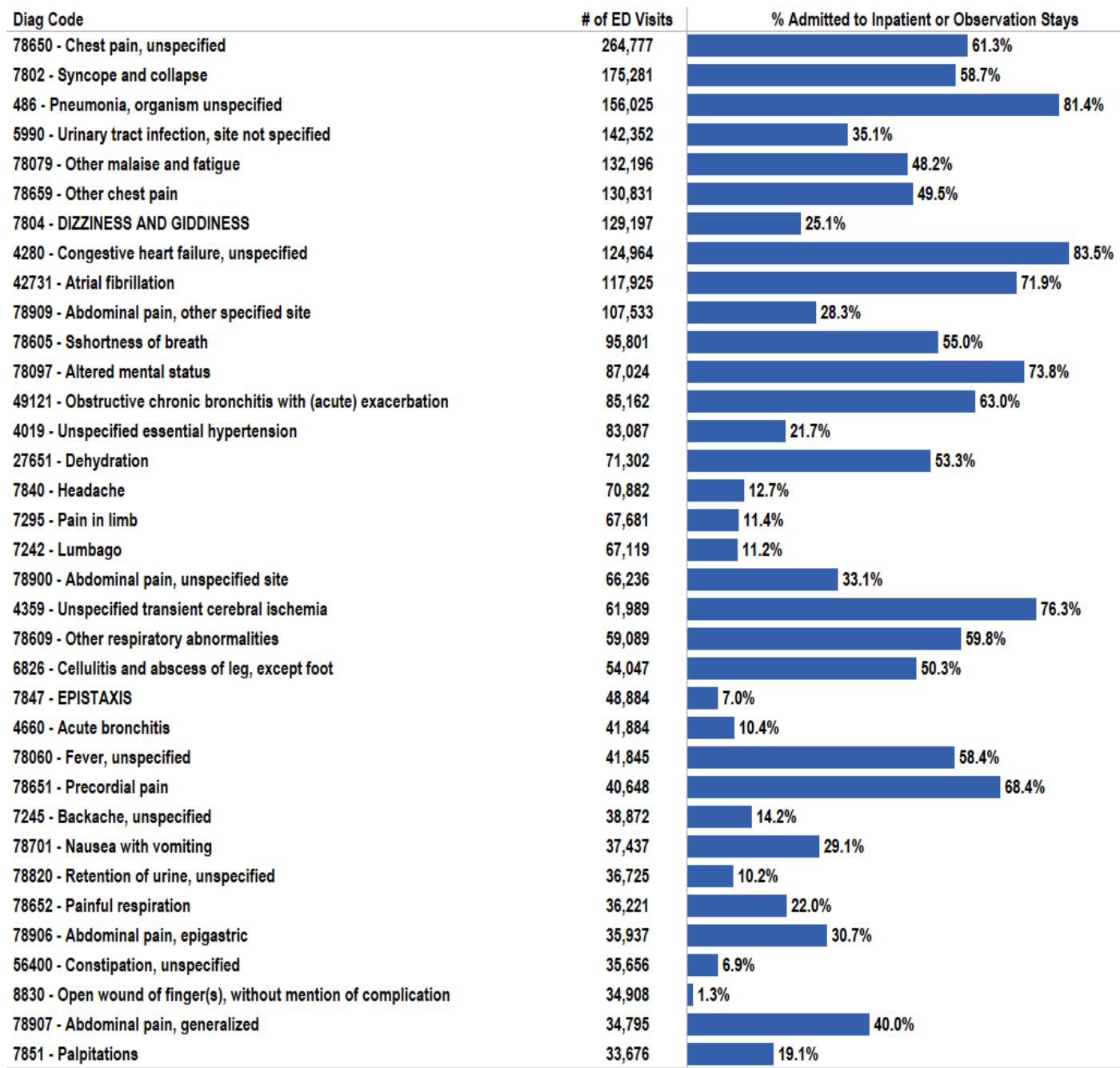
ACEP is not requesting coverage for the temporary installation of telehealth equipment into a home setting. ACEP anticipates that telehealth services would be utilized in very rare circumstances. In one scenario the patient had been transferred by an initial treating rural or small hospital to a tertiary care center for potential admission. Upon evaluation and treatment, it was determined that they did not require admission. In this case, the follow up visit might occur at a rural clinic or hospital that has telehealth capabilities. A second scenario might occur when patients are sent to assisted living facilities that may have telehealth capabilities in place.

⁵ MPA Healthcare Solutions analysis of the CMS Limited Data Set (LDS) for 2014. ED visits were identified using a physician claim for ED services.

Attachment 1. ICD-10 codes defining the targeted diagnostic groups.

Symptom Group	ICD-10	ICD-10 Description
Syncope	R55	Syncope and collapse
Chest Pain	R079	Chest pain, unspecified
	R072	Precordial pain
	R0782	Intercostal pain
	R0789	Other chest pain
Abdominal Pain	R109	Unspecified abdominal pain
	R100	Acute abdomen
	R1011	Right upper quadrant pain
	R1012	Left upper quadrant pain
	R1031	Right lower quadrant pain
	R1032	Left lower quadrant pain
	R1033	Perumbilical pain
	R1013	Epigastric pain
	R1084	Generalized abdominal pain
	R1010	Upper abdominal pain, unspecified
	R102	Pelvic and perineal pain
	R1030	Lower abdominal pain, unspecified
	R10829	Rebound abdominal tenderness, unspecified site
	R10819	Abdominal tenderness, unspecified site
	R10821	Right upper quadrant rebound abdominal tenderness
	R10811	Right upper quadrant abdominal tenderness
	R10812	Left upper quadrant abdominal tenderness
	R10822	Left upper quadrant rebound abdominal tenderness
	R10823	Right lower quadrant rebound abdominal tenderness
	R10813	Right lower quadrant abdominal tenderness
	R10824	Left lower quadrant rebound abdominal tenderness
	R10814	Left lower quadrant abdominal tenderness
	R10825	Perumbilic rebound abdominal tenderness
	R10815	Perumbilic abdominal tenderness
	R10826	Epigastric rebound abdominal tenderness
	R10816	Epigastric abdominal tenderness
	R10827	Generalized rebound abdominal tenderness
	R10817	Generalized abdominal tenderness
Altered Mental Status	R410	Disorientation, unspecified
	R4182	Altered mental status, unspecified

Attachment 2. Variations in admission rates at the ED diagnosis level.



Derived from analysis of the 2014 Carrier/Part B claims that met the definition for inclusion in the Acute Unscheduled Care Model.

Attachment 3. Sample “topped out” diagnoses excluded from the proposed APM due to >=90% admission rates.

Diag Code	# of ED Visits	% Admitted to Inpatient Stays or Observations
43491 - Cerebral artery occlusion, unspecified with cerebral infarction	89,381	94.9%
0389 - Unspecified septicemia	74,971	97.9%
8208 - Closed fracture of unspecified part of neck of femur	54,793	97.1%
51881 - Acute respiratory failure	48,818	96.9%
5849 - Acute kidney failure, unspecified	40,867	94.2%
5609 - Unspecified intestinal obstruction	38,262	95.7%
79902 - Hypoxemia	30,243	91.3%
41071 - Subendocardial infarction, initial episode of care	30,096	96.8%
4111 - Intermediate coronary syndrome	29,666	90.5%
82021 - Closed fracture of intertrochanteric section of neck of femur	25,614	98.0%
41091 - Acute myocardial infarction of unspecified site, initial episode of care	17,705	94.7%
41519 - Other pulmonary embolism and infarction	15,725	94.8%
431 - Intracerebral hemorrhage	14,836	93.7%
41090 - Acute myocardial infarction of unspecified site, episode of care unspecif..	8,622	95.0%
85220 - Subdural hemorrhage following injury without mention of open intracran..	8,383	92.2%
4321 - SUBDURAL HEMORRHAGE	7,831	92.3%
4329 - Unspecified intracranial hemorrhage	7,007	93.3%
41070 - Subendocardial infarction, episode of care unspecified	6,873	96.6%
82100 - Closed fracture of unspecified part of femur	6,664	94.9%
82009 - Other closed transcervical fracture of neck of femur	6,067	97.2%
51882 - Other pulmonary insufficiency, not elsewhere classified	5,888	91.6%
436 - Acute, but ill-defined, cerebrovascular disease	5,337	95.6%
5750 - Acute cholecystitis	5,168	92.1%
5070 - Pneumonitis due to inhalation of food or vomitus	5,078	91.9%
51884 - Acute and chronic respiratory failure	5,073	97.6%
99591 - Sepsis	4,522	97.3%
430 - SUBARACHNOID HEMORRHAGE	4,471	91.6%
4260 - Atrioventricular block, complete	4,390	95.2%
72888 - RHABDOMYOLYSIS	4,079	96.2%
25010 - Diabetes with ketoacidosis, type II or unspecified type, not stated as unc..	4,021	95.3%
85300 - Other and unspecified intracranial hemorrhage following injury without ..	3,887	91.9%
41041 - Acute myocardial infarction of other inferior wall, initial episode of care	3,720	95.8%
34830 - Encephalopathy, unspecified	3,665	92.8%
42823 - Acute on chronic systolic heart failure	3,562	95.3%

Derived from analysis of the 2014 Carrier/Part B claims that met the definition for inclusion in the Acute Unscheduled Care Model.

PRT Summary of American College of Emergency Physicians (ACEP) Proposal
&
Additional PTAC PRT Questions for ACEP
Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admission
Model Proposal

Sources: ACEP PTAC proposal and written responses to PRT questions dated January 11, 2018

NOTE TO SUBMITTER: The PRT wants to make sure that they understand the model. We have provided a summary and outline of specific aspects of the model. We would like ACEP to correct any misunderstanding of the model and provide answers to the questions included below.

ACEP Response: Thank you for the opportunity to clarify certain aspects of the model summary during our call of March 5, 2018. Please accept this document that provides our full responses to the questions and additional information regarding the proposed target price methodology, quality scoring and risk-adjustment methodology.

ACEP strongly desires that this model be in harmony with other advanced payment models that have been undertaken through the Center for Medicare & Medicaid Innovation (CMMI). As we developed the model, we were aware that CMS was actively reviewing the lessons learned from the Comprehensive Care for Joint Replacement Program (CJR) and other bundled services programs included in the Episode Payment Models and was also assessing the Bundled Payments for Care Improvement Initiative (BPCI).¹ It was for this reason that we chose not to include a detailed methodology and quality scoring model in the original proposal. Our intention, as stated in the initial application, was to work with CMS to ensure alignment between this proposal and other evolving programs.

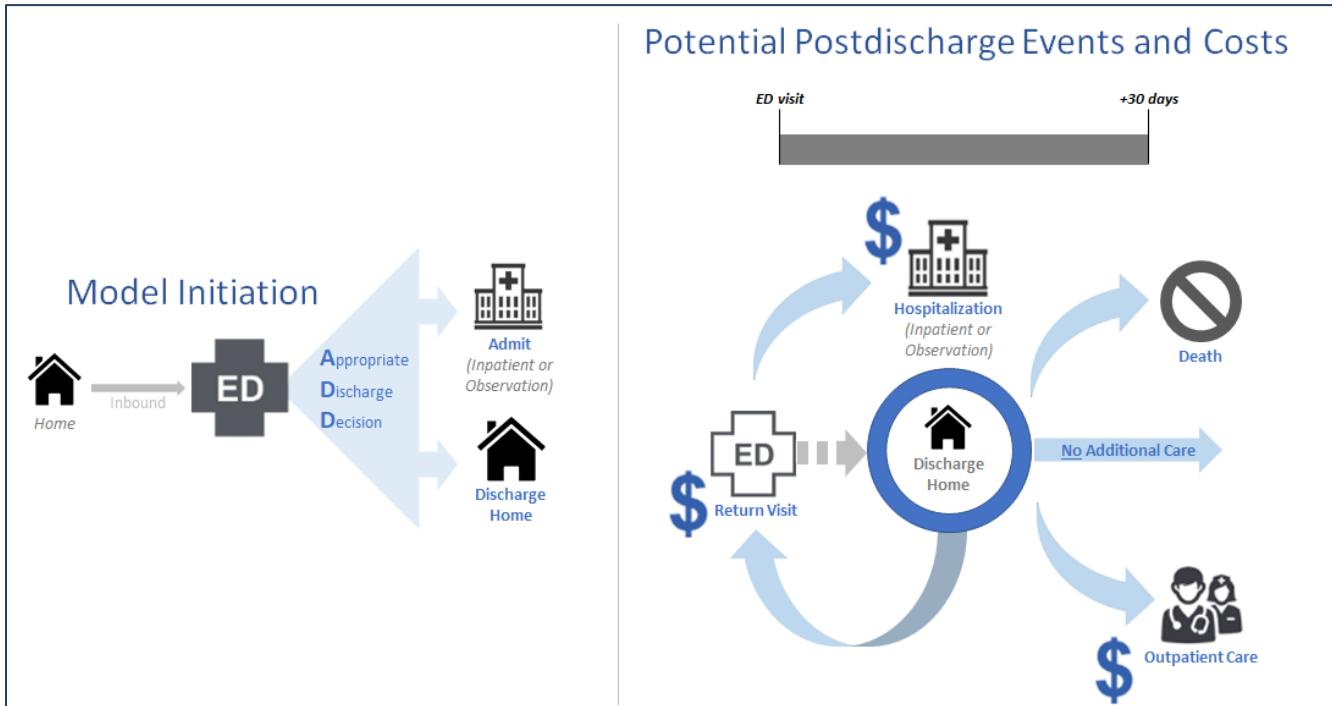
ACEP has proposed a model that is based upon an episode framework (in alignment with other CMS and private payer Advanced Alternative Payment Models including BPCI-Advanced) and embraces the goals of the Centers for Medicare & Medicaid Services (CMS) Hospital Readmission Reduction program. It is designed to support safe, appropriate discharge from the emergency department while ensuring that beneficiaries are protected from harm through the monitoring of post-discharge services including hospital admission, death and return ED visits without admission within 30 days of the qualifying ED visit.

The goals of improving quality and decreasing costs will be accomplished through the adoption of patient-centric care redesign that focuses on identifying patients at risk for post-discharge events and enhancing post-ED discharge care. It will be driven by quality measurement and incentivized through waivers that are available in other CMMI models. Savings are generated when an emergency physician chooses to discharge a Medicare beneficiary who presents with

¹ CMS. CMS finalizes changes to the Comprehensive Care for Joint Replacement Model, cancels Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model.

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-30.html>

one or more of four initially selected conditions, based on sound data and experience (abdominal pain, altered mental status, chest pain or syncope). In the proposed model, savings are calculated as the difference between a facility-specific, targeted price for an eligible episode and the actual amount spent for the ED services and 7-day post-ED discharge services. (ACEP is amenable to changing this to include 30-day post-ED discharge costs.)



SUMMARY OF MODEL:

The ACEP model includes the following concepts:

- Episode framework (using “retrospective reconciliation methods” and “in alignment with other CMS and private payer AAPM models)
- Outcome metrics
- Shared savings
- Target price

A target price/bundle for each presenting condition (one for syncope, chest pain, abdominal pain, altered mental status) is determined BY CMS based on claims and specified target admission rate reduction target (3 or 8%) for initial ED visit + all costs incurred for 7 and/or 30 days post discharge (including new services that are only possible with waivers, e.g. telehealth by ED docs)

If eligible and attributed patients, post discharge per AUCM, spend less than target during 7/30 day episode, there exist savings

- Participating ED groups could keep (share in) a fraction of the shared savings IF they hit quality targets

If attributed patients spend more than target, there exist losses

- Participating ED groups will be required to pay a fraction of the shared losses, presumably also as a function of quality scores

The following parameters are not defined in the payment model: initial target prices, risk adjustments within condition, how quality scores affect shared savings percentages or shared losses liability. ACEP proposes moving to national from local/regional benchmarks by year 3 and adding dual eligibles in year 3.

ACEP Response: *We agree that the summary of the model is correct with two exceptions. The quality score will determine the threshold performance necessary for eligibility for reconciliation payments. The level of the score will impact the discount rate that is used to adjust the target rate. The national benchmarks are specific to post-ED patient safety measures that will be added to the model once national performance has been established.*

Goals of ACEP Model: Per ACEP its physician-focused payment model (PFPM) for emergency department (ED) physicians is designed to increase the ED physician's and patient's comfort with a discharge disposition (versus hospitalization) by including financial incentives that reward care coordination, enhanced discharge planning, support patient and family engagement, and ensure follow-up care when barriers exist to rapid access to primary or specialty care.

Per ACEP, the model aims to reward clinicians for reducing costs, with equivalent or better outcomes in three ways: 1) reducing hospital inpatient admissions or observation stays; 2) enhancing the ability of emergency physicians to coordinate, manage, and avoid unnecessary post-discharge services, when appropriate; and 3) avoid post-ED visit patient safety events and their associated costs.

ACEP Response: *This is correctly stated.*

Clinical Conditions and Episode Definitions:

Conditions: For years 1 and 2 of the model, ACEP identified four high-volume ED conditions: syncope, chest pain, abdominal pain, altered mental status. For year 3 and subsequent years, additional conditions would be added, but exclude those conditions that result in greater than a 90% IP admission rate.

