

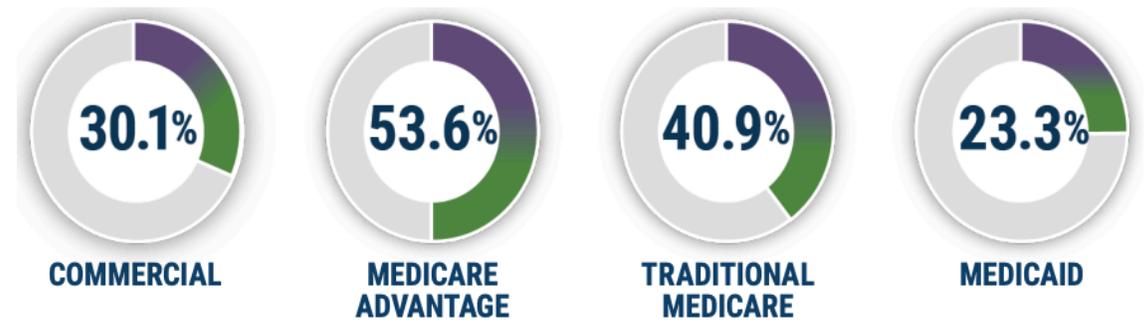


# Exploring the Acute Unscheduled Care Model

# Healthcare Focused on “Value Over Volume” and Patient-Centric Care

- Our healthcare system is moving towards greater coordination and integration of services and systems to **optimize resource utilization, improve quality, reduce overall costs**, and **align provider incentives**
- Innovative payment and care-delivery efforts within **Medicare** (federally operated), **Medicaid** (state-based), and **commercial markets** signify payors, policymakers and other healthcare stakeholder's commitment to fostering a system that values quality and efficient patient-centric care

- Payors are making a **concerted effort to invest in value-based models**



Percent of payments flowing through shared accountability models

# Broad Theoretical Support But Disagreement Over Healthcare System Reform Strategy



Physicians and employers/consumers agree a complete **restructuring of our healthcare system** is needed to encourage uptake of innovative payment and delivery models



Payors are very **optimistic about the future of value-based arrangements** and their capacity to lower healthcare costs and improve quality



Physician and employer groups are **split over who is responsible** for driving reform contributing to delayed system progress.

# Medicare's QPP Program Promotes Physician-Focused Healthcare Reform

**APMs:** CMS defines an APM as the rules and structures outlining the payments made to physicians and other clinicians that incentivize delivering high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Examples of APMs include accountable care organizations (ACOs), medical homes, and bundled payment models

## MACRA-defined APM

MACRA defines an APM as any payment model being tested by CMMI or demonstration required by federal law as well as the Medicare Shared Savings Program (the national ACO program)

## MACRA-defined AAPM

Advanced APMs are subset of all MACRA-defined APMs that include additional requirements, such as having a nominal amount of financial risk

**Other Payor-defined APM:** The term “APMs” can also refer to payment models sponsored by payors other than CMS such as commercial insurers or state Medicaid agencies

# Few Opportunities for EM Physicians to Directly Participate in CMS' MACRA-defined APMs

## Barriers to EM participation in healthcare reform include:

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### Misaligned Incentives

Most APMs have structured incentives that exclude initial care provided in the ED or designed with the explicit goal of avoiding all ED visits

### Regulatory and Payor Clarity

Lack of tactical directions for implementation, frequent changes to policies and absence of unifying goals creates uncertainty and confusion among stakeholders interested in pursuing APMs