Two Episode Definitions: one episode is used to track Medicare spending (i.e., 7 days post discharge home from qualifying ED visit) and one episode is used to track quality performance (i.e., 30 days post discharge home from qualifying ED visit).

SUBMITTER QUESTION: Is ACEP open to using the same 30-day episode definition for both cost and quality?

ACEP Response: ACEP is amenable to using the same 30-day episode window for cost. ACEP understands the need to align this proposed model with others such as the recently launched BPCI Advanced model. In its original research, ACEP identified post-discharge services between days 8-30 that may be attributable to the qualifying ED visit, and as a result, adopted a 30-day post-discharge period for calculation of the quality score. ACEP recognizes that it is reasonable to include the cost of these events in setting target prices. If this change is adopted, we believe that it will be important to modify the target price calculation to include Medicare expenditures that occur in the 30-days post-ED discharge period for patients admitted to the hospital or who receive non-ED observation services. This will allow for a better comparison to costs that are associated with an admission decision.

The triggering event for either episode is the qualifying ED visit. Per ACEP, episode ends at the beneficiary's death or 30 days post- discharge after a qualifying ED event.

Medicare spending episode – qualified ED visit and patient is discharged home to the community for patients with the same diagnosis (i.e., years 1 and 2 - syncope, chest pain, abdominal pain, or altered mental status). All Medicare Part A and B claims (excluding durable medical equipment (DME)) that occur during the 7 days post discharge are included in the calculation of Medicare spending attributed to the episode. The spending also includes the new payments for waivers included in the ACEP proposal – transitional care management services, telehealth, and post-discharge home visits.

ACEP Response: This is correct regarding the initial proposal. ACEP is amenable to bringing the definition of included and excluded services in alignment with BPCI Advanced and defining scheduled return visits.

Quality performance episode - qualified ED visit and patient is discharged home to the community for patients with the same diagnosis (i.e., years 1 and 2 - syncope, chest pain, abdominal pain, or altered mental status). The 30day post-discharge events are used for quality measurement only.

ACEP Response: ACEP is amenable to including 30-day post-discharge events for cost.

Qualified ED Visit/Anchor Event for ACEP's Model: Figure 3 in 1/11/18 ACEP response to question document aggregates inpatient admission (IP) and observation stay claims (Obs) as one outcome (i.e., aggregate claims for IP/Obs stay across all hospitalized cases (Part B and IP/OP facility claims). If the cases were not admitted or transferred to IPs/OBs stays and transferred home, then the post-discharge episode appears to be triggered. The PRT is under the impression that there are four main outcomes for an ED visit and a potential claim under Medicare:

- 1) ED – no observation stay – discharge home to the community
- 2) ED- observation stay – discharge home to the community
- 3) ED- observation stay – IP admission
- 4) ED – IP admission

ACEP Response: As the model is focused on the ED disposition decision and attribution to an ED physician, we have identified the following outcomes:

- 1) *ED – discharge home to the community*
- 2) *ED- ED observation stay – discharge home to the community*
- 3) *ED- non-ED observation stay- discharge*
- 4) *ED – IP admission- discharge (This includes stays where patients admitted to non-ED observation ultimately are discharged from inpatient status.)*

The PRT asked ACEP to define the anchor event(s) which would trigger the post-discharge episode under its model during all performance years. The response was a qualified ED visit triggers the episode.

SUBMITTER QUESTION: Does ACEP envision #1 or #2 above as the definition of a qualified ED visit which would trigger the 7-day post discharge episode for purposes of spending and the 30-day post discharge episode for purposes of quality performance under this model?

ACEP Response: Qualifying visits include visits that result in discharge home (1), AND visits in which observation services were provided in the ED (2). We believe that this is appropriate, as the decision to utilize observation services (in a separate unit or within the ED proper) is made by the emergency physician, care continues under the supervision of an ED physician, and the ultimate decision to discharge or admit the patient is either made by, or heavily influenced by, the ED physician. In addition, the inclusion of observation services as directed by the emergency physician further supports an appropriate range of therapeutic dispositions for the patient (insuring optimal “fit” for their condition), and appropriately includes the cost of services in the model. ED observation has been shown to improve outcomes compared to inpatient care and in some studies to improve patient satisfaction.² Medicare beneficiaries in ED observation will be provided the same care coordination services and have the same option for discharge to the preferred home environment as those ED patients whom do not require observation prior to discharge.

In this model, observation stays that take place in the hospital in locations other than the ED are considered the equivalent to an inpatient admission for calculating the target price. This is justifiable as in both instances, there is a similarity in the care process because in many facilities, observation services are not provided in dedicated units but in traditional nursing units alongside inpatients. ACEP believes that this designation is also appropriate as the ED physician has handed-off the patient to a physician who will be responsible for further care and the ultimate discharge decision.

It has also been reported that Medicare beneficiaries are often confused about the difference between observation and inpatient status and become dissatisfied when they receive bills for outpatient services they believed to be covered through Part A. In response to this issue, CMS now requires that Beneficiaries who are in outpatient status for greater than 24 hours receive a

² Ross M, Aurora T, Graff L, et al. State of the Art: Emergency Department Observation Units. Crit Pathways in Cardiol 2012;11:128-138.

Medicare Outpatient Observation Notice (MOON).³ As the model is designed to decrease admissions to observation status, it will decrease the likelihood that Beneficiaries will find themselves in this situation. Finally, the Medicare program will recognize savings as additional facility and professional services will not be duplicative as the ED physician will bill only for the observation services and not an additional E&M code, since there is an inherent exclusion for billing for both services by Medicare.

Model Intervention:

The link between quality performance and spending is unclear in the current ACEP model. Many models include a quality performance standard that must be met prior to receiving any payments associated with spending efficiencies in care delivery.

SUBMITTER QUESTION: How does ACEP plan to incorporate a quality performance methodology in its proposed model? While there are individual potential measures suggested in the proposal, a composite or weighting of such measures is not included. Given the critical aspect of quality in the value aspect of model under PTAC consideration, the PRT would like to gain a better understanding of current performance on the planned measures and a possible quality scoring methodology for consideration.

ACEP Response: ACEP did not initially include a methodology for the quality score as MIPS-comparable outcome measures for post-ED care were not yet available. We anticipate that relevant MIPS-compatible measures will become available for inclusion in a quality score since CMS is actively seeking to rectify this gap as highlighted in the report, “CMS Quality Measure Development Plan, Environmental Scan and Gap Analysis Report.”⁴ In addition, the recent grant notice of March 2, 2018, “Medicare Access and Chip Reauthorization Act (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program” includes emergency medicine as an area of interest.⁵

In the long-term, we envision a composite outcome measure that computes the rate of qualifying cases that come into the Emergency Department, are discharged to home and in the subsequent

³ CMS. Medicare Outpatient Observation Notice. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-08-3.html>. Accessed on March 8, 2018.

⁴ CMS. Environmental Scan and Gap Analysis Report (MACRA, Section 102). https://www.cms.gov/Medicare/.../MACRA.../MDP_EScan_GapAnalysis_Report.pdf. Feb 17, 2017.

⁵ CMS-1V1-18-002. Measure Development for the Quality Payment Program. Department of Health and Human Services. Centers for Medicare & Medicaid Services. March 2, 2018.

30 days, and do not have an unscheduled return to the ED or admission to an acute care facility. We expect that this measure would ultimately be risk-adjusted and performance on the outcome measure portion for an Episode-Initiator-specific Composite Quality Score (CQS) would be determined by comparing the observed rate at a facility to its predicted rate.

In the interim, we have proposed a quality scoring methodology that would be used to define successful participation and eligibility for reconciliation payments. The proposed quality score is composed of three measures in the domains of patient engagement, the process of care coordination, and post-discharge outcomes. Please see Appendix B for a full description of the quality scoring methodology. Found below is an alternative option to the methodology outlined in Appendix B that would allow for a smoother transition for Participants, especially small groups who may need additional time to redesign care or who are inexperienced in taking on downside risk. This option allows for two years of pay for reporting before moving to pay for performance.

Alternative Quality Scoring Methodology**Year 1-2- Pay for Reporting**

#	Measure Domain	Measure	Minimum Threshold
1.	Patient Engagement/Experience	% of eligible cases in which shared-decision making about discharge plan occurred is reported	Submission of data
2.	Process/Care Coordination	% of eligible cases in which an SDA was completed and reviewed by physician is reported	Submission of data
3.	Outcomes	% of eligible cases where an unscheduled ED revisit, hospitalization or death did not occur within 30 days compared to the prior reference period.	Meets or exceeds standardized historical rate

Year 3-5- Pay for Performance

#	Measure Domain	Measure	Minimum Threshold
1.	Patient Engagement/Experience	% of eligible cases in which shared-decision making about discharge plan occurred is reported	40%
2.	Process/Care Coordination	% of eligible cases in which an SDA was completed and reviewed by physician is reported	40%
3.	Outcomes	% of eligible cases where an unscheduled ED revisit, hospitalization or death did not occur within 30 days compared to the prior reference period.	(See Formula)

Definition of categories

Pay for Reporting

Unacceptable performance is defined as the failure to report in any domain.

Acceptable performance is defined as reporting data in the first and second domain AND meeting or exceeding the participants standardized rate in the reference period.

Pay for Performance

Unacceptable performance is defined as the failure to achieve minimum threshold in any one domain.

Acceptable performance is defined as meeting the minimum threshold in all three categories.

Good performance is defined as meeting the minimum threshold for domain 1 and domain 2 AND 1) having a combined rate of clean trips of at least 80% OR 2) meeting or surpassing the participant's historical combined rate of clean trips.⁶ An absolute rate of 80% is included to reward participants with already very high rates of clean trips at a given facility, for whom there is less room for improvement.

Excellent performance is defined as meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 90% OR 2) meeting or surpassing a threshold rate of clean trips that is calibrated to each participant's historical performance. An absolute rate of 90% is included to reward participants with already very high rates of clean trips at a given facility, for whom there is less room for improvement.

⁶ A clean trip is triggered when NO post-discharge event of interest occurs within 30 days of discharge after a qualifying ED visit.

Categories of performance and impact on effective discount rate

Option 1

Year 1-2 (Pay for reporting option)

Performance Category	Effect on discount rate	Eligibility for reconciliation payments
Unacceptable	The effective discount is 3%	<i>Not eligible</i>
Acceptable	The effective discount is 1.5%	<i>Submits data in Domain (1) and Domain (2) AND meets or surpasses a threshold rate of clean trips that is calibrated to the facility's historical performance.</i>

Years 3-5 (Pay for performance)

Performance Category	Effect on discount rate	Eligibility for reconciliation payment
Unacceptable	<i>The effective discount is 3%</i>	<i>Not eligible</i>
Acceptable	<i>The effective discount is 3%</i>	<i>Meeting the minimum threshold in all three categories</i>
Good	<i>The effective discount is 2%</i>	<i>Meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 80% OR 2) meeting or surpassing the participant's historical combined rate of clean trips that is calibrated to each facility's historical performance.</i>
Excellent	<i>The effective discount is 1.5%</i>	<i>meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 90% OR 2) meeting or surpassing a threshold rate of clean trips that is calibrated to each facility's historical performance.</i>

Type of Payment Model - Payment Method to Determine Risk - Shared Savings or Other Model Type:

SUBMITTER QUESTION: Please clarify the type of payment methodology planned in the model (i.e., shared savings or bundled payment with retrospective reconciliation, other). These concepts are included in the ACEP response document on pages 7 and 8.

ACEP Response: *The payment methodology is a bundled payment model with retrospective reconciliation. A qualified episode is triggered by the submission of a claim for an eligible visit to Medicare by an ED physician who has re-assigned their rights to receive Medicare payment to a Participant. Medicare FFS claims for all items and services furnished during that clinical episode will continue to be processed under the relevant Medicare payment system rules. On an annual basis, Medicare FFS expenditures for the Clinical Episode will be subsequently reconciled against the final target price.*

Payment and Pricing Methodology - Clarification of Reconciliation of Spending in the 7 Day Post-Discharge Period and Hospital Specific Targets:

For performance years 1 and 2, Hospital level historical spending targets will use 3 years of inpatient spending in each of the specified four volume conditions reduced by 3%. For years 1 and 2 of the model, ACEP identified four high-volume ED conditions: syncope, chest pain, abdominal pain, altered mental status. For year 3 and subsequent years, additional conditions would be added, but exclude those conditions that result in greater than a 90% IP admission rate.

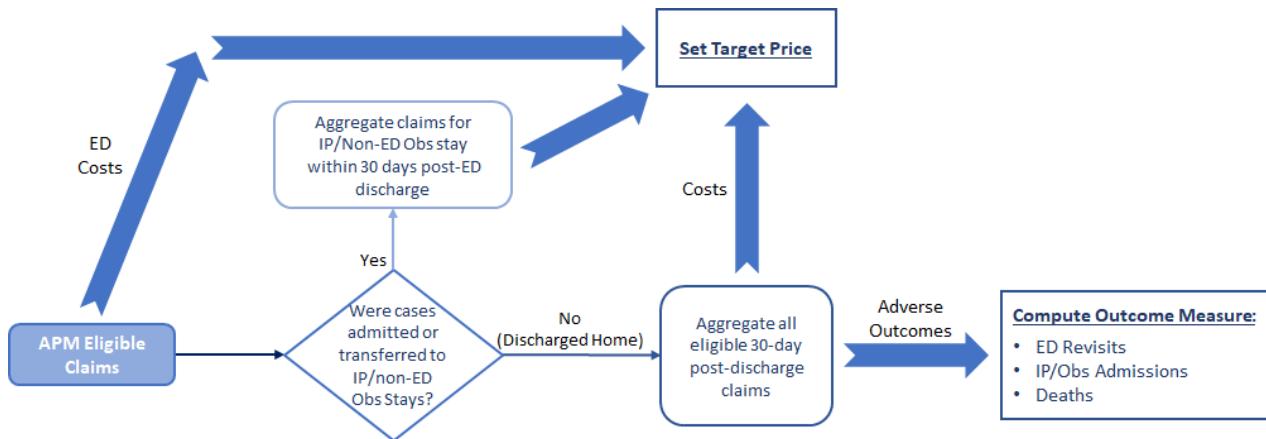
For each of the four conditions (syncope, chest pain, abdominal pain, altered mental status) with a qualifying ED visit:

- (A) CMS would calculate 3-year historical inpatient admission spending less 3%.

SUBMITTER QUESTION: Please clarify whether this is solely IP or IP plus observation as included in Figure 3 in the response to PRT questions document.

ACEP Response: *This includes IP and non-ED Observation stays. Please see updated Figure 3.*

Figure 3. Claim Aggregation and Reconciliation Process



- (B) For a performance year, CMS would calculate IP spending associated with the four conditions
- (C) For a performance year, CMS would calculate spending on each condition attributed to the 7 days post discharge episode from the qualifying ED visit. Services included in the 7-day episode are Medicare A and B. Including new payments for waiver services – care transition codes, tele-health, and home visits. Excluding DME.

ACEP Response: ACEP is amenable to moving to a 30- day window for calculating post-discharge spending, we would propose the following amended claim aggregation process. it includes spending in the 30-days post-ED discharge (including those subsequent to inpatient and non-ED observation services) into the calculation of the target price. This spending was not included in the original model due to the truncated model using 7 days for calculating post-discharge spending.

Potential Shared Savings (page 7 of response to PRT questions document)

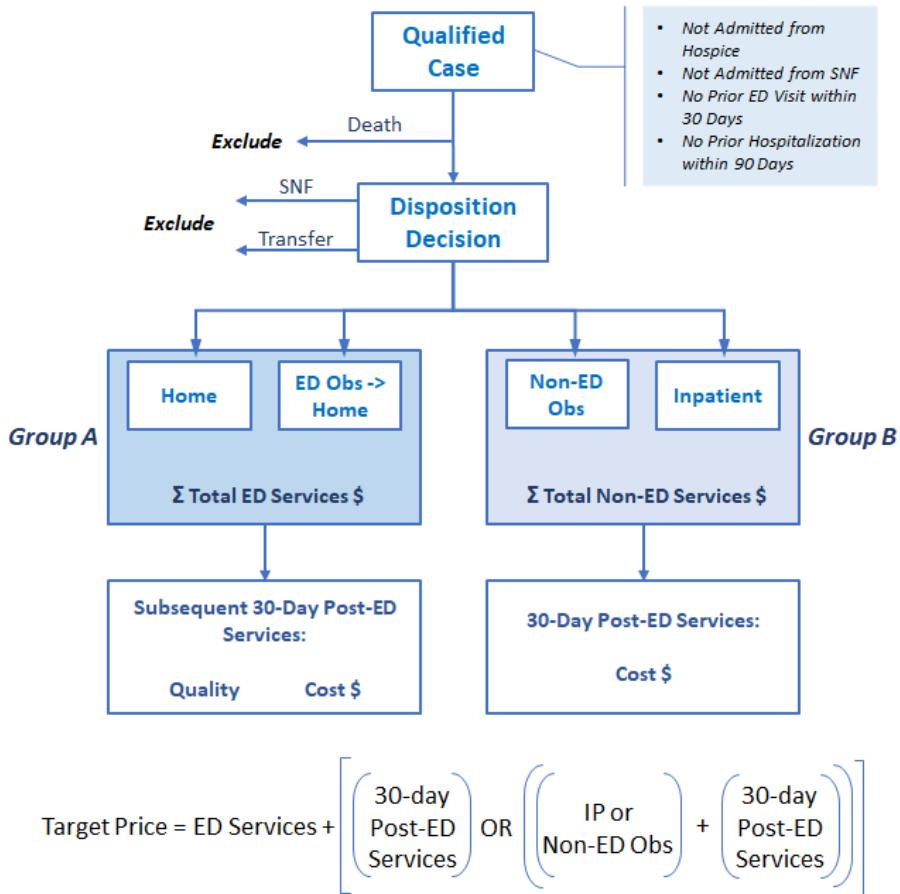
The potential shared savings are calculated based on the difference between the inpatient care for eligible ED cases minus aggregate expenditures for services provided to patients discharged with the same diagnosis (A portion goes back to Medicare.)

SUBMITTER QUESTION: If a quality standard to-be-defined is met, is the risk bearing entity potentially receiving a share of savings in a given performance year if the difference between the inpatient care for eligible ED cases minus aggregated expenditures for services provided to patients discharged home with the same diagnosis in the 7 day post-discharge episode is lower than the historical inpatient spending for the IP cases less 3% (e.g., share in savings if (B-C) is less than A for each specified condition)?

OR

Is the historical benchmark of inpatient spending for IP cases less 3% (A) solely applied to the spending associated with inpatient care for eligible ED cases (B) in the annual determination of spending in a performance year?

ACEP Response: The first instance is correct. If the post-discharge period is extended to 30-days post-ED discharge, expenditures that occur in the 30-days inclusive of the inpatient stay or non-ED observation stays would be included in the target price calculation. If participants have an unacceptable quality score, they would not eligible for a reconciliation payment.



SUBMITTER QUESTION: Please clarify the proper formula/understanding of the methodology envisioned in the model.

One Sided Risk – For years 1 and 2, there is only upside risk. The risk bearing entities would be responsible for meeting quality performance standards in the 30 day period and may receive a payment for efficiencies relative to historical spending benchmarks for the 7 day episode period used to track spending.

SUBMITTER QUESTION: Related to previous question about payment methodology – How does ACEP envision upside risk in years 1 and 2? Would upside risk remain constant or change in year 3 with the introduction of downside risk?

Two-Sided Risk – Year 3 and subsequent years, downside risk is included in the model without specifications.

SUBMITTER QUESTION: How does ACEP envision the incorporation of downside risk in year 3 and subsequent years of the model?

ACEP Response: In the original proposal, we envisioned only upside risk in years 1 and 2 for all participants with a transition to include an expanded set of diagnoses, the dual-eligible population and down-side risk in years 3-5. However, we have recently received feedback that some groups would like to participate in a risk-bearing APM sooner. In developing these options, we attempted to balance the needs of small groups who may not have the infrastructure to effect care redesign or cash reserves to take on risk in Year 1 with those of larger groups who would like accept downside risk beginning in Year 1.

Option One
(Pay for Reporting transitioning to Pay for Performance)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/ Stop Loss	Quality	Patient Safety
1-2	FFS excluding dual eligibles	Abdominal pain, chest pain, syncope	No	10% / None	Pay for Reporting (see above)	Measure frequency of post-ED patient safety events
3	FFS excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% /10%	See proposed model in Appendix B	Set benchmark national rates
4-5	All FFS	All*	Yes	10% / 10%	Add new outcome measures	Integrated into CQS

Option Two
(Pay for Performance with stop gain/loss of 10%)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/ Stop Loss	Quality	Patient Safety
1-2	FFS Excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% / 10%	See proposed model in Appendix B	Measure frequency of post-ED patient safety events
3	All FFS	All*	Yes	10% / 10%	Adopt additional outcome measures	Set benchmark national rates
4-5	All FFS	All*	Yes	10%/10%	Maintain outcome measures	Integrated into CQS

Option Three
(Pay for Performance with progressive stop gain/stop loss capped at 20%/20%)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/Stop Loss	Quality	Patient Safety
1-2	FFS Excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% / 10%	See proposed model in Appendix B	Measure frequency of post-ED patient safety events
3	All FFS Excluding dual eligibles	All*	Yes	10% / 10%	Adopt additional outcome measures	Set benchmark national rates
4-5	All FFS	All*	Yes	20%/20%	Maintain outcome measures	Integrate into CQS

**Excludes conditions are those that resulted in admission rates of over 90% in the previous year. We believe that this should be the only exclusion criteria and that exempting certain conditions (e.g., mental disorders and altered mental status) would exempt patients from the benefits of enhanced discharge planning and additional care coordination services that may bridge gaps that have previously been identified in their post-ED discharge outcomes.⁷ Please note that national benchmarks will be developed for the patient safety measure and incorporated into the CQS in Years 4-5.*

Patient Assessment – In the response to PRT questions document, ACEP refers to a safe discharge assessment (SDA) as part of the model.

SUBMITTER QUESTION: Please confirm the SDA is in the public domain.

ACEP Response: ACEP has consulted with experts in geriatric emergency medicine and performed an environmental analysis of tools that are available in the public domain. We understand that there are limitations to these tools. However, we agree with Hwang and Carpenter, who in a recent editorial in the Emergency Medicine Journal stated that, “until better risk-stratification tools are developed, instruments such as the ISAR and others should continue to be utilized.”⁸ We are recommending that an objective version of the Identification of Seniors at Risk (ISAR) tool or the Triage Risk Stratification Tool (TRST) be suggested, but other validated tools would also be considered acceptable. Although these tools are not perfect, their adoption in this proposed model will encourage the screening of this vulnerable population and will provide valuable information that will enhance shared decision-making and improve patient care. (Appendix C)

⁷ Obermeyer Z, Cohn B, Wilson M, Jena AB, Cutler DM. Early death after discharge from emergency departments: analysis of national US insurance claims data. BMJ. 2017;356:j239.

⁸ Hwang. U, Carpenter,C. Assessing geriatric vulnerability for post emergency department adverse outcomes: challenges abound while progress is slow. Emerg Med J 2016; 33:2-3.

Risk Adjustment Methodology Used in the ACEP Proposal:

SUBMITTER QUESTION: Please provide additional detail on the application of the CMS-HCC methodology used in the proposal (e.g., year of HCC score used to calculate the utilization rates etc.). On page 14A of the ACEP proposal, appendix D is referenced as part of the risk adjustment discussion but does not appear to be included in the document.

ACEP Response: *Two different risk-adjustment models were utilized in developing the initial proposal. The first method utilized the CMS Hierarchical Condition Category (HCC) methodology. In addition, custom risk-models were built by MPA. The methodology for these models can be found in Appendix D. We have included the outputs of these models for the four conditions in Appendix E.*

Appendix A: Glossary

Acute Care Hospital (ACH) – A Medicare-enrolled subsection (d) hospital, as defined in Section 1886(d)(1)(B) of the Act, to include facilities where ED visits are performed in hospital outpatient departments (HOPDs). PPS-Exempt Cancer Hospitals, inpatient psychiatric facilities, CAHs, hospitals and Maryland, hospitals are excluded from the definition of an ACH for purposes of this proposal.

Benchmark Price - A metric used by CMS, together with the CMS Discount, to calculate an Episode Initiator-specific Target Price for each Clinical Episode.

Bundled Payment / Bundling – A predetermined payment amount for all items and services (including physician, hospital, and other healthcare provider services) furnished during an episode of care. In ACUM, this is paid retrospectively.

Care Redesign Model- A model that includes the following services: care coordination services, the use of a Safe Discharge Assessment Tool (SDA), shared-decision making with patients and families regarding discharge disposition and contact with primary care provider or their designee.

Clean Trip- occurs when NO post-discharge event of interest occurs within 30 days of discharge during a Clinical Episode.

Clinical Episode – The defined period of time triggered by the submission of a claim for a Qualifying ED Visit (Anchor Event) during which all Medicare FFS expenditures for all non-excluded items and services furnished to a Medicare Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation.

CMS Discount — A set percentage by which CMS reduces the Benchmark Price to calculate the Target Price. In the AUCM proposal, a 1.5% to 3% discount would be applied to historical inpatient and non-ED observation spending calculated using 3- year historical data.

CQS -- Composite Quality Score.

CQS Adjustment Amount – The adjustment applied to the CMS discount percentage.

Eligible Beneficiary – A Medicare beneficiary entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for a qualified ED visit associated with a Clinical Episode for which a Participant has committed to be held accountable. Eligible Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of end-stage renal disease (ESRD); (3) Medicare beneficiaries for whom Medicare is not the primary payer; (4) Medicare beneficiaries enrolled in the hospice benefit; and those who die during the qualifying ED visit or within 30 days of discharge. Beneficiaries who have been discharged from an inpatient stay in the prior 90 days or who have

had an ED visit without admission or observation within the prior 30 days are also ineligible.

Emergency Department Disposition Decision- the decision by an ED physician to complete care in the emergency department. Potential ED dispositions include 1) ED- discharged home; 2) ED observation stay- discharged home; 3) ED- non-ED observation stay; and 4) ED- inpatient admission. (This final category includes patients who were dispositioned to non-ED observation stay, who were ultimately transitioned to inpatient status.)

Excluded Conditions- Conditions for which the national historical admission rate is $\geq 90\%$.

Medicare Fee-for-Service (FFS) – Medicare Part A and Part B. The term Medicare FFS does not include Medicare Part C (Medicare Advantage) or Medicare Part D.

Model Year – A full or partial calendar year during the Performance Period of the Model.

Negative Reconciliation Amount -- If applicable, the amount by which all non-excluded Medicare FFS expenditures for a Clinical Episode exceeds the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to a Participant at an ACH, together with all Positive Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Participant.

Negative Total Reconciliation Amount – If applicable, the negative sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes at an ACH attributed to a Participant. CMS will adjust the Negative Total Reconciliation Amount by an Episode-Initiator-specific CQS Adjustment Amount to calculate the Adjusted Negative Total Reconciliation Amount.

Participant – An emergency department physician group practice or Acute Care Hospital that enters into a Participation Agreement with CMS to participate in the AUCM model.

Participating Practitioner- A Medicare-enrolled physician or non-physician practitioner (e.g., nurse practitioner, physician assistant, social worker, or physical therapist) who: (1) is participating in the AUCM model and (2) has re-assigned their rights to receive Medicare payment to a Participant

Patient Safety Measures- Measures that are designed to capture the occurrence of patient safety events that occur in the 7 days subsequent to an ED visit. A national benchmark for these measures will be defined based performance across all ACH-based emergency departments.

Performance Period—The defined period of time during which Clinical Episodes may be triggered

Physician Group Practices (PGPs)—Medicare-enrolled physician group practices.

Positive Reconciliation Amount – If applicable, the amount by which all non-excluded Medicare FFS expenditures for a Clinical Episode is less than the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to the facility, together with all Negative Reconciliation Amounts for such Clinical Episodes, to

determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

Post-Episode Spending Monitoring Period – The period of 30 days after the end of a Clinical Episode during which Medicare FFS spending for items and services furnished to BPCI Advanced Beneficiaries is monitored by CMS for purposes of conducting the Post-Episode Spending Calculation.

Qualified ED Visit – An emergency department visit by an eligible Beneficiary identified by a qualifying ICD-10 diagnosis code identified for which a Participant submits a claim to Medicare FFS, which in turn triggers a Clinical Episode. A qualified ED visit is an Anchor Event.

Reconciliation – The semi-annual process of comparing the aggregate Medicare FFS expenditures for all items and services included in a Clinical Episode attributed to the Participant against the Target Price for that Clinical Episode in order to determine whether the Participant is eligible to receive an NPRA payment from CMS or is required to pay a Repayment Amount to CMS.

Safe Discharge Assessment- an assessment of qualifying Medicare Beneficiaries using a publicly available, validated tool used to assess vulnerability for post-emergency department adverse outcomes.

Start Date – The first day of the first Performance Period after a Participant begins participating in the Model.

Target Price – a figure determined by CMS for each presenting condition utilizing historical claims. The target price is specific to the participating Acute Care Hospital (facility).

Appendix B: Quality Scoring Methodology

#	Measure Domain	Measure	Minimum Threshold	
1.	Patient Engagement/Experience	% of eligible cases in which shared-decision making about discharge plan occurred is reported	40%	
2.	Process/Care Coordination	% of eligible cases in which an SDA was completed and reviewed by physician is reported	40%	
3.	Outcomes	% of eligible cases where an unscheduled ED revisit, hospitalization or death did not occur within 30 days compared to the prior reference period.	(See Below)	

Categories of performance and impact on effective discount rate.

Unacceptable. The effective discount is 3% and the participant is not eligible for a reconciliation payment.

Acceptable The effective discount is 3% and the participant is eligible for a reconciliation payment.

Good The effective discount is 2% and the participant is eligible for a reconciliation payment.

Excellent The effective discount is 1.5% and the participant is eligible for a reconciliation payment.

Definition of categories

Unacceptable performance is defined as the failure to achieve minimum threshold in any one domain.

Acceptable performance is defined as meeting the minimum threshold in all three categories.

Good performance is defined as meeting the minimum threshold for domain 1 and domain 2 AND 1) having a combined rate of clean trips of at least 80% OR 2) meeting or surpassing the participant's historical combined rate of clean trips.⁹ An absolute rate of 80% is included to reward participants with already very high rates of clean trips, for whom there is less room for improvement.

Excellent performance is defined as meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 90% OR 2) meeting or surpassing a threshold rate of clean trips that is calibrated to each participant's historical performance. An absolute rate of 90% is included to reward participants with already very high rates of clean trips, for whom there is less room for improvement.

Calculating the combined rate of clean trips

The combined rate of clean trips is a weighted average rate of clean trips. However, it must be standardized to account for differences in case mix across the groups. If clean trips are more difficult to achieve in one group than another, lower rates of clean trips resulting from increased percentages of cases in the more challenging group should not be penalized. To compute weighted average rates of clean trips, the rate of clean trips for each group is multiplied by the percentage of the total qualifying cases in the corresponding group and the results are added together.

Three combined rates of clean trips are used in evaluating performance: a standardized national rate, a participant's standardized rate in the reference period, and a participant's rate in the current period. The national rate and the participant's rate in the reference period are standardized to reflect the distribution of cases across the groups that the participant experienced in the current period. This allows equitable comparisons of performance, removing the influence of any shifts in the mix of cases across groups.

A standardized national combined rate of clean trips for a participant is calculated by multiplying the national rate of clean trips in the reference period for each group by a participant's percentage of total qualifying claims in the corresponding group for the current period. The results are then aggregated to arrive at the standardized national combined rate of clean trips.

A participant's standardized rate in the reference period is computed by multiplying that participant's rate of clean trips in the reference period for each group by that participant's percentage of total qualifying claims in the corresponding group for the current period. The

⁹ A clean trip occurs when NO post-discharge event of interest occurs within 30 days of the qualifying ED visit.

results are then aggregated to arrive at the participant's standardized combined rate of clean trips in the reference period.

While participants with fewer than 20 qualifying cases in the reference period (approximately 6.75% of facilities) would be excluded from participation in the program, it is possible that a participant may have a very low volume in one or more groups. The participant-specific rate in the reference period would, therefore, be unstable. To account for this, we propose the following blended rate approach:

- <3 cases: apply the national rate of clean trips
- 3 to <6 cases: apply a rate calculated as $(0.3 * \text{participant rate}) + (0.7 * \text{national rate})$
- 6 to <9 cases: apply a rate calculated as $(0.7 * \text{participant rate}) + (0.3 * \text{national rate})$
- 9 or greater: apply the participant rate

Finally, a participant's rate in the current period is calculated by multiplying that participant's rate of clean trips in the current period for each group by that participant's percentage of total qualifying claims in the corresponding group for the current period. The results are then aggregated to arrive at the participant's combined rate of clean trips in the current period.

Definition of thresholds

Minimum threshold: The minimum threshold is designed to identify a cut point below which there is reason to believe that performance has deteriorated substantively and is not poorer purely due to random variation. The binomial standard deviation (SD), calculated as $\sqrt{n * p * (1-p)}$, is used to estimate the lower bound at the 99% confidence level. N is the total number of cases in the current period and p is the participant's standardized combined rate of clean trips in the reference period. A significance threshold would then be calculated as $p - (2.58 * SD)$.

However, since SD depends upon n, participants with very high volumes of cases may have unreasonably small standard deviations. Optically, it would be problematic to penalize a large volume participant because their combined rate of clean trips declined by a fraction of a percent. Therefore, the magnitude of the shift is also considered in establishing the threshold.

The national combined rate of clean trips, standardized to the participant, and an importance factor (we are proposing 10%) are used to compute an importance threshold. The standardized national combined rate of clean trips is multiplied by the importance factor and the result is subtracted from the participant's standardized combined rate of clean trips in the reference period to arrive at an importance threshold.