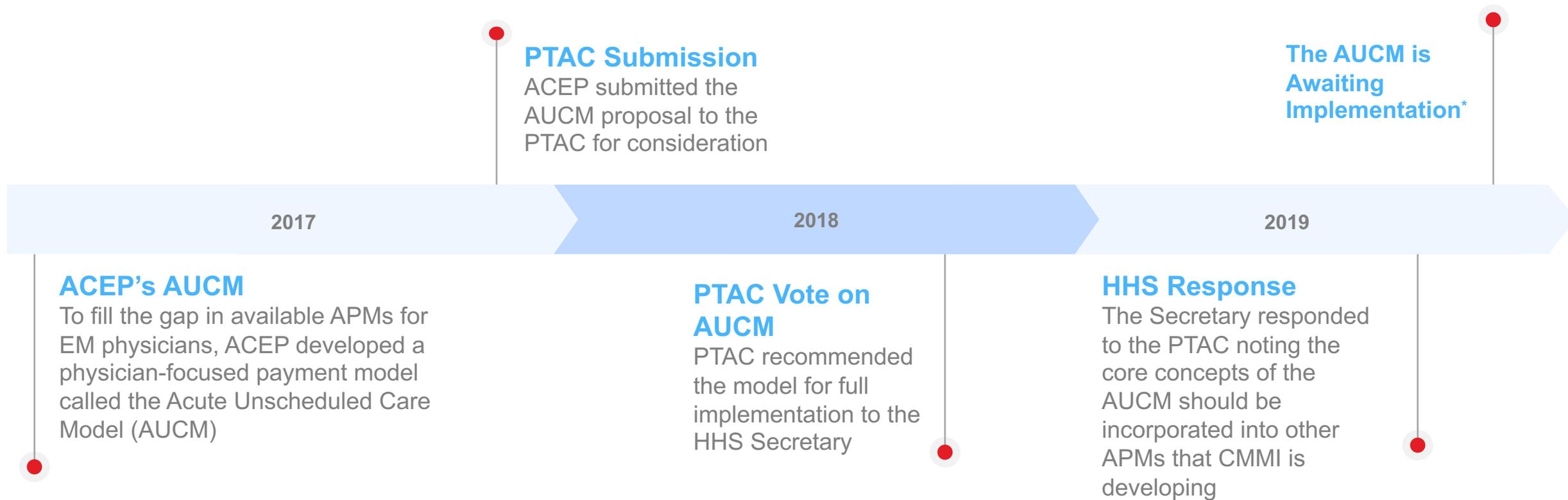
### Infrastructure Gaps

Hospitals do not always have the structure in place to integrate EM physicians into these models



# **The Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions**

# EM Physicians In Prime Position to Participate in Value-based Arrangements



\* ACEP has participated in CMMI meetings and they are beginning to review the AUCM for implementation

# Developed for Medicare but Broadly Applicable

## The AUCM's Original Intention and Design

- The AUCM was developed with the **intention of functioning within MACRA's QPP as a Medicare Advanced APM but the model was designed with enough flexibility** that its components could be adopted by different payors for various conditions regardless of practice size or geographic location

## The AUCM's Cross-Payor Potential

- **A non-Medicare version of the AUCM would be an ideal APM** construct for Medicaid and private payors to pursue as they continue moving away from fee-for-service contracts towards value-based payment arrangements

## The AUCM's Core Concepts

- Payors can begin to **incorporate core concepts of the AUCM into other EM-focused APMs**
- Adaptation may require some changes to various features of the model, thus new models will be different from the AUCM proposal that was submitted to the PTAC

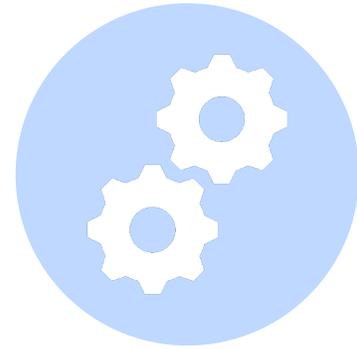
# The AUCM is Specifically Designed for Direct EM Physician Participation



Seeks to **reduce inpatient admissions and observation stays** when appropriate through enhanced care coordination



Directly engages EM physicians by **accepting financial risk attributed to discharge disposition decisions** within qualifying episodes of acute unscheduled care



Ensures EM physicians have the **necessary tools to facilitate** to make the decision to provide safe, efficient outpatient care