The minimum threshold would be computed as the lower of the significance threshold and the importance threshold.

Good threshold: The good threshold is designed to identify where care has been maintained or improved. The participant's performance in the reference period (the participant's standardized combined rate of clean trips in the reference period) establishes this threshold.

Excellent threshold: The excellent threshold is designed to identify a cut point above which there is reason to believe that performance has improved substantively and is also not better purely due to random variation. This threshold is similar to the Minimum threshold calculation in that it has both a significance threshold and an importance threshold (again, it would be optically challenging to reward a large volume participant as excellent when the combined rate of clean trips increased only a fraction of a percent).

The binomial distribution is used as in the calculation of the Minimum threshold, and a significance threshold is computed as $p + (1.96 * SD)$. To calculate an importance threshold, the national combined rate of clean trips, standardized to the participant, is multiplied by the importance factor. The result is added to the participant's standardized combined rate of clean trip from the reference period to arrive at the importance threshold. The Excellent threshold is then the higher value of the significance threshold and the importance threshold.

Current Performance

Group	25 th Percentile	50th Percentile	75th Percentile	National Average
Combined	32%	42%	54%	41%
Syncope	22%	33%	46%	33%
Chest Pain	21%	32%	46%	31%
Abdominal Pain	60%	69%	77%	65%
Altered Mental Status	12%	19%	27%	21%

Appendix C: Examples of Safe Discharge Assessment Tools¹⁰

Triage Risk Stratification Tool (TRST)

1. History or evidence of cognitive impairment (poor recall or not oriented)?
2. Lives alone or without a central caregiver?
3. Difficulty walking/transferring or recent falls?
4. Five or more medications?
5. ED use in previous 30 days or hospitalization in previous 90 days?
6. ED nurse concern for elder abuse/neglect, substance abuse, medication non-compliance, activities of daily living problems, or other issues? †

Interpretation ≥ 2 “yes” responses = high risk older adult.

†Answered by ED nurse. Nurse recommendation omitted in the Flemish version of the TRST.

Identification of Seniors at Risk (ISAR)

1. Before the illness or injury that brought you to the emergency department, did you need someone to help you on a regular basis?
 2. Since the illness or injury brought you to the emergency department, have you needed more help than usual to care for yourself?
 3. Have you been hospitalized for one or more nights during the past 6 months?
 4. In general, do you see well?
 5. In general, do you have serious problems with your memory?
 6. Do you take more than three different medications every day?
- Interpretation ≥ 2 “yes” responses = high risk older adult.

¹⁰ Carpenter C, Shelton, E, Fowler S, et al. Risk Factors and Screening Instruments to Predict Adverse Outcomes for Undifferentiated Older Emergency Department Patients: A Systematic Review and Meta-analysis. Academic Emergency Medicine 2015;22: 1-21.

Appendix C: Risk-adjusted Disposition and Postdischarge Events

HCC Score Risk-Adjustment

The HCC community scores were generated for all observations in the diagnosis cohorts using the software for the appropriate year. A logistic regression was then run to fit the HCC score against the binary dependent variable (discharged to inpatient or observation setting or discharged home) within each diagnosis cohort. Facilities with less than 10 episodes were dropped from the model. The model was then re-standardized to the entire study population, so the total observed rate of inpatient/observation admission equaled the total predicted. A facility's risk adjusted rate of inpatient/observation admission was computed as

$$k = \frac{\bar{y}_{\text{hospital}}}{\hat{y}_{\text{hospital}}}$$

$$s = \frac{\bar{y}_{\text{nation}}}{1 - \bar{y}_{\text{nation}}}$$

$$\text{odds} = k * s$$

$$\text{risk adujsted rate} = \frac{\text{odds}}{1 + \text{odds}}$$

where \bar{y} is the observed rate of inpatient/observation discharge and \hat{y} is the mean probability of an inpatient/observation admission.

Custom Risk-Adjustment Models

Population Restrictions for Model Development

Cases were excluded from all models if any of the following criteria were met.

- Inpatient admission within 90 days prior to index ED visit
- ED visit within 30 days prior to index ED visit
- Patient died in ED during index visit
- Patient was admitted to ED from hospice, skilled nursing facility, or long term acute care facility
- Patient was discharged to somewhere other than inpatient setting, observation, home, or home health agency (HHA) based on discharge disposition on index ED visit

Development of Predictive Models

For each study group, predictive models were build using one year of data (2014) from CMS RIF data (See Appendix A). Stepwise logistic regression was used to develop models to predict outcomes of all

study groups accounting for influences by general risk factors, including diagnosis, age, gender, and year risk factors. Hospital dummies were created for all models and added to the model prior to offering other risk factors. Cases discharged in the last 7 days of the study data were excluded from all models predicting postdischarge outcomes due to lack of complete information on their postdischarge events.

Models Predicting Discharge to Inpatient Setting or Observation

Models predicting a patient's discharge to the inpatient setting or observation were built using all qualifying index ED visits. The total number of cases used to build the models, the number and percentage of cases with discharges to the inpatient setting or observation, and the c-statistic for the final model for ED-diagnosed syncope (with hospital removed) is reported below.

Models Predicting Postdischarge Admission to Inpatient Setting or Observation (7 days)

Models predicting a 7-day postdischarge admission to the inpatient setting or observation were developed using a subset of data containing only cases that were discharged to either home or a HHA, did not die before admission, and did not have an ED visit over 24 hours prior to admission.

Models Predicting Postdischarge ED revisit (7 Days)

Models predicting a 7-day postdischarge ED revisit were developed using a subset of data containing only cases that were discharged to either home or a HHA, did not die before ED revisit, and did not have a preceding admission to the inpatient setting or observation or within 24 hours of admission to ED.

Models Predicting Postdischarge Mortality (7 Days)

Models predicting a 7-day postdischarge mortality were developed using a subset of data containing only cases that were discharged to either home or a HHA, did not have an admission to inpatient setting or observation within 7 days, and did not have an ED revisit within 7 days.

Application of Predictive Models

Upon completion of the model development, final derived predictive models were applied to one year of data (2014) to compute the predicted postdischarge event rates for each of the cases. Four predicted rates were generated for cases in each of the study groups using the models developed.

- A. Probability of a case to be discharged to inpatient setting or observation
- B. Probability of a case discharged to either home or HHA to have a postdischarge admission to the inpatient setting or observation
- C. Probability of a case discharged to either home or HHA to have a postdischarge ED revisit without preceding admission to inpatient setting or observation
- D. Probability of a case discharged to either home or HHA to have a postdischarge mortality without preceding admission to inpatient setting, observation, or ED.

Predicted rates B, C, and D were calculated using a set of conditional probabilities. For example, condition B above was computed as:

(probability of a case to be discharged to home or HHA) \times (probability of a case to have a postdischarge admission to the inpatient setting or observation given a discharge home or to HHA)

Before the predicted rates were computed, each conditional probability was standardized to the corresponding modeling population so that the sum of the predicted probabilities equals the sum of the

observed probabilities for all cases used to develop the specific model. Once the four predicted rates described above were computed, they were used to further generate the probability of any postdischarge event occurring for a case that was discharged home or to a HHA. This was computed as:

$$P(\text{postdischarge event for home or HHA discharge}) = \mathbf{B} + \mathbf{C} + \mathbf{D}$$

Calculation of Risk-Adjusted Postdischarge Event Rates

After computation of predictions, risk-adjusted postdischarge event rates were computed for all hospitals in each study group using one year of data (2014). Five risk-adjusted rates were generated for hospitals in each of the study groups using the computed predictions.

- A. Risk-adjusted rate of discharge to inpatient setting or observation
- B. Risk-adjusted rate of postdischarge admissions to the inpatient setting or observation for discharges to home or a HHA
- C. Risk-adjusted rate of postdischarge ED visits without admission to inpatient setting or observation for discharges to home or a HHA
- D. Risk-adjusted rate of postdischarge mortalities without admission to inpatient setting, observation, or ED for discharges to home or a HHA.
- E. Risk-adjusted rate of postdischarge events for discharges to home or a HHA.

To compute the risk-adjusted rates, predicted values are standardized to cases at hospitals that have at least 8 observed postdischarge events or 4.5 predicted postdischarge events. Predicted and observed rates were then aggregated by hospital and the observed-to-predicted ratio (OE ratio) was computed for each hospital. Each hospital's OE ratio was applied to the national average to get its risk-adjusted rate. The risk-adjusted rate was then tested for significance against the national average.

Final FFS Model for Syncope Admissions to Observation or Inpatient

Overview of syncope admissions model

N = 143,249

N admitted = 88,341

% admitted = 61.7%

c-statistic (hospital removed) = 0.665

Risk factors that stepped into syncope admissions model for Medicare FFS patients

Risk Factor	Odds Ratio
Skeletal disorders (femur fracture, skull fracture, traumatic cerebral hemorrhage)	64.08
Rhabdomyolysis	33.67
Acute cerebrovascular accident	17.03

Conduction disturbance (complete atrioventricular block)	16.80
Gastrointestinal bleeding	15.54
Acute renal failure	7.99
Pulmonary failure	6.57
Pneumonia/empyema	5.88
Cerebrovascular disease (transient cerebral ischemia)	4.32
Conduction disturbance (right bundle branch block)	4.29
Cardiac Dysrhythmia (unspecified)	4.03
Miscellaneous symptoms / abnormal findings	4.00
Renal disorders	3.89
Vertebral disorders	3.79
Postop infection/surgical site infection	3.48
Cardiac dysrhythmia (ventricular tachycardia, atrial fibrillation)	3.23
Cardiac dysrhythmia (supraventricular tachycardia)	3.23
White blood cell disorders	3.10
Skeletal disorders (fracture)	3.04
Miscellaneous neurological symptoms	2.86

Appendix D: Results of the application of risk-adjustment models (2014 and 2015)

ED Index Case Inpatient Stay and Observation Admission Rate Percentile Statistics– 2014 Data

Observed ED-IP/Obs Admission Rates

Hospital Variations in % ED Index Cases Admitted to IP or Observation Stays						
Group Description	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	29.4%	45.2%	61.5%	74.1%	83.3%	29.0%
Chest Pain	28.3%	45.1%	62.2%	75.1%	83.5%	30.0%
Abdominal Pain	7.7%	17.8%	27.6%	37.7%	47.1%	19.9%
Altered Mental Status	33.3%	58.3%	73.6%	84.6%	94.3%	26.3%

HCC Model Risk Adjusted ED-IP/Obs Admission Rates

Variations in Risk Adjusted ED-IP/Obs Admission Rates across Hospitals Risk adjustment performed using CMS HCC risk adjustment models						
Group	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	48.7%	59.0%	65.8%	69.9%	72.2%	10.9%
Chest Pain	49.2%	60.7%	67.6%	71.3%	73.4%	10.6%
Abdominal Pain	10.4%	22.7%	31.1%	37.8%	43.0%	15.2%
Altered Mental Status	66.5%	75.1%	78.8%	80.8%	82.3%	5.7%

Custom Model Risk Adjusted ED-IP/Obs Admission Rates

Variations in Risk Adjusted ED-IP/Obs Admission Rates across Hospitals						
Risk adjustment performed using MPA risk adjustment models						
Group	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	47.6%	58.9%	65.7%	70.1%	72.5%	11.2%
Chest Pain	49.2%	60.3%	67.5%	71.6%	73.9%	11.3%
Abdominal Pain	12.0%	24.6%	31.8%	38.3%	44.2%	13.7%
Altered Mental Status	67.1%	75.1%	78.8%	80.8%	82.1%	5.6%

ED Index Case Inpatient Stay and Observation Admission Rate Percentile Statistics – 2015 DataObserved ED-IP/Obs Admission Rates

Hospital Variations in % ED Index Cases Admitted to IP or Observation Stays						
Group Description	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	27.3%	43.6%	59.2%	72.5%	81.6%	28.9%
Chest Pain	25.0%	42.1%	59.3%	73.2%	82.2%	31.1%
Abdominal Pain	6.3%	16.0%	26.0%	36.0%	45.7%	20.0%
Altered Mental Status	33.3%	57.6%	73.3%	84.0%	92.3%	26.4%

HCC Model Risk Adjusted ED-IP/Obs Admission Rates

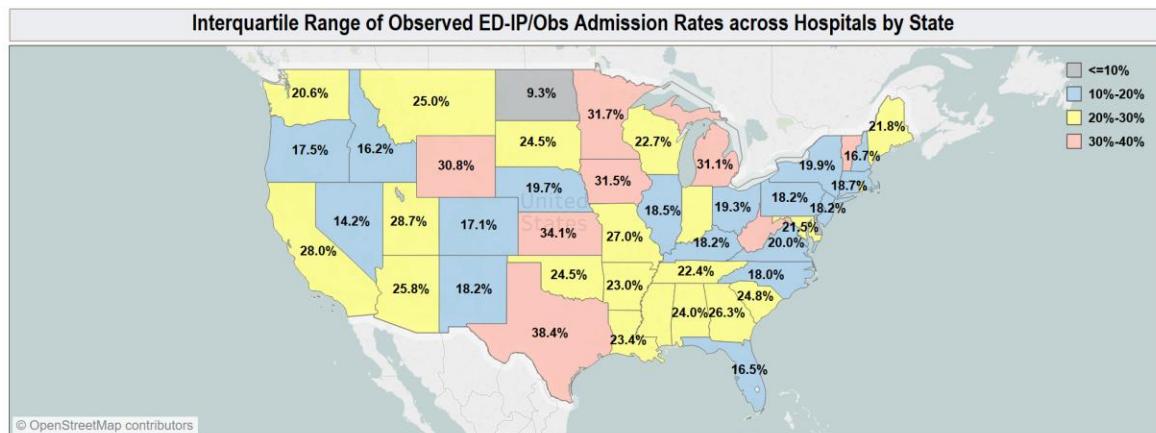
Variations in Risk Adjusted ED-IP/Obs Admission Rates across Hospitals						
Risk adjustment performed using CMS HCC risk adjustment models						
Group	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	45.4%	56.3%	63.9%	68.1%	70.8%	11.8%
Chest Pain	43.9%	57.3%	65.3%	69.7%	72.0%	12.4%
Abdominal Pain	7.2%	20.0%	29.3%	36.2%	41.6%	16.3%
Altered Mental Status	64.2%	75.4%	79.1%	81.2%	82.6%	5.8%

Custom Model Risk Adjusted ED-IP/Obs Admission Rates

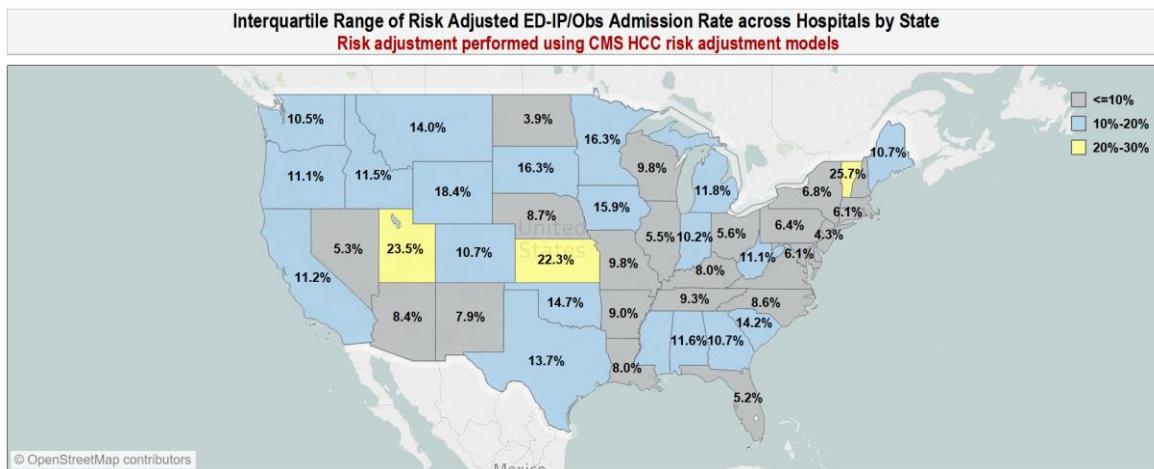
Variations in Risk Adjusted ED-IP/Obs Admission Rates across Hospitals						
	Risk adjustment performed using MPA risk adjustment models					
Group	10th PCT	25th PCT	50th PCT	75th PCT	90th PCT	Interquartile Range
Syncope	45.5%	56.3%	63.8%	68.3%	71.1%	12.0%
Chest Pain	43.5%	57.2%	65.4%	69.9%	72.4%	12.7%
Abdominal Pain	7.9%	21.8%	30.1%	36.8%	43.3%	15.0%
Altered Mental Status	64.9%	75.4%	79.2%	81.1%	82.4%	5.7%

Hospital Variations in ED-IP/Obs Admission Rates by State – 2014 Data for Syncope

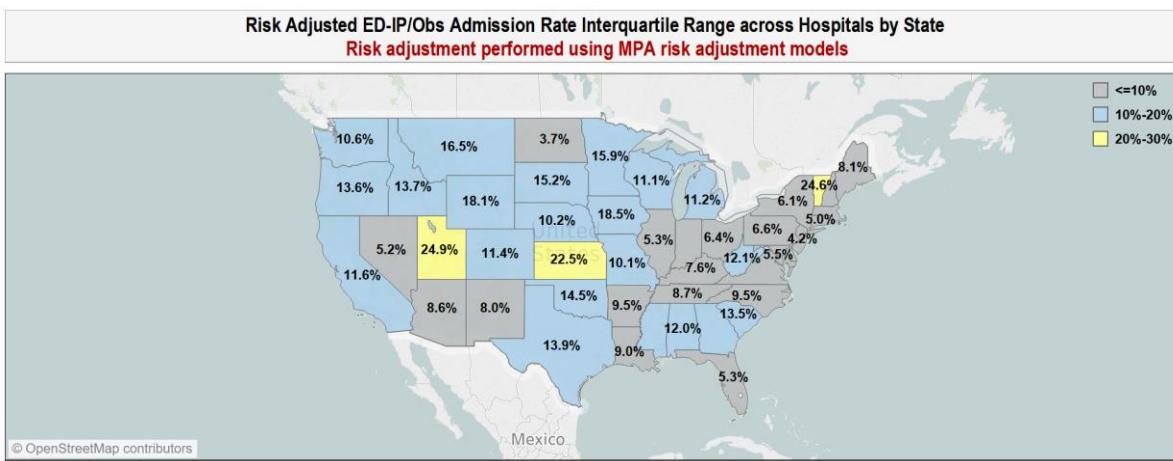
Observed ED-IP/Obs Admission Rates



HCC Model Risk Adjusted ED-IP/Obs Admission Rates

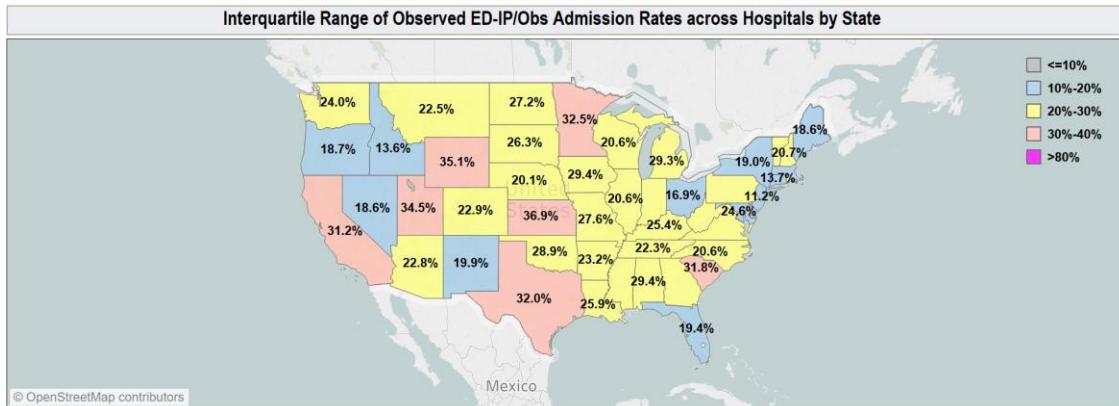


Custom Model Risk Adjusted ED-IP/Obs Admission Rates

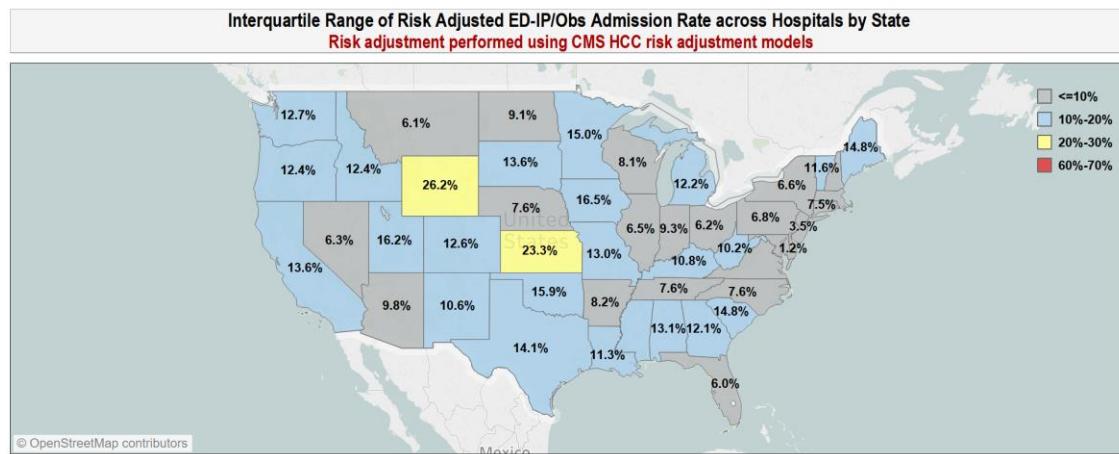


Hospital Variations in ED-IP/Obs Admission Rates by State – 2015 Data for Syncope

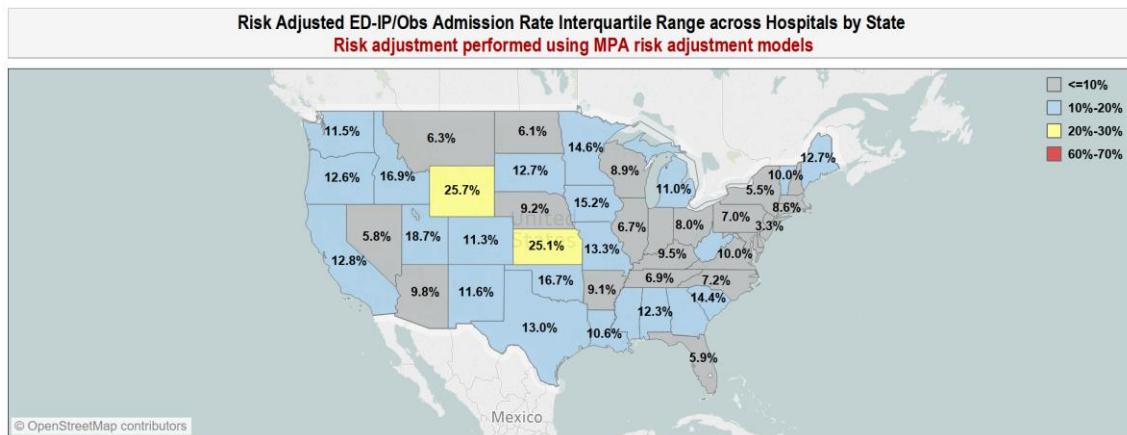
Observed ED-IP/Obs Admission Rates



HCC Model Risk Adjusted ED-IP/Obs Admission Rates



Custom Model Risk Adjusted ED-IP/Obs Admission Rates



Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions

Summary Document

Submitted by the American College of Emergency Physicians

March 22, 2018

In October 2017, the American College of Emergency Physicians (ACEP) submitted the proposed Physician-Focused Payment Model (PFPM), *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions*, to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for consideration. This document provides a summary of the model, including updates to the original submission that have been made over the course of our engagement with the Preliminary Review Team.

Model Overview

Specifics of the model follow in the coming pages, but in short, the AUCM will serve as a viable Advanced Alternative Payment Model (AAPM) that emergency physicians can participate in that will allow them to accept financial risk that is directly attributable to their discharge disposition decisions within qualifying episodes of acute unscheduled care. This episode of care (bundled) model incentivizes and facilitates post-discharge care coordination for Medicare beneficiaries in the emergency department (ED). The AUCM ensures that emergency physicians who make decisions regarding hospital or outpatient care following discharge have the necessary tools to support this transformation and are rewarded for their decision making.

The goals of improving quality and decreasing costs in Medicare will be accomplished through the adoption of patient-centric care redesign that identifies patients at risk for post-discharge events and enhances their post-ED discharge care. This redesign will be quality-driven, and incentivized through waivers that are available in other CMMI models. Specifically, savings in the proposed model are generated to the Medicare system when the actual amount spent for ED services and 30-day post-discharge services for a Medicare beneficiary who presents with selected conditions, is below a facility-specific, targeted price for that eligible 30-day episode.¹ Performance on a set of quality measures will determine a participant's eligibility for reconciliation payments, as well as the size of the discount that is built into the target price.

The model will focus for the first two to three years on episodes around four high-volume ED conditions – abdominal pain, chest pain, altered mental status, and syncope – and will then add more episodes over time. ED conditions that result in a greater than 90 percent inpatient admission rate would be excluded.

The AUCM will reward clinicians who are able to reduce costs in three possible ways while continuing to provide high-quality care. The first is by reducing avoidable hospital inpatient admissions or observation stays. The second is by enhancing the ability of emergency physicians to coordinate and manage post-discharge services and, when appropriate, avoid them. The third is by avoiding post-discharge return ED visits, patient safety events, and their associated costs.

The monitoring of post-discharge events (death, repeat ED visits, inpatient admissions, and observation stays) that is built into the model protects Medicare beneficiaries and will ensure that attempts to decrease the cost of care do not result in any decreased quality. The AUCM will honor patient preference in its efforts to avoid hospital inpatient admissions and observation stays through provision of transitional follow-up care.

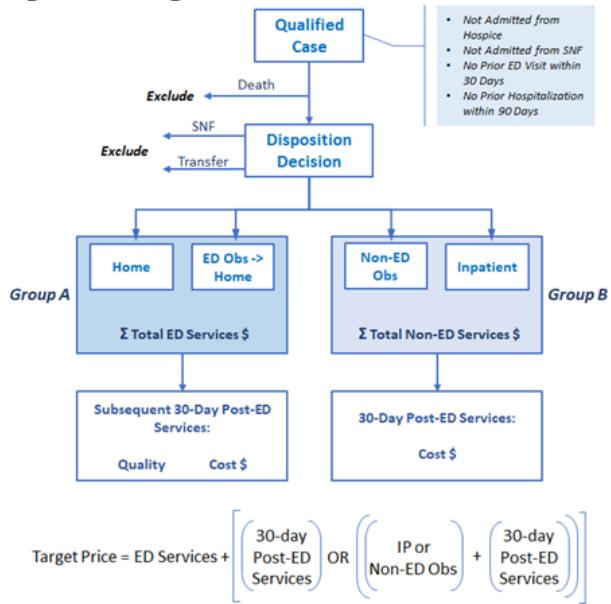
¹ The 30-day post-ED discharge episode for calculating cost was updated to be in alignment with BPCI Advanced post-anchor event cost and quality measurement.

Features of the Model

Target Price

A target price for each presenting condition is calculated by CMS based on three years of historical claims and a specified discount percentage (based on a reduction in expected hospital admissions) for the initial ED visit plus all costs incurred for 30 days post discharge (including new services that are only possible with waivers). The discount percentage will range from 1.5 percent to 3.0 percent depending on the Participant's performance on quality. The target prices will be updated annually and risk adjusted using the CMS-HCC methodology.

Figure 1: Target Price Calculation



Quality Score

The model includes a quality scoring methodology that would be used to define successful participation and eligibility for reconciliation payments. The proposed quality score is composed of three measures in the domains of patient engagement (the Shared Discharge Assessment), the process of care coordination (the Shared Decision Making), and post-discharge outcomes. The Shared Discharge Assessment and Shared Decision Making measures would be submitted through the use of certified electronic health record technology (CEHRT). The model also includes an alternative option for quality scoring that would allow for a smoother transition for participants, especially small groups who may need additional time to redesign care or who are inexperienced in taking on downside risk. This option allows for two years of pay for reporting before moving to pay for performance.

In the long term, ACEP envisions a composite outcome measure that computes the rate of qualifying cases that come into the ED, are discharged to home, and in the subsequent 30 days do not have an unscheduled return to the ED or admission to an acute care facility. We expect that this measure would ultimately be risk-adjusted and be determined by comparing the observed rate at a facility to its predicted rate. We also anticipate enhancing the quality scoring methodology over time with registry-reported patient safety measures.

Overview of Quality Scoring Methodology

Performance on the three measures found in Table 1 below would be classified as unacceptable, acceptable, good, and excellent, based on the ability to meet or surpass the minimum thresholds for each measure.

Table 1: Overview of Quality Measures

#	Measure Domain	Measure	Minimum Threshold
1.	Patient Engagement/Experience	% of eligible cases in which shared-decision making about discharge plan occurred is reported	40%
2.	Process/Care Coordination	% of eligible cases in which a Shared Discharge Assessment was completed and reviewed by physician is reported	40%
3.	Outcomes	% of eligible cases where an unscheduled ED revisit, hospitalization, or death did not occur within 30 days compared to the prior reference period. (event free post discharge period)	Calculated at Facility Level

As stated above, performance on quality will impact both eligibility for reconciliation payments and the size of the discount built into the target price. Please see Table 2 below:

Table 2: Categories of Performance and Impact on Effective Discount Rate

Performance Category	Effect on Discount Rate	Eligibility for Reconciliation Payment
Unacceptable	The effective discount is 3%	Not eligible
Acceptable	The effective discount is 3%	Meeting the minimum threshold in all three categories
Good	The effective discount is 2%	Meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 80% OR 2) meeting or surpassing the Participant's historical combined rate of clean trips that is calibrated to each facility's historical performance.
Excellent	The effective discount is 1.5%	Meeting the minimum threshold in all three categories AND 1) having a combined rate of clean trips of at least 90% OR 2) meeting or surpassing a threshold rate of clean trips that is calibrated to each facility's historical performance.

Payment Methodology

The payment methodology is a bundled payment model with retrospective reconciliation. A qualified episode is triggered by the submission of a claim for an eligible visit to Medicare by an ED physician who has re-assigned their rights to receive Medicare payment to a Participant. Medicare fee-for-service (FFS) claims for all items and services furnished during that clinical episode will continue to be processed under the relevant Medicare payment system rules. On an annual basis, Medicare FFS expenditures for the qualifying episode will be subsequently reconciled against the final target price.

If spending for eligible and attributed patients is less than the target during the 30-day episode, then savings are yielded that participating ED groups could keep if they hit quality targets. If spending for attributed patients is more than the target, then participating ED groups will be liable for those losses.

Consistent with other Advanced APMs, the amount of savings and losses that Participants would either receive or be liable for will be capped at certain percentages. The model includes three options for risk-sharing that balance the needs of small groups who may not initially have the infrastructure to effect care redesign or the cash reserves to take on risk, with those of larger groups who would like accept downside risk immediately.

Please see Table 3 below for the risk sharing options that would be available for Participants in the model.

Table 3: Risk Sharing Options

Option One (Pay for Reporting Transitioning to Pay for Performance)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/ Stop Loss	Quality	Patient Safety
1-2	Fee-for-Service (FFS) excluding dual eligibles	Abdominal pain, chest pain, syncope	No	10% / None	Pay for Reporting	Measure frequency of post-ED patient safety events
3	FFS excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% /10%	Pay for Performance	Set benchmark national rates
4-5	All FFS	All*	Yes	10% / 10%	Add new outcome measures	Integrated into quality score

Option Two (Pay for Performance with Stop gain/loss of 10%)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/ Stop Loss	Quality	Patient Safety
1-2	FFS Excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% / 10%	Pay for Performance	Measure frequency of post-ED patient safety events
3	All FFS	All*	Yes	10% / 10%	Adopt additional outcome measures	Set benchmark national rates
4-5	All FFS	All*	Yes	10% /10%	Maintain outcome measures	Integrated into quality score

Option Three (Pay for Performance with Progressive Stop gain/ loss Capped at 20%)

Year	Medicare Beneficiaries	Conditions	Downside Risk	Stop Gain/ Stop Loss	Quality	Patient Safety
1-2	FFS Excluding dual eligibles	Abdominal pain, altered mental status, chest pain	Yes	10% / 10%	Pay for Performance	Measure frequency of post-ED patient safety events
3	All FFS Excluding dual eligibles	All*	Yes	10% / 10%	Adopt additional outcome measures	Set benchmark national rates
4-5	All FFS	All*	Yes	20%/20%	Maintain outcome measures	Integrated into quality score

Please see Table 4 below for a general overview of the model specifications.

Table 4: Overview of Model Specifications

Model Parameter	Specifications
Population	Medicare fee-for-service (FFS) beneficiaries. Dual eligible beneficiaries will be rolled into the AUCM in year three.
Qualifying ED Visit/Anchor Events	An ED visit that results in: <ul style="list-style-type: none"> • discharge home to the community • ED observation stay followed by discharge home to the community • non-ED observation stay followed by discharge (any location) • IP admission followed by discharge (This includes stays where patients admitted to non-ED observation ultimately are discharged from inpatient status.)
Qualifying Episodes	All live ED discharges where the first-listed ED diagnosis does not result in admission over 90% of the time. <ul style="list-style-type: none"> • Program Limited Test Years (One-Two): A select group of episodes for a basket of targeted symptoms or diagnoses • Program Implementation Years (Three): All episodes of acute unscheduled care rolled into program
Post-discharge Events of Interest	In the 30 days following discharge home: <ul style="list-style-type: none"> • Return ED visits • Observation stays • Inpatient admission • Death
Patient Safety Metrics	Repeat ED visit, inpatient or observation stay within 7 days for: <ul style="list-style-type: none"> • Injuries • Adverse drug reaction • Post-ED procedure complications
Cost Metrics	Post-discharge costs for included services* within 30 days of the ED disposition decision
Waivers	Participating ED physicians become eligible to provide telehealth services, receive care coordination payments, and supervise postdischarge visits (non-home health)
Exclusions	Patient transfers, deaths in ED, hospice cases, Medicare beneficiaries with an inpatient admission 1-90 days prior to the index ED visit.