# The AUCM is Voluntary and Flexible

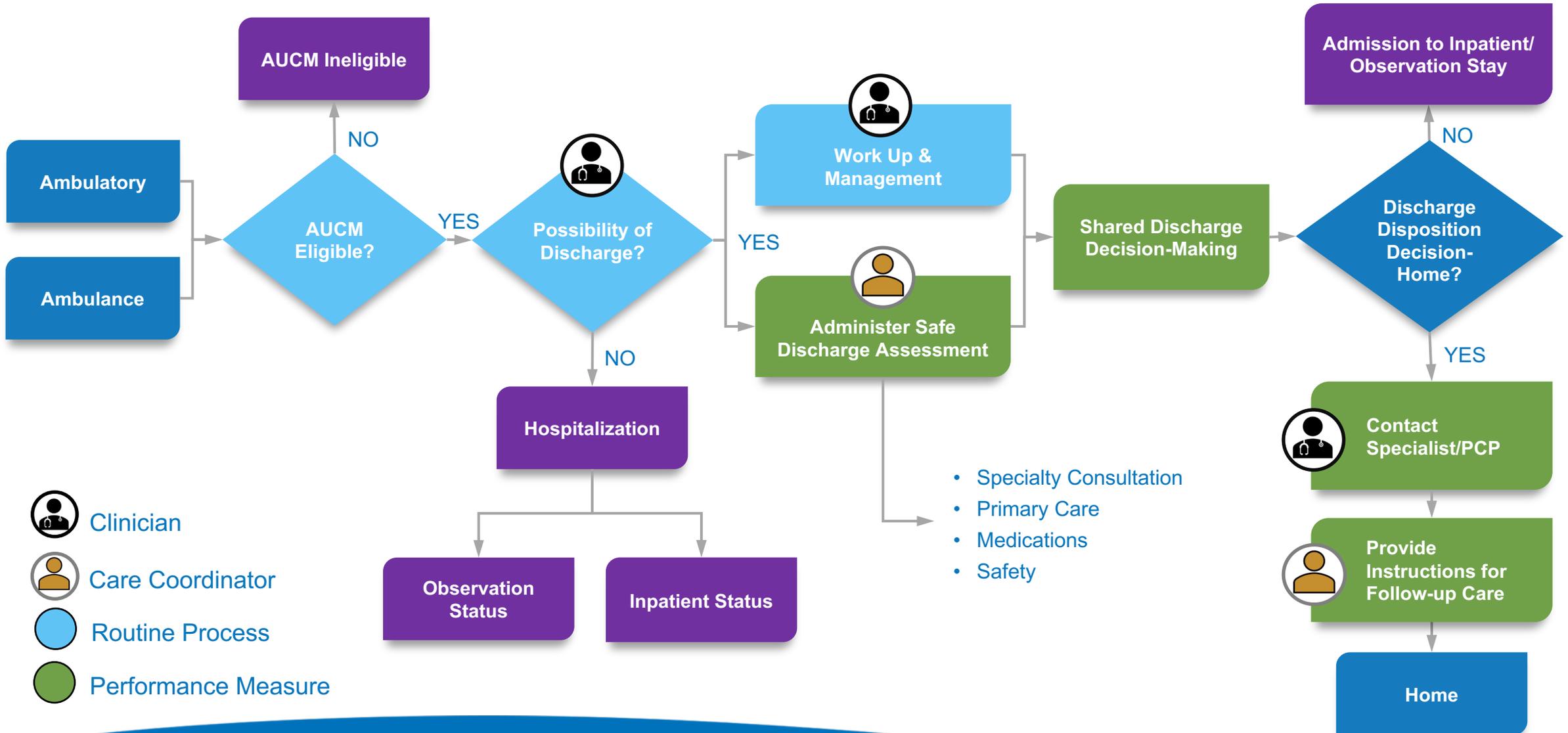
- **Built on traditional fee-for-service** Medicare payments but **provides financial incentives linked to patient outcomes**
- EM physicians and groups can participate **regardless of employment model**

## Turn-key Elements:

### Current CMS Program Alignment

- Readmission Reduction Program
- Hospital Acquired Condition Reduction Program
- Transitional Care Management Payments
- CJR Model
- BPCI Advanced

# Proposed ED Care Process Under The AUCM



# The AUCM Includes Waivers to Support EM Physicians

## Telehealth

Emergency physicians will be allowed to provide telehealth services into the beneficiary's home or residence and to bill one of the in-home visits under the same waiver that was put in place in the Next Generation ACO Model and other APMs.

## Post Discharge Home Visit

Licensed clinical staff may provide home visits under the general supervision of an emergency physician to eligible Medicare beneficiaries. The providers may bill these services utilizing the same G-codes utilized in other APMs.

## Transitional Care Management

Authorize emergency physicians to bill for a transitional care management code. This could be done utilizing the current CPT codes (99494 and 99496) or the ED specific Acute Care Transition codes submitted to the CPT Editorial panel in 2016.

# Physician Reimbursement Encourages Improved ED Performance

Under the AUCM, participants receive **positive or negative reconciliation payments** based on performance metrics and quality measure scores

## Positive Reconciliation

If actual cost of an episode is **less** than the pre-determined price; participants **share the savings** (participants keeps a portion of the difference)

## Negative Reconciliation

If actual cost of an episode is **higher** than the pre-determined price; participants **share the losses** (participants owes a portion of the difference to Medicare)

## Pre-Determined Price

The **facility-specific episode benchmark** is set using 3 years of historical claims data; it is then **risk-adjusted** and used to determine the **episode-specific target price** which is used by CMS to determine a positive or negative reconciliation payment to the participant

# Incentives Tied to the Quality of ED Care Delivered

Provider **performance metrics** in key **quality measure categories** determine reconciliation payments and the size of the discount built into the pre-determined price

## The Quality Measures and Performance Metrics Include:

Patient  
Engagement

Through completion of **Safe Discharge Assessment**

Process of Care  
Coordination

Engaging in **Shared Decision Making** about discharge plan

Post-discharge  
Outcomes

Utilizing the **Event-free Post-discharge Rate** to determine if an unfavorable post-ED event occurred during the discharge period

# The AUCM Fosters Patient-Centric Redesign and Direct Engagement

EM physicians are directly engaged to improve quality of care and reduce healthcare system costs through the adoption of patient-centric care redesigns that identifies at-risk patients and enhances their post-ED discharge care



## **Patient-centric** efforts built-in

- SDA and direct engagement through shared decision making
- Monitoring post-discharge events ensures efforts to decrease cost of care
- Follow-up services built into the model may positively impact patient satisfaction scores



## **Improves clinician's capacity** to deliver safe, valuable, and efficient care

- ED clinicians are empowered to make the right disposition decision for the right patient at the right time.

# Positive and Proactive Value-based Effort to Reduce System Costs

## Value Over Volume

- Provides healthcare systems an opportunity to **effectively and proactively engage in transformation efforts** through a novel EM-focused value-based arrangement
  - ▶ **Improve scores** in other CMS programs and **save money** through built-in metrics
  - ▶ Supports efforts to **decrease ED boarding** addressing high-occupancy concerns

## Estimated Cost Savings

- Reducing admissions for the qualifying four high-frequency conditions stipulated under the AUCM will **yield substantial savings for Medicare**:
  - ▶ A 3% decrease in admission rates could **reduce spending by approximately \$314 million** in the first year
  - ▶ An 8% decrease in admission rates over the first three years of the model could **save over \$840 million annually**



- ✓ Stakeholders across the healthcare system are interested in efforts to increase patient quality and improve costs through value-based arrangements
- ✓ Physician participation in value-based reform efforts benefits the entire healthcare system yet there are no avenues for EM physicians to directly participate
- ✓ ACEP developed the AUCM to provide EM physicians with an opportunity to participate directly in an Advanced APM; while designed for Medicare, components of the AUCM could be utilized across payors
- ✓ Stakeholders are encouraged to gain a deeper understanding of the AUCM and begin laying the groundwork for EM transformation discussions

## **Additional Resources**

# Learn More About the AUCM

- ACEP's the Acute Unscheduled Care Model Homepage: [www.acep.org/apm](http://www.acep.org/apm)
- PTAC Homepage: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>
- American College of Emergency Physicians. The AUCM Proposal. (2018)  
<https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDF>
  - ▶ Letter of Intent: <https://aspe.hhs.gov/system/files/pdf/255906/LoIACEP.PDF>
  - ▶ Public Comments: <https://aspe.hhs.gov/system/files/pdf/255906/ACEPPublicComment.pdf>
  - ▶ Preliminary Review Team (PRT) Report: [https://aspe.hhs.gov/system/files/pdf/259886/PRT\\_Report\\_ACEP\\_08-13-18\\_508.pdf](https://aspe.hhs.gov/system/files/pdf/259886/PRT_Report_ACEP_08-13-18_508.pdf)
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  - ▶ Committee Member Disclosures: [https://aspe.hhs.gov/system/files/pdf/259886/ACEP\\_Disclosures\\_508.pdf](https://aspe.hhs.gov/system/files/pdf/259886/ACEP_Disclosures_508.pdf)
  - ▶ Report to the Secretary: [https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary\\_ACEP\\_10.20.18.pdf](https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary_ACEP_10.20.18.pdf)

## Learn More About ACEP's Clinical Emergency Data Registry (CEDR)

- Clinical Emergency Data Registry (CEDR) was developed by ACEP as the first EM specialty-wide registry to measure acute care quality, outcomes, practice patterns, and trends in emergency care
- CEDR, a qualified clinical data registry (QCDR), is primarily used as a mechanism for helping EM physicians and other providers meet reporting and attestation requirements in MIPS (Track 1 for physician participation in MACRA's Quality Payment Program)
- The CEDR registry ensures that physicians, rather than other parties or payors, are identifying what works best for their own clinical practice and patients
- Additional Information: <https://www.acep.org/federal-advocacy/federal-advocacy-overview/APM>