**Included services are defined in the BPCI Advanced program.*

American College of Emergency Physicians
Responses to PTAC
April 16, 2018

- 1. Why are the group A patients in ED observation who are discharged home and the group B patients in non-ED observation who are also discharged home in separate groups if both sets of patients were in observation and discharged home?**

This is a PFPMP that is focused on the disposition decision made by emergency physicians to whom the care/cost will be attributed for the episode of care. In the case of ED-observation cases, an ED provider is making the final disposition decision. When patients are discharged to non-ED observation or admitted to the hospital, the care is transferred to another physician who then is accountable for the final disposition decision.

Non-ED observation status is not dictated by the emergency physician. The hospital (through its utilization management function) makes the ultimate decision as to the use status (observation or inpatient) for patients that are discharged from the emergency department to these services. These decisions are often dependent on widely available standards to determine if the patient's condition meets the criteria for inpatient status.

- 2. Why are no quality metrics included in the 30-day post discharge period for group B?**

The group B patients have been discharged from the ED, and the new physician of record is now responsible for any further decision-making. As they are not participants in the model, the quality metrics that determine the eligibility for reconciliation payments do not apply to them.

ACEP would be open to aligning performance measurement related to this population if it would provide additional information to CMS to support future policy decisions or foster the development of complementary APM models that may be developed for hospitalists.

- 3. Will the model apply to patients in freestanding EDs?**

The model as currently envisioned is targeted at IPPS hospital on-campus emergency departments.

- 4. How does ACEP envision coordination of care by the risk bearing entity in the 30 day post-discharge period for both patient groups A and B (i.e., coordination with post-acute care services, primary care physicians, other)?**

The model includes a mandated physician-physician communication at the time of disposition of Group A patients from the ED to determine when follow-up will occur, to identify consultants who will assume care for the patient. For Group B patients, ED

physicians contact a hospitalist or other physician who assumes responsibility when the patient is placed into observation status.

5. Does the payment model have implications for the 3-day prior hospital stay requirement for the Medicare Part A skilled nursing facility benefit? Does ACEP envision use of a 3-day stay rule waiver as has been included in other APMs?

A request to waive the 3-day rule was not included in this proposal as the initial focus is on optimizing safe discharges to the home environment. We did not feel that a waiver of the 3-day stay rule would be required in order for this proposed model to be successful.

PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH THE
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)

Monday, March 5, 2018
2:00 p.m.

PRESENT:

TIMOTHY FERRIS, MD, MPH, PTAC Committee Member
LEN M. NICHOLS, PhD, PTAC Committee Member
JEFFREY BAILET, MD, PTAC Committee Member

SUSAN BOGASKY, Office of the Assistant Secretary for
Planning and Evaluation (ASPE)
MARY ELLEN STAHLMAN, ASPE

ANJALI JAIN, MD, Social & Scientific Systems, Inc. (SSS)

JEFFREY BETTINGER, MD, FACEP, Co-Chair, ACEP Alternative
Payment Model Task Force

JEFFREY DAVIS, Director, Regulatory Affairs, ACEP

DAVID MCKENZIE, CAE, Director of Reimbursement, ACEP

SUSAN NEDZA, MD, MBA, SVP, Clinical Outcomes, MPA
Healthcare Solutions

RANDY PILGRIM, MD, FACEP, Co-Chair, ACEP Alternative
Payment Model Task Force

MICHAEL PINE, MD, MBA, President, MBA Healthcare Solutions

LAURA WOOSTER, MPH, Public Affairs, ACEP

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

2 [2 : 01 p.m.]

3 DR. FERRIS: So Tim Ferris. I have the
4 honor of -- I don't know -- chairing this PRT, and
5 I'm an internist at Mass General and look forward
6 to the ACEP. It's a pleasure to meet you all. I
7 really enjoyed engaging with your proposal and look
8 forward to this conversation.

9 Do you want to go Len next?

10 DR. NICHOLS: Hi. I'm Len Nichols. I'm a
11 health economist, member of the PTAC, and looking
12 forward to this discussion.

13 DR. FERRIS: And Jeff?

14 DR. BAILET: And Jeff -- yeah. Jeff
15 Bailet, ENT surgeon, also looking forward to
16 today's discussion on the PTAC. Thank you.

17 DR. FERRIS: Susan, do you want to
18 introduce our team at -- with you?

19 MS. BOGASKY: Sure. My name is Susan
20 Bogasky. I am staffing the PRT on the ACEP
21 proposal. I am a senior health policy analyst at
22 ASPE and primarily work on Medicare payment policy
23 and reform.

24 MS. STAHLMAN: And also in ASPE, this is
25 Mary Ellen Stahlman. I'm here with Susan, and I'm

1 the staff director for PTAC. And Susan and I are
2 both in the Assistant Secretary for Planning and
3 Evaluation office.

4 So maybe the submitters could introduce
5 themselves.

6 DR. PILGRIM: Sure. Once again, this is
7 Dr. Randy Pilgrim. I'm an emergency physician and
8 chief medical officer with Schumacher Clinical
9 Partners, who has 300 emergency departments in 30
10 or so states. I am the co-chair of ACEP's National
11 APM Task Force along with Dr. Bettinger.

12 Jeff?

13 DR. BETTINGER: Good afternoon. Yes.
14 This is Dr. Jeff Bettinger. I am also an emergency
15 physician. I've been pretty deeply involved in
16 many reimbursement issues for the college over the
17 last 10 years, and like Randy said, I'm also co-
18 chair of this APM Task Force.

19 DR. NEDZA: And I'm Dr. Susan Nedza. I'm
20 a member of the Alternative Payment Model Task
21 Force at ACEP and former ACEP board member,
22 emergency physician, and I'm part of MPA Healthcare
23 Solutions, the group that has helped to develop and
24 so some of the research behind the scenes for this
25 particular proposal.

1 And I'm joined by Dr. Michael Pine.

2 DR. PINE: Michael Pine. I'm the
3 president and founder of MPA Healthcare Solutions,
4 cardiologist by training.

5 MS. WOOSTER: And this is Laura Wooster.
6 I'm the associate executive director for Public
7 Affairs. I oversee the Washington office for the
8 emergency physicians, and I'm joined by Jeffrey
9 Davis.

10 MR. DAVIS: I'm the director of Regulatory
11 Affairs at ACEP.

12 MR. MCKENZIE: And I'm David McKenzie.
13 I'm the reimbursement director for ACEP and staff
14 for the APM Task Force.

15 MS. BOGASKY: I just wanted to remind
16 everyone that this phone call is being transcribed
17 for the official PTAC record, and if you could
18 please introduce yourself when you're speaking for
19 the rest of the meeting.

20 Thank you so much.

21 DR. FERRIS: All right. So this is Tim
22 Ferris.

23 Susan, should I make some introductory
24 comments?

25 MS. BOGASKY: That sounds great, Tim.

1 Thank you.

2 DR. FERRIS: All right. Well, thank you
3 all. I want to thank you in a few different ways.
4 So, first of all, thank you for all the work you
5 have put into this. This is --

6 Did someone just join?

7 DR. JAIN: Hi. Yeah. It's Anjali from
8 SSS.

9 DR. FERRIS: Oh, great. All right.

10 So just so that the folks on the phone
11 know, SSS is a contractor that helps the PTAC and
12 the PRT keep all of our -- try to keep all of our
13 facts straight.

14 So where was I? I was welcoming you all
15 and extending my thanks to you for this submission.

16 This is hard work. If it wasn't hard
17 work, it would have been done a long time ago, and
18 we -- all of us on the PRT -- I think I can speak
19 for all of us in this case -- have a profound
20 respect for the challenges that come with both
21 conceptualizing but also communicating proposals in
22 this space and want -- and hope you will view this
23 as a conversation that is giving you an opportunity
24 to clarify a number of points and questions that we
25 had.

1 And we thought it would be much better to
2 do this through a conversation than back and forth
3 on paper because this is actually quite complicated stuff
4 to communicate, and oftentimes we find ourselves using the
5 same words but having a different reference for what that
6 word means or implies. And so this is really about
7 clarifying the details, and let me underscore the details
8 here because the concept of a bundled payment, either
9 through an episode or a sequence of events, is an old
10 concept, but the -- and I think a generally well-regarded
11 concept, not universally well regarded but generally well
12 regarded.

13 And then the challenge is obviously that the
14 details can -- things deep in the weeds can have really
15 profound implications for the success and/or fairness of a
16 particular proposal, and so if you've been paying attention
17 to our public deliberations, you will know that we get into
18 the weeds on these proposals. And that's what we'd like to
19 do on this phone call.

20 I'm going to propose -- and Susan and Mary Ellen
21 and my colleagues on the PRT, please chime in here -- a
22 process for this phone call. I'm going to suggest that you
23 provide us with an opening statement. It doesn't have to
24 be long or formal or anything like that, just the things
25 that you think you would like to communicate and emphasize

1 over the course of this call.

2 And then I would suggest we go sort of question
3 by question in the PRT summary, where we've tried to put
4 into words what we think your proposal is saying. We would
5 very much like it for you to correct us where we're wrong.
6 This is your opportunity to say, "No, that's not what we
7 intended." And then we would like to go question by
8 question.

9 And I just want to ask Susan or other members of
10 the PRT if -- would you like to make any amendments to that
11 proposal for how we proceed?

12 MS. BOGASKY: No. That sounds perfect. Thank
13 you.

14 DR. NICHOLS: I agree.

15 DR. FERRIS: Okay. So, with that, who will be
16 the spokesperson for the group on the phone?

17 DR. PILGRIM: Yes. So this is Dr. Randy Pilgrim.

18 We talked a little bit about that ahead of time.
19 On behalf of the group, I will lead or triage, if you will,
20 to the folks that worked on this. I guess I can say that,
21 being an emergency physician, right?

22 DR. FERRIS: I guess so.

23 DR. PILGRIM: So per your suggestion, Dr. Ferris,
24 I'm happy to do this.

25 So a quick introduction of the model, and then we

1 have in fact looked very carefully at your questions and
2 prepared some thoughts about them as well, a couple of
3 ideas, first of all, from us.

4 First of all, we love the idea of a conversation.
5 We're very much wired that way. We think things get better
6 that way, and so thank you for that approach.

7 Thank you also, while we're at it, for the
8 tremendous work that you as a group are doing. We respect
9 it. We get the communication that you just mentioned. I
10 thought that was incisive, not only coming up with the
11 model, backing it up with rigor, knowing details matter,
12 but also knowing that communication matters, so we're in on
13 that stuff.

14 We are today wanting to present a model that just
15 to call to mind for the many of them that you looked at --
16 this is a proposed model on behalf of the American College
17 of Emergency Physicians that is based on an episode
18 framework, aligns with other CMS and other APM models, as
19 you know. It does embrace the goals for -- that CMS has
20 for hospital readmission reduction programs and similar in
21 its design to support the safe discharge from an emergency
22 department for certain selected diagnostic conditions that
23 were based in evidence that we look back at, but also very
24 much based in our own experience. These are the patients
25 that we think would benefit from additional resources and

1 from additional focus and attention that this model
2 supports.

3 So out of these four initially selected
4 conditions, we think that -- which we will discuss I'm sure
5 -- that we do also think that we have a pathway for making
6 sure that patients are not harmed in the process of doing
7 this, and that there are reasonable monitors in place, some
8 of which are in development, but most of which we have a
9 pretty clear beat on. And, again, that's where our
10 conversation comes in very nicely.

11 We know that you're in -- about the business of
12 reviewing what you've learned from the comprehensive care
13 for joint replacement stuff and other evidence payment
14 models. So we think there's probably yet an opportunity
15 for us to make sure that we're aligned going forward, but
16 we think we're pretty clear about what could be the
17 benefit. So we're excited about getting as deep as we need
18 to, to make sure that we're clear and clean there and as
19 high levels we need to for the same reason.

20 DR. FERRIS: Great. Thank you.

21 So any thoughts from the PRT before we dive right
22 into the questions, then?

23 DR. NICHOLS: Dive in.

24 DR. FERRIS: Okay. So the questions, at least in
25 what I'm looking at, are not numbered. I'm going to assume

1 -- or I can first ask if I can assume that what is written
2 on page 1 of our summary and the top of page 2, up to the
3 first question, is -- do you guys consider to be accurate.
4 So let me stop there before the first question. Is that --
5 can I -- is that a fair statement?

6 DR. NEDZA: Randy, if I may?

7 DR. PILGRIM: Yes.

8 DR. NEDZA: It's Dr. Susan Nedza.

9 DR. PILGRIM: Go ahead, Sue.

10 DR. NEDZA: There was only one small area that
11 we'll clarify a little bit later when we talk about the
12 performance measures, and this is the bullet point -- it's
13 actually a bullet point after the language about adding
14 dual eligibles in year one --

15 DR. FERRIS: Yeah.

16 DR. NEDZA: -- or year three at the bottom of
17 page 1.

18 DR. FERRIS: Yeah.

19 DR. NEDZA: The idea of national benchmarks is
20 related to the patient safety measures, and we'll do some
21 clarification of that as we get further down into the
22 details of the model.

23 DR. FERRIS: Great. Thank you.

24 DR. PILGRIM: And that is an important
25 clarification, so we'll want to make sure we get to that.

1 But I think later is fine. Yes.

2 DR. FERRIS: Okay.

3 Great. So the first question is related to the
4 30-day episode definition for both cost and quality, and,
5 you know, one of the things, just to give you context -- I
6 expect you understand the context for this question, but
7 the things that we try to balance, which you may have heard
8 us talk about in our deliberations, is accuracy -- you
9 know, clinical accuracy, and often with that comes
10 complexity with some administrative -- being simple enough
11 to administer.

12 And we just wanted to ask what you were thinking
13 about with the 30-day -- with having -- I understand at
14 least from memory is that the episodes were not all the
15 same length. So do you want to comment on that?

16 DR. PILGRIM: Yeah. This is Dr. Pilgrim.

17 DR. BETTINGER: Yeah. Hi.

18 DR. PILGRIM: Jeff, I think that was your
19 comment, correct?

20 DR. BETTINGER: Yeah, yeah. I'll be happy to
21 answer. This is Dr. Jeff Bettinger.

22 Yeah. We are amenable, short answer, to
23 extending that 7-day post-discharge evaluation to a 30-day.
24 We originally did measure the post-discharge services that
25 were provided in the 8-to-30-day period, and we did that

1 more along the lines of calculations for quality scores.
2 But we recognize that it's reasonable to include the cost
3 of those events and setting the target prices.

4 We're amenable to the 30-day window. We would
5 ask that if that change is adopted that we have a bit of a
6 modification of a target price to benchmark calculation for
7 that admission stay, that it also include the post -- 30-
8 day post-discharge from the admitted status, either
9 admitted from the hospital or the non-ED observation
10 services to make it more of an apples-to-apples type of
11 comparison.

12 But short answer, yes, we're amenable to that 30-
13 day period. Does that answer your question?

14 DR. FERRIS: It certainly does for me. I always
15 prefer comparing apples to apples instead of oranges and
16 appreciate that you framed this in terms of a tradeoff, and
17 these are the kinds of tradeoffs that's very useful for us
18 to understand how you were thinking about this, so that's
19 very useful.

20 Len or Jeff, any further --

21 DR. NICHOLS: No.

22 DR. BAILET: No. I'm good, Tim.

23 DR. FERRIS: Okay. So then I'm going to keep
24 going and use the same format. So after the first
25 question, the bottom of page 2 and the very top of page 3,

1 can I assume that what we've written there is -- up to the
2 second question, that what we've written there is accurate?

3 DR. PILGRIM: This is Dr. Pilgrim.

4 You're talking in particular about the model
5 aiming to reward clinicians for reducing cost with better
6 outcomes, that particular paragraph, Tim; is that right?

7 DR. FERRIS: That's correct. Yes.

8 DR. PILGRIM: Yes. I think we are in agreement
9 with that, as stated, reducing a hospital inpatient
10 admissions or observation stays, reducing the ability of
11 physicians -- or enhancing, rather, the ability of
12 physicians to coordinate essentially post-discharge
13 services, and then avoiding post-ED patient safety events,
14 yes. That's accurately collected. Yes.

15 DR. FERRIS: Okay. So the next question then at
16 the top of page 3 is, does ACEP envision No. 1 or No. 2
17 above as the definition of qualified ED visit, which would
18 trigger the seven-day post-discharge episode for purposes
19 of spending.