## Medicare AAPM Participation and Clinical Emergency Data Registry (CEDR)

- One of ACEP's goals for the APM Initiative is to help EM physicians directly participate Medicare AAPMs (Track 1 for physician participation in MACRA's QPP) through the QPP newly available All-Payer Option
- The AUCM is still under development at CMS, so most EM physicians are still required to participate in MIPS—and can continue to use or consider using CEDR for reporting
- EM physicians may begin qualifying for additional payments and avoid reporting in MIPS if CMMI decides to incorporate elements of the AUCM into an existing Medicare AAPM or if other payors utilize the AUCM framework to qualify for the All-Payer Option
- CEDR will remain integral to measuring quality of care and providing essential data for transitioning into new payment models
- Additional Information: <https://www.acep.org/federal-advocacy/federal-advocacy-overview/APM/>

# Citations

- American College of Emergency Physicians (ACEP). Regs & Eggs. The Awesome AUCM Model. (2019). <https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs-eggs/regs--eggs8/>
- American College of Emergency Physicians (ACEP). Regs & Eggs. This Just In: The HHS Secretary Thinks AUCM is Awesome! (2019). <https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs-eggs/regs--eggs1032019/>
- Centers for Disease Control (CDC). National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Summary Tables. (2016). [https://www.cdc.gov/nchs/data/nhamcs/web\\_tables/2016\\_ed\\_web\\_tables.pdf](https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf)
- Center for Improving Value in Healthcare (CIVHC). Colorado's Accountable Care Collaborative. <https://www.civhc.org/change-agent-gallery/colorados-accountable-care-collaborative/>
- Centers for Medicare and Medicaid Services. Health Care Innovation Awards: Project Profile. Mount Sinai School of Medicine. (2020). <https://innovation.cms.gov/initiatives/participant/Health-Care-Innovation-Awards/Mount-Sinai-School-Of-Medicine.html>
- Centers for Medicare and Medicaid Services (CMS). MACRA About. (2019). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs>
- Centers for Medicare and Medicaid Services (CMS). QPP Program Overview. (2019). <https://qpp.cms.gov/apms/overview>
- Colorado Center on Law and Policy. The Colorado Medicaid Accountable Care Collaborative Program. (2011). [http://www.healthpolicyproject.org/Publications\\_files/Medicaid/ColoradoAccountableCarePresentation.pdf](http://www.healthpolicyproject.org/Publications_files/Medicaid/ColoradoAccountableCarePresentation.pdf)

# Citations

- Health Care Payment Learning & Action Network (HCP-LAN). APM Framework. (2017). <https://hcp-lan.org/apm-refresh-white-paper/>
- Health Care Payment Learning and Action Network (HCP LAN). APM Measurement Effort. <https://hcp-lan.org/apm-measurement-effort/>
- Health Care Payment Learning & Action Network (HCP-LAN). APM Framework. (2017). <https://hcp-lan.org/apm-refresh-white-paper/>
- Health Leaders. Highmark Health, Contessa Launch Home-Based Acute Care Model. (2019). <https://www.healthleadersmedia.com/innovation/highmark-health-contessa-launch-home-based-acute-care-model>
- Jacqueline LaPointe. Doctors, Employers Disagree on Healthcare Payment Reform Strategy. (2018). <https://revcycleintelligence.com/news/doctors-employers-disagree-on-healthcare-payment-reform-strategy>
- Leavitt Partners. Medicare Alternative Payment Models: Not Every Provider Has a Path Forward. (2017). <https://leavittpartners.com/whitepaper/medicare-alternative-payment-models-not-every-provider-path-forward/>
- Martine Sanon, Ula Hwang, Gallane Abraham, et al.. ACE Model for Older Adults in ED. (2019). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6473391/#!po=73.5294>
- Modern Healthcare. Highmark Health to deliver hospital care at home. (2019). [https://www.modernhealthcare.com/home-health/highmark-health-deliver-hospital-care-home?utm\\_source=modern-healthcare-daily-dose-wednesday&utm\\_medium=email&utm\\_campaign=20191113&utm\\_content=article2-readmore](https://www.modernhealthcare.com/home-health/highmark-health-deliver-hospital-care-home?utm_source=modern-healthcare-daily-dose-wednesday&utm_medium=email&utm_campaign=20191113&utm_content=article2-readmore)
- Nursing Center. GEDI WISE Model Feasible for Geriatric Emergency Care. (2015). [https://www.nursingcenter.com/healthdayarticle?Article\\_id=699162](https://www.nursingcenter.com/healthdayarticle?Article_id=699162)

# Glossary

# Glossary

- **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 the AUCM, 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.
- **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.

# Glossary

- **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.

# Glossary

- **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.
- **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.

# Glossary

- **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).