20 DR. PILGRIM: Yeah. Dr. Nedza, you had primary
21 comments on that.

22 DR. NEDZA: Thank you, Randy.

23 So we would like to further define No. 2. We
24 agree that it wasn't quite clear in some of the things that
25 we've been submitting in writing.

1 But there's two different kind of observation
2 stays post-ED. The first is ED, ED observation stay,
3 discharge home, which we envision being part of the
4 definition of a qualified visit, and then we have the non-
5 ED observation stays that are not under the purview of the
6 emergency physician. And if you'd like, I can provide a
7 little bit more background in the thought process on that.

8 DR. FERRIS: Yeah. Well, I think working at a
9 hospital where my department of medicine has an obs unit
10 and my ED also has an obs unit and I would say which one
11 the patients go to is mostly a reflection of time of day or
12 random. I'd be interested in your thinking there.

13 DR. NEDZA: I think we were really focusing on --
14 the entire model seeks to reward the emergency physician
15 for making an appropriate discharge disposition that's safe
16 and using the potential waivers within the model to
17 increase the potential for discharge more patient safely.

18 And when we have patients that are in the ED
19 observation status, I think the most important one is
20 they're still under the management of that emergency
21 physician, who will be making the ultimate discharge,
22 physician decision, home. You know, it's really heavily
23 influenced by that physician, and it's -- we believe it's
24 appropriate because in the other instance, as you
25 mentioned, an internal medicine observation unit or

1 observation on a floor with hospitalists or some other
2 model, there's really a handoff involved in that.

3 And so this is an emergency medicine-focused
4 model. We believed it was appropriate and beneficial to
5 include the ED observation as a qualified stay.

6 I think the other reason that we've thought about
7 that is that this directs the emergency physician to
8 support appropriate range of therapeutic dispositions, so
9 things like optimal fit for their condition and
10 appropriately include the cost of service within the model.
11 So from a quality perspective, we're including the best
12 decision-making support prior to disposition, but at the
13 same time, from a cost perspective, we're attributing the
14 cost associated with that observation decision to the
15 emergency department.

16 When we think about cost, we recognize the
17 Medicare program will recognize some additional facility
18 savings potentially in professional services. It's not
19 going to be duplicative, as the emergency physicians will
20 only bill for the observation services and not observation
21 in an E&M code, since there's an inherent exclusion for
22 billing for both.

23 So, to summarize, we believe it fits with our
24 goal of a conceptual model of a decision model. It
25 captures all of the costs within an emergency department

1 and the quality of the care determined by the emergency
2 physicians who are really the ones who are going to be both
3 at risk in this model and will be charged with ensuring the
4 dispositions are safe.

5 PARTICIPANT: Yeah. Tim?

6 DR. FERRIS: Yeah. So I guess I have two follow-
7 up questions. One is you spoke about the handoff. I guess
8 certainly in my institution, the ED docs who are in the ED
9 obs unit are different, at least on a shift-by-shift basis
10 from the docs in the ED, and so there is still a handoff
11 that occurs.

12 And that leads to the second question, which is
13 departmental distinctions in the care of patients can be
14 somewhat arbitrary, as we just described, and so from a
15 patient care point of view, are we -- are we potentially
16 making a lot of patients ineligible for this because a
17 hospital happens to have more patients go to a floor obs?
18 Like some hospitals don't even have a specific obs unit
19 that's managed by the ED.

20 So I guess I'm -- I'd encourage you to put on the
21 hat of a sort of the CMS administrator, if you could
22 possibly do that, but I know that's a scary prospect.

23 DR. PILGRIM: Yeah.

24 DR. NEDZA: So I used to be a CMS medical
25 officer, so I can kind of get there.

1 DR. FERRIS: Okay.

2 DR. PILGRIM: Yeah.

3 DR. FERRIS: And think do you really want to
4 exclude people based on, you know, departmental
5 affiliations?

6 DR. NEDZA: Yeah. I think that --

7 DR. PILGRIM: This is Dr. Pilgrim. I think --

8 DR. NEDZA: Yes. Go ahead, Randy.

9 DR. PILGRIM: Let me weigh in quickly on that.
10 So this is great. This is a good discussion, and the
11 reason for this call, amongst others, we actually see it as
12 a way of including additional options for hospitals that do
13 have emergency department observation. And in our
14 experience, that's still a minority of institutions that
15 actually have ED observation, but where they did, we wanted
16 to be able to include that as an option for the emergency
17 physician to make that call or to use, as you mentioned, an
18 internal medicine-staffed and -run obs unit or others in
19 the hospital that may be available.

20 In short, saying this sort of in the negative, we
21 didn't want to -- we didn't want to put an emergency
22 physician at odds. We wanted to make sure that they had
23 every option available to them, even at their own
24 potentially financial peril because, as Sue properly said,
25 in a large majority of the cases, if I am in Level 4 or

1 Level 5 for a patient within a specified time period, I
2 cannot also bill and expect to collect an observation code.

3 But sometimes that's the best thing for the
4 patient because, as we know, we have patients that say,
5 "Look, if you think I'm just going to be here for three or
6 four hours to get ruled out or to allow for therapeutic
7 effect or things like that, can't I just stay here?"
8 Amazingly, that is uttered relatively frequently. So that
9 gives the physician an option to deal with the patient in a
10 way that they may prefer if, in fact, it's therapeutically
11 and practically okay.

12 So we actually saw it as expanding the options
13 without necessarily excluding any of them or directing --
14 overly directing the geography, as you say, of the care
15 itself to one specified unit.

16 Sue, I'm sorry. You were going to say something
17 also?

18 DR. NEDZA: And on a practical level, we built
19 the attribution in the model to -- where the decision goes
20 to the last emergency physician that touches the patient,
21 just as we hand off patients between an ED, E&M service and
22 an obs visit, we often do it between shifts, and therefore,
23 it's the last emergency department physician who -- in the
24 line who is going to be charged with looking at the results
25 of the shared decision-making, looking at the risk

1 assessment of a patient, checking their clinical status,
2 and determining whether the discharge is safe or not to be
3 the one who that decision is attributed to.

4 So by including ED obs, it allows us to, as Dr.
5 Pilgrim mentioned, take advantage of those extra
6 therapeutic opportunities and time-based opportunities for
7 a patient as opposed to the other kind of either inpatient
8 in an obs unit or on the floor, where that final decision
9 about home or not is in the hands of someone who the model
10 isn't targeting.

11 DR. FERRIS: Well --

12 DR. PILGRIM: I think you --

13 DR. FERRIS: Yep.

14 DR. PILGRIM: Dr. Pilgrim.

15 I'll finally say you are correct, though, in
16 times that the number of handoffs may not be always
17 different. It just might be, depending on the time frame.

18 DR. BAILET: So, Tim, this is Jeff. Can I ask a
19 question?

20 DR. FERRIS: Yeah, go ahead.

21 DR. BAILET: Yeah. So I guess I'm not clear.

22 The ER physician makes a decision that the patient is
23 eligible for observation. They move them to an observation
24 unit, which may or may not be under the auspices of the ER,
25 whether it's that doctor or a different ER team. Does that

1 still count if it's the hospitalist or an internal medicine
2 group that's looking after that person in the obs unit?

3 DR. BETTINGER: Jeff, this is Jeff Bettinger.

4 No. We're saying basically that we would not
5 like that to count because the person who's making that
6 decision to send the patient home --

7 DR. BAILET: Right.

8 DR. BETTINGER: -- and is going to be responsible
9 for all of these events --

10 DR. BAILET: Yeah.

11 DR. BETTINGER: -- we want it to be the emergency
12 physician, so --

13 DR. BAILET: Right. So that's my -- so if that
14 is in fact the case, then when you look at what's happening
15 on the ground, I would say more times than not, those
16 observation units are staffed by others, not the emergency
17 medicine teams. Is that a fair statement? Because I
18 believe that's what someone said, but I just want to
19 confirm that's been my experience.

20 DR. PILGRIM: This is Dr. Pilgrim.

21 That's what I said, and yes, I think that --

22 DR. BAILET: Okay.

23 DR. PILGRIM: -- has been really our experience.
24 Yes.

25 DR. BAILET: So from a practical standpoint on

1 implementing something like this, how do you -- because
2 observation is a huge volume of patients. How do you get
3 around that if you have to carve out? I'm just thinking,
4 as Tim was saying, from a CMS administrative standpoint.
5 How do you carve out that flow? I'm just trying to
6 mechanically think this through. Do you guys have a point
7 of view on that?

8 DR. NEDZA: Yes. On the claims, we -- when we
9 did the initial analysis, we looked at observation services
10 that were provided in Location 23, which is the emergency
11 department, and if the NPI for the providing -- who is
12 related to the Part B claim for the provision of services
13 is an emergency medicine physician was our way of finding
14 an administrative model for differentiating this.

15 This is a model that others have used in studies
16 regarding ED observation versus non-ED observation. So we
17 adopted the methodology they've used from prior studies
18 related to these services.

19 DR. BAILET: Okay.

20 DR. FERRIS: And do you have a sense of how --
21 this is Tim. Do you have a sense of what proportion of all
22 ED patients who would have been eligible for the model
23 would subsequently be ineligible because they went to a non
24 -- because they were discharged by a non-ED doctor?

25 DR. NEDZA: So I think we -- one of the things I

1 need to -- what we proposed to do was to roll those
2 patients as if admitted patients. So they're still within
3 the model, and the cost associated with their care is.
4 Generally, that decision --

5 DR. FERRIS: Ah, okay.

6 DR. NEDZA: Yeah. So, see, we're not losing
7 them. They're just being attributed as a handoff to a
8 colleague, if you will, on the inpatient side or in the --

9 DR. PILGRIM: Right.

10 DR. NEDZA: -- in the outpatient observation
11 side, so that we don't lose them, because in fact, there --
12 some of those patients -- and this is one of the conundrums
13 we had -- then get -- depending on what their outcome is,
14 their observations from testing -- get moved into an
15 inpatient stay. So this facilitated and I think made it a
16 little bit easier to manage those patients that emergency
17 departments hand off -- hand off to observation who then
18 become inpatients.

19 So all those people are still in the model, and
20 they're in the arm of -- we talk about the target pricing.
21 They're in that group that we would be looking at as
22 potentially those instances where with ED observation and
23 the various things available and the care coordination
24 waivers, we could move the needle on some of those patients
25 set up on that inpatient obs side or the other obs unit

1 side to the ED discharge side.

2 DR. FERRIS: I get it. That's a really important
3 clarification. I misunderstood. I thought they would be
4 excluded from the model, but you're just switching the
5 category that they would be in, in the model.

6 DR. NEDZA: Correct.

7 DR. PILGRIM: That is correct.

8 DR. NEDZA: We think it's also better for the
9 patients. I mean, we've thought of -- there are a lot of
10 issues, as you know, related to patients not knowing what
11 status they're in, finding out they were really in
12 outpatient status and not an inpatient getting Part B
13 claims and not having the services covered and all of those
14 things the agency has been trying to rectify and to help
15 identify.

16 And we believe this model, as Randy said, is more
17 patient-centric, first of all, because you're not moving
18 them. You don't have a handoff. You might move them into
19 an ED obs unit.

20 But in addition to that, it feels like it's the
21 same stay and gives you the opportunity. As Randy said,
22 maybe they do want to go home in three hours, or as we've
23 often found, they're the caretaker for another Medicare
24 beneficiary, and the idea of being admitted to the hospital
25 is very problematic. So the patient-focused -- I guess, if

1 you will, the emphasis here by trying to optimize ED
2 observation, it will benefit the beneficiaries.

3 DR. FERRIS: This is a great discussion. I
4 realize we're halfway through the hour here, and we're
5 going to have to keep moving because we have some big
6 questions. So anything further on this?

7 [No response.]

8 DR. FERRIS: Great. Very helpful.

9 So the next question is this is a biggie, and I
10 imagine you spent some time. So this is about the quality
11 measures. So we would like to -- we'd love to hear your
12 thoughts about our question here.

13 DR. PILGRIM: Yeah. We did -- this is Dr.
14 Pilgrim.

15 We did spend a lot of time in responding to this,
16 and it's important that we communicate to you why we did
17 what we did, where we are, and where we think we might go.

18 So, Dr. Nedza, do you want to lead us through
19 that?

20 DR. NEDZA: Yeah. I think we've certainly
21 realized that when we were building the model or when we're
22 approaching any of the macro-related programs, there are
23 not currently emergency department outcome measures
24 available.

25 And specifically, in this post-discharge space,

1 it really is new. Even in the environmental scan, we
2 weren't able to really find a lot of research in the area,
3 and so we know CMS is -- noticed this, and we also know
4 that the ED has been identified as part of their most
5 recent proposal that came out, the task orders related to
6 performance measures for MACRA. So we're anticipating
7 there will be the development of some metrics in that area.

8 We looked at one, proxies that are already
9 available, and I think we commented on those in the
10 questions -- the responses we submitted at the beginning of
11 January, including the potential to use excess days, an
12 acute care metric for each of these four conditions. I
13 won't go into that now.

14 But in -- we recognize that over the next -- by
15 the time this model would be either put in place for
16 testing or adoption, there would be a need to have more
17 rigorous quality metrics available and tested for inclusion
18 in the model.

19 So we're -- as a -- in the interim, what we've
20 done is we've got a proposed methodology. We'll forward it
21 to you later because, as you said, this is a very complex
22 area that allows for a composite quality score that's
23 similar to what was put in place initially in CJR, where we
24 have three components, the first being a patient engagement
25 experience measure, about -- just from the claims, percent

1 of eligible cases with -- shared decision-making took
2 place. That's part of the model that was included in our
3 last set of comments.

4 The second is a process metric, which includes
5 what was the percent of eligible cases in which the shared
6 decision-making assessment was completed. So we know the
7 shortcoming is the process measures, but it's an important
8 place to start. And in conversations with our colleagues
9 who have published extensively in this area, it is not
10 something that's routinely done in emergency departments,
11 in spite of the fact that there are validated tools.

12 And then the third area, what we've built and
13 we'll share with you is a model where we had developed the
14 concept of a clean trip. So, in other words, for each one
15 of these four targeted conditions, at every facility
16 there's a historical performance related to the 30 days
17 post-discharge in which the patients -- we're targeting the
18 rate where patients did not die, did not come back to the
19 emergency department, and were not admitted. So there's
20 probably other terms that we could use here. We've termed
21 it a clean trip, but it's really a period of time -- it's
22 for each patient where there was no post-discharge event of
23 interest occurs.

24 And the model that we've put in place or are
25 proposing include setting up targets for those -- for that

1 particular rate at the institution level. So, again, if
2 you've got chest pain and you have a historical performance
3 of 25 percent of those patients, only 25 percent of those
4 patients avoiding any of those post-discharge events,
5 there's room for improvement there. So it becomes our
6 ability to -- the formula itself would be set so that you
7 can reward additional cases or improvement in that
8 particular measure.

9 And then the three of the metrics will then roll
10 up like they do in some of the other programs, to the
11 acceptable, unacceptable, good, and excellent levels, and
12 those will all affect the discount rate, the 3 percent
13 discount rate that we've often -- that you've often put in
14 place in multiple, different programs.

15 I'm a little reticent to go further into the
16 methodology on the phone. I'd prefer to just leave --
17 would be happy to send it to you for your review because
18 we've done extensive work in the area that you did not have
19 access to prior to this.

20 DR. FERRIS: That is terrific, and I agree with
21 you that the time on the phone is best used to talk about
22 it and really appreciate all the work that you've put into
23 this.

24 I want to ask if my colleagues, including Susan
25 and Mary Ellen, have anything that -- if you have any

1 questions that you would like to ask about the plan for the
2 quality measures.

3 DR. NICHOLS: So, Tim, this is Len.

4 I would just make sure we make clear that we
5 would like to see this written explanation that you all
6 have worked on since the proposal because I think that
7 would help us.

8 DR. NEDZA: Yeah. We'll be happy to send it over
9 later today or tomorrow with an extensive description of
10 the methodology as well as the data that we use to set up
11 what we believe are the appropriate targets.

12 DR. NICHOLS: Great. Thanks.

13 DR. BAILET: That would be helpful. Thank you.

14 DR. FERRIS: Yeah. Terrific.

15 And is it safe to say that you would envision --
16 because there hasn't -- the research on this hasn't been
17 done, that like other models implemented by CMS, where they
18 didn't have sort of the final answer on the quality measure
19 when they rolled it out, that the -- you know, the initial
20 year or year-plus would be a submission, just submit the
21 data and analyze the data, and that the -- and that it
22 would be -- the modification of anything would be based on
23 data submission, and that further down the road, usually in
24 year two, once benchmarks were established, then the full
25 weight of the measures would be more directly implemented?

1 Is that a fair summary of how one -- how you would see it
2 implemented?

3 DR. PILGRIM: Yeah. This is Dr. Pilgrim.

4 DR. NEDZA: Yeah. We originally -- go ahead,
5 Randy.

6 DR. PILGRIM: I'm sorry, Sue.

7 Yeah. We actually -- that's one of the reasons
8 we wanted to have a conversation, without delaying things,
9 because we did think about that as well. We don't like to
10 kick too many cans down the road, but this was really a key
11 conversation because that is, in fact, what we were
12 thinking about proposing.

13 But with that said, there was enough reason to
14 think that we had independently enough data and rigor
15 behind it that we could get a pretty good idea of what
16 success might look like.

17 So with the three measures that Sue just
18 described verbally and which we'll send to you, we did
19 absolutely think about that, that method that you
20 mentioned, the year one, year two, year three method.

21 Dr. Nedza, you were going to say something also?

22 DR. NEDZA: Yeah. I think that part was part of
23 our reasoning for not having -- there are groups that would
24 potentially be interested in diving right in who may be
25 more sophisticated and have data and feel that they can do

1 this, implement the -- again, the care redesign piece more
2 quickly than others, and they may be willing to take risks
3 sooner.

4 So one of the other things that we've thought
5 about that we certainly would appreciate feedback on or
6 open to is, for those that don't take risk, having it be a
7 submission model, and for those that want to begin taking
8 risk early, having a -- accelerating that pathway, if you
9 will.

10 DR. FERRIS: Sure. So having multiple paths,
11 great, which there's certainly other models that have shown
12 -- or have chosen to have alternatives at the outset and t
13 hen narrowing those alternatives over time.

14 DR. NEDZA: And certainly putting a time limit on
15 it based on I think what's been learned in the ACO
16 programs, where there's an understanding that you will move
17 to take risk in as rapid a model as possible.

18 DR. FERRIS: Yeah.

19 DR. PINE: I believe -- this is Michael Pine.

20 I believe there are also two issues here. One is
21 the maturity of the measure, and that will probably move
22 more rapidly than the second, which is the risk adjustment.
23 And until you have methods of risk adjustment which have
24 national recognition because even when you're publishing
25 methods of risk adjustment in peer-reviewed journals, my

1 sense is CMS likes to see them vetted and approved
2 nationally.

3 But until you have accepted risk adjustment, you
4 have to be exceedingly careful that you're not penalizing
5 people because their poorer performance is really due to a
6 more difficult case mix.

7 So when we set these standards and built these
8 measures, we tried to be very careful not to end up
9 penalizing places that have more difficult patients because
10 there really is no risk adjustment built into this.

11 So I would see two steps, first, getting the
12 measures perfected, and then secondly, getting risk
13 adjustment, which will allow us to take out some of the
14 funny little pieces we put in to protect institutions that
15 have on a case mix have this initial break-in point.

16 DR. FERRIS: Great. Thank you.

17 So I would propose that we move to the next
18 topic, which is also a big topic and as time winds down,
19 and you can see from our question here that we were really
20 unclear about the payment methodology. And so I'm going to
21 just open -- turn it back over to you and ask you to take
22 us through what you're thinking here.

23 DR. PILGRIM: Yeah. Dr. Nedza, do you want to --
24 we can probably give you the short answer and then the
25 expansive answer. Sue, do you want to have at that?

1 DR. NEDZA: Yeah. The payment methodology really
2 is a bundled payment with a retrospective reconciliation.
3 I think because we were thinking in terms of the Medicare
4 readmission reduction program, I think some of the language
5 became less clear. And we interchanged terms, and I
6 apologize for that. But this really is in alignment with
7 the language that's been determined for BPCI Advanced and
8 around triggering episode, and the methodology for the
9 reconciliation payments is in alignment with those new
10 models that have been released since we did this original
11 application.

12 DR. FERRIS: Great. That's actually very
13 helpful, and don't -- no need to apologize around the
14 language. I will tell you this is -- this is tricky stuff,
15 and as I said at the outset, there is -- there is yet to be
16 sort of a standardization of the lexicon around these
17 alternative payment methodologies.

18 So I guess I would ask, do you have that more
19 detailed answer, the longer answer --

20 DR. NEDZA: Mm-hmm.

21 DR. FERRIS: -- available in written form?

22 DR. NEDZA: Yes. Yes, we do.

23 DR. BAILET: Okay, great.

24 And so I then ask my colleagues, should we keep
25 going, or do you want to linger over this target a little

1 longer?

2 DR. NICHOLS: No. I'm salivating over reading
3 the details, and I love the fact that things are becoming
4 more clear to you and us at the same time. That makes me
5 feel very good.

6 DR. NEDZA: Yeah. Well, we -- well, the
7 questions were quite insightful as we've gone through the
8 process, and we -- I think you've helped us sharpen our
9 thinking as well as our desire to make sure that things are
10 in alignment.

11 DR. FERRIS: Great.

12 So I'm going to move on to the next question,
13 then, which is -- this is at the bottom of page 3: Please
14 clarify whether this is solely IP or IP-plus observation
15 that's included in Figure 3. This should be a simple one.

16 DR. NEDZA: Right. So it's both, based on our
17 earlier conversation. So we've -- so it's inpatient plus
18 non-ED obs.

19 DR. FERRIS: Yeah.

20 DR. NEDZA: And we'll -- we're going to submit a
21 modified version of Figure 3 to you.

22 DR. NICHOLS: Yeah. That's helpful. Thank you.

23 DR. FERRIS: That's great, and you're right. It
24 does go back to the prior question. That was actually
25 probably the source of our confusion about that.

1 So I'm now going -- this -- we're picking up
2 speed here. So the next question, this gets into how the
3 quality measure is actually used in the payment model. So
4 this is on sort of the upper section of page 4. Do you
5 want to respond? I don't want to read the whole question
6 because it's a long question. Do you want to respond to
7 that?

8 DR. NEDZA: This is the part that started with
9 potential shared savings. My numbers are off because I had
10 some of our answers, but the question is the quality
11 standards to be defined as met? Is that the one we're --

12 DR. FERRIS: Yes. Correct.

13 DR. NEDZA: Yeah. So the first instance is a
14 correct one. If the post-discharge period -- again, if
15 we're going to extend it to 30 days post-discharge for both
16 cost and quality, you'll want to include the expenditures
17 in the 30-day post-inpatient stay as well in the target
18 price calculation.

19 And if there is not an acceptable quality score,
20 like in some of the other models, there would be no
21 eligibility for reconciliation payment, so similar to BPCI
22 Advanced or CJR or the recently withdrawn, our EPM models,
23 if you don't hit the baseline quality target, you're not
24 eligible, but you still would have the 3 percent reduction.

25 DR. PILGRIM: Yeah.

1 DR. FERRIS: That's very helpful.

2 Jeff and Len, further on this question?

3 DR. NICHOLS: Good to go.

4 DR. BAILET: Yep.

5 DR. FERRIS: Okay. So for the one-sided risk --

6 so the question was related to previous questions about

7 payment. How does ACEP envision upside risk in year one

8 and two? Would upside risk remain constant or change in

9 year three with the introduction of downside risk?

10 This gets into like symmetry and things, fun

11 things like that.

12 DR. NEDZA: Right. So maybe if we can answer

13 both at the same time --

14 DR. FERRIS: Yeah.

15 DR. NEDZA: -- both of them, one-sided risk and

16 two-sided risk. As our thinking has evolved and as the

17 models have evolved, we've had feedback from members and

18 groups -- and I'll defer to Jeff and Randy if they'd like

19 to comment on this. People want to participate in risk

20 bearing, so downsized risk, earlier. When we originally

21 put this in place, I think it was before a lot of people

22 understood what an APM model looked like, and there's been

23 more comfort with it as we've moved forward.

24 So what we've proposed is to -- or we'd like to

25 amend our proposal, and we'll send this to you -- that

1 after -- that there may be a different model. So for the
2 first year, having the opportunity for some groups to take
3 only upside risk, but others to be able to assume downside
4 risk, and then in the first year, again, we're testing
5 these four conditions -- abdominal pain, chest pain,
6 syncope, and altered mental status -- and maybe potentially
7 changing the -- making the stop loss for that first year 10
8 percent as opposed to 20 percent, which seems to be more in
9 alignment with the newer models. And then we've talked
10 about the quality for those.

11 And then what would happen, there would be the
12 second group, where if someone chose to -- in the first
13 year, they could take downside risk, and at that point,
14 they would be -- it would be a potential 20/20; upside,
15 downside; stop loss, stop gain.

16 And then in years two through five is when we
17 anticipated-- you know, we'll have learned a lot in the
18 first year, moving to include other diagnoses and other
19 conditions into the model as well as the dual eligible
20 population, the idea being in order to get to the point
21 where we -- our members would qualify for an advanced APM,
22 we want to be able to increase the amount of participation.
23 And that's going to require more of our cases to be
24 included. It also makes it more amenable to some of the
25 private payers, who are interested in the model for

1 multiple reasons, and with the addition of the private
2 Medicare Advantage plans or the private fee-for-service
3 models, moving towards all conditions being included seems
4 to be -- that's something everyone is interested in doing.

5 DR. FERRIS: That's great, and I know you have
6 more detail that you will provide.

7 And I think that also covers the next question as
8 well on the two-sided risk. So let me just pause there and
9 ask my colleagues if there are any more questions about
10 this one.

11 DR. NICHOLS: So, Tim, I did have one here, and
12 I'll try to be brief. But I just want to be clear.

13 As I understood it, it sort of sounded like you
14 all were open to having people come in with different
15 downside risk at different times. Did I hear that
16 correctly?

17 DR. NEDZA: Right. So I think the difference
18 would be for --

19 DR. PILGRIM: Yes.

20 DR. NEDZA: -- for people that didn't want to
21 take risk, a downside risk, they would have a lower level
22 of upside risk.

23 DR. NICHOLS: Okay. I just want to --

24 DR. PILGRIM: Yes. We're open to that.

25 DR. NICHOLS: We interact with folks who just

1 like to know the rules over there at CMS, so we have to be
2 very clear. Thank you.

3 DR. BAILET: So is that -- just one quick -- so
4 is that in perpetuity then if they don't want to take
5 downside risk, they can stay in the model with a limited
6 upside? Is that right?

7 DR. NEDZA: No. We didn't believe that was
8 appropriate based on I think what's --

9 DR. BAILET: Okay.

10 DR. NEDZA: -- been some of the experience at
11 MSSP, right? You know, you're going to have to move into
12 the --

13 DR. BAILET: Right.

14 DR. NEDZA: Take a risk.

15 DR. BAILET: Okay.

16 DR. FERRIS: This was just different speeds,
17 different speeds. That's all --

18 DR. BAILET: But they all ultimately will be in a
19 downside environment at some point?

20 DR. NEDZA: Yes.

21 Randy, maybe you can talk -- we don't have a lot
22 of time here, but we'll submit something about just ED
23 groups come in all kinds of different shapes and sizes, and
24 some will be -- have the infrastructure and the ability to
25 move more quickly. And this gives us more -- we believe

1 we'll have more voluntary participation by this more
2 flexible model.

3 DR. PILGRIM: Yeah. This is Dr. Pilgrim again.

4 The conversation nature of this is important here
5 to us because we do think that patients will benefit from
6 this. We do think that Medicare overall will benefit from
7 this, and we do think it's important to change the paradigm
8 in which we are currently practicing.

9 So what we wanted to do was develop a system that
10 had options so that adoption initially was optimized or
11 more likely to be so.

12 The conversation that we probably need to have is
13 whether or not we absolutely must target everybody that
14 starts at whatever pace or risk level to ultimately bear
15 risk.

16 So Dr. Nedza is correct. Our general sense is we
17 ought to learn from what CMS has already learned from
18 there. You can help us there, but we are open to options
19 as well because, again, we think that patients are going to
20 benefit from this, and that overall broader adoption may be
21 a laudable goal than high levels of risk.

22 DR. FERRIS: Great. I think that's very helpful.

23 And I might suggest -- I have to be careful here.
24 Your approach of providing a specific proposal, as specific
25 as possible, but also at the same time suggesting that

1 where there is -- where there's room for modification
2 through an administrative process at CMS, for example, to
3 meet their need, that combination is most useful to us.

4 DR. PILGRIM: Great.

5 DR. FERRIS: The specifics allow us to see what
6 it is you intend, and that is the basis for our assessment.
7 I think I stated that without violating any of the rules.

8 DR. PILGRIM: This is Dr. Pilgrim again.

9 That is actually very helpful, and we can do
10 exactly that because I think by doing so, first of all, I
11 think it will produce ultimately the best impact for the
12 entire intention of the program. So what we will submit to
13 you very shortly after this call will incorporate those
14 kinds of things and those thoughts in the context, so thank
15 you.

16 DR. FERRIS: Great. So I'm going to take the
17 Chair's prerogative here and say that the next two
18 questions seem like practically yes-or-no questions, and
19 I'll expect to hear those, to get those in writing.

20 We did have a concern that we wanted to raise,
21 and this is actually the most clinical of all of our
22 questions. And in thinking about the inclusion of altered
23 mental status, we were -- I guess I would say on one hand,
24 altered mental status has so many different causes that
25 there's plenty of room for variability. But it also is a

1 somewhat concerning diagnosis, and we just wanted to
2 understand the source of your confidence that including
3 this was not going to lead to adverse patient outcomes.

4 DR. PILGRIM: This is Dr. Pilgrim. I'll take a
5 first stab at this. Dr. Bettinger and others, please chime
6 in.

7 DR. BETTINGER: Sure.

8 DR. PILGRIM: First of all, given -- we are
9 fairly confident that this will happen, that this will not
10 lead to an unusual amount of adverse outcomes.

11 You are correct that altered mental status being
12 heterogeneous in its origins as well as its dispositions is
13 a very broad category. We actually think that's the beauty
14 of this model, is that it allows a fair amount of options
15 for patients who are to be discharged and a pretty good
16 onus on the physician to be doing a safety discharge
17 assessment, so that we think this will be an opportunity so
18 that these kinds of diagnoses and all the contributing
19 factors will be taken more seriously rather than less
20 seriously.

21 We do not think that there will be an untoward
22 opportunity for patients to be denied or directed away from
23 hospitalization, but in fact, we think that there will be a
24 more accurate disposition and a more therapeutic one,
25 whether that be hospitalization as an inpatient

1 observation, ED observation, or discharge.

2 So the shortest answer I can think of is we think
3 that's going to be better for this group, even given its
4 heterogeneous presentation and disposition nature.

5 Jeff?

6 DR. BETTINGER: Yeah, yeah. I would agree with
7 that. I think this is right in our wheelhouse. As
8 emergency physicians, we deal with this heterogeneity, a
9 polymorphic type of presentation all the time, and even in
10 the other diagnoses that are in our model, chest pain,
11 abdominal pain, this happens frequently. And clinically,
12 we usually work backwards from the worst possible scenario
13 and eliminate that clinically until we arrive at a more
14 comfort level.

15 So it may sound outwardly that altered mental
16 status may be more confusing to us. Actually, it's right
17 within the comfort level that we have clinically,
18 practicing emergency medicine.

19 DR. NEDZA: And on a practical level, this was
20 built using the MDCs, and we've picked a subset of
21 diagnoses that would be included. Altered mental status is
22 the label we've given it, but it wouldn't necessarily be
23 all.

24 We've put in place an exclusion for any diagnosis
25 with the national rate. It's over 90 percent for

1 admission. So if the standard of care at this point is
2 admit, we didn't want to -- didn't want to encourage people
3 not to admit those patients or include them into the model.

4 And the other thing that drove us was there was
5 an article that came out by Obermeyer and another group
6 that looked at what's actually happening with these
7 patients within seven days, and the altered mental status
8 group, it had a rather significant death rate. And so we
9 included this one specifically because of that particular
10 article that we reviewed and that the research that they
11 had because we felt that our colleagues could benefit again
12 for the model to impact this particular group of patients.

13 There's others as well that we've identified in
14 the initial workup that you think might be really high
15 risk, but that's part of the reason we've included them.

16 DR. FERRIS: That's great.

17 I realize we're at time now. I want to -- gee, I
18 have just another minute. I want to ask my colleagues if
19 they have further questions.

20 DR. BAILET: I don't have any further questions,
21 Tim. I just want to compliment the sophistication and the
22 discipline that you guys have applied in creating this
23 proposal and your incredibly thoughtful responses. It's a
24 pleasure talking with you guys today and look forward to
25 reviewing the information that you're going to forward on

1 after the call, so thank you for that.

2 DR. NICHOLS: Ditto. And I'd say this is among
3 the more productive one hours I've spent in quite some
4 time.

5 DR. FERRIS: Well, you're going to -- so I'll
6 just make it unanimous, then, from the Chair's perspective.
7 It's really a pleasure talking to you when you are so well
8 informed and so committed, so we applaud both of those
9 characteristics and very much look forward to working with
10 you as this makes its way through the PTAC process. So
11 thank you very much to all of you.

12 DR. PILGRIM: On behalf of all of us --

13 DR. NEDZA: Well, thanks to all --

14 DR. PILGRIM: -- thank you very kindly.

15 DR. PINE: And thank you so much.

16 DR. FERRIS: Thank you too.

17 DR. BETTINGER: Thanks, guys.

18 DR. FERRIS: Okay.

19 DR. BAILET: Bye, now.

20 DR. FERRIS: Bye.

21 DR. NEDZA: Bye.

22 [Whereupon, at 3:02 p.m., the conference call
23 concluded.]

24

25

