URGENT Matters

Payment Reform:
Evolving Models and Strategy in Emergency Medicine

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October 15, 2016

George Washington University
School of Medicine & Health Sciences

Disclosures

- Enterprise Chief Medical Officer
  - Schumacher Clinical Partners
- Board of Directors
  - EDPMA
- Co-Chair, Alternative Payment Model Task Force
  - ACEP
- Co-Chair, Federal Health Policy Committee
  - EDPMA

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Chips are down. . .

- The value of the ED
- 2% Campaign
- RAND Study
- The ED as a strategic asset for a health system
- *Choosing Wisely* Campaign . . .
- Generalized whining and complaining

Time to ante up.

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Today

- Brief refresher on MACRA
- The ED as a unique domain
- Alternative Payment Models and the ED
- ACEP APM Task Force
- Alternative Payment Model frameworks
- Preparing your practice for Alternative Models

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FOUNDATIONS

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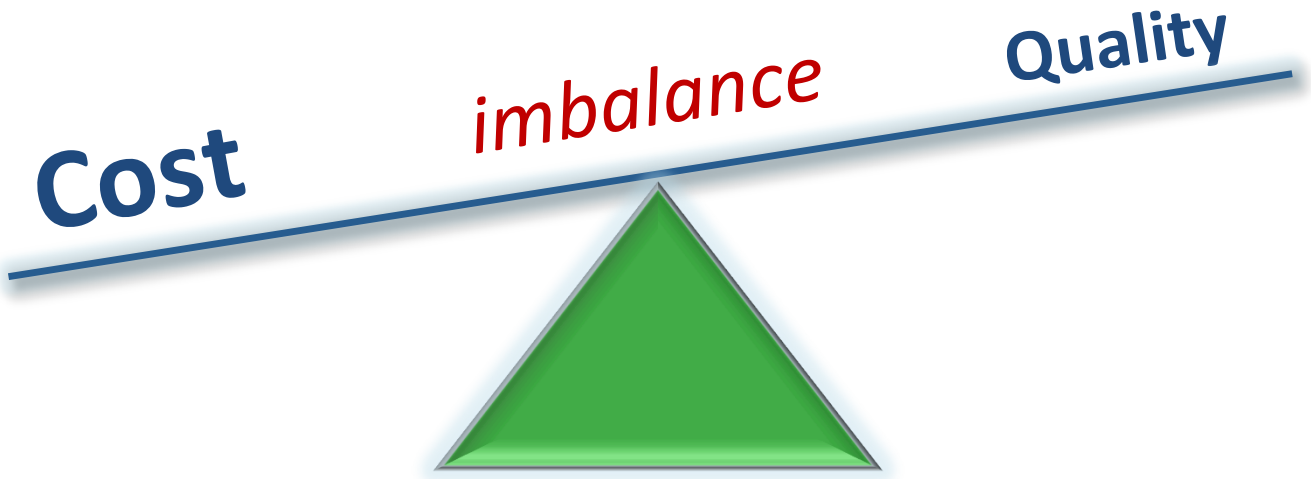
What was the "*Problem*"?



$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

Now, there are two “patients”

My Patient

- *Quality Care*
- *Acceptable cost*

The Delivery System

- *Population health*
- *Sustainable cost*

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Effective Payment Reform

Quality	Cost	Value
• Define • Measure • Report • Align with payment	• Define • Measure • Report • Align with payment	• **Define** • **Measure** • **Report** • **Align with payment**

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"Top 5" List: Improving the Value of EM

Do not order:

1. **CT of C-spine** for patients after trauma who don't meet NEXUS criteria
2. **CT for PE** without risk stratification
3. **MRI of the L-spine** for lower back pain without high risk features
4. **CT of head** for patients with mild traumatic head injury who do not meet New Orleans criteria or Canadian CT Head Rule
5. **Coagulation studies** for patients without hemorrhage or suspected coagulopathy

A Top-Five List for Emergency Medicine
A pilot Project to Improve the Value of Emergency Care
JAMA Internal Medicine
April 2014, Vol 174, Number 4

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MACRA Basics

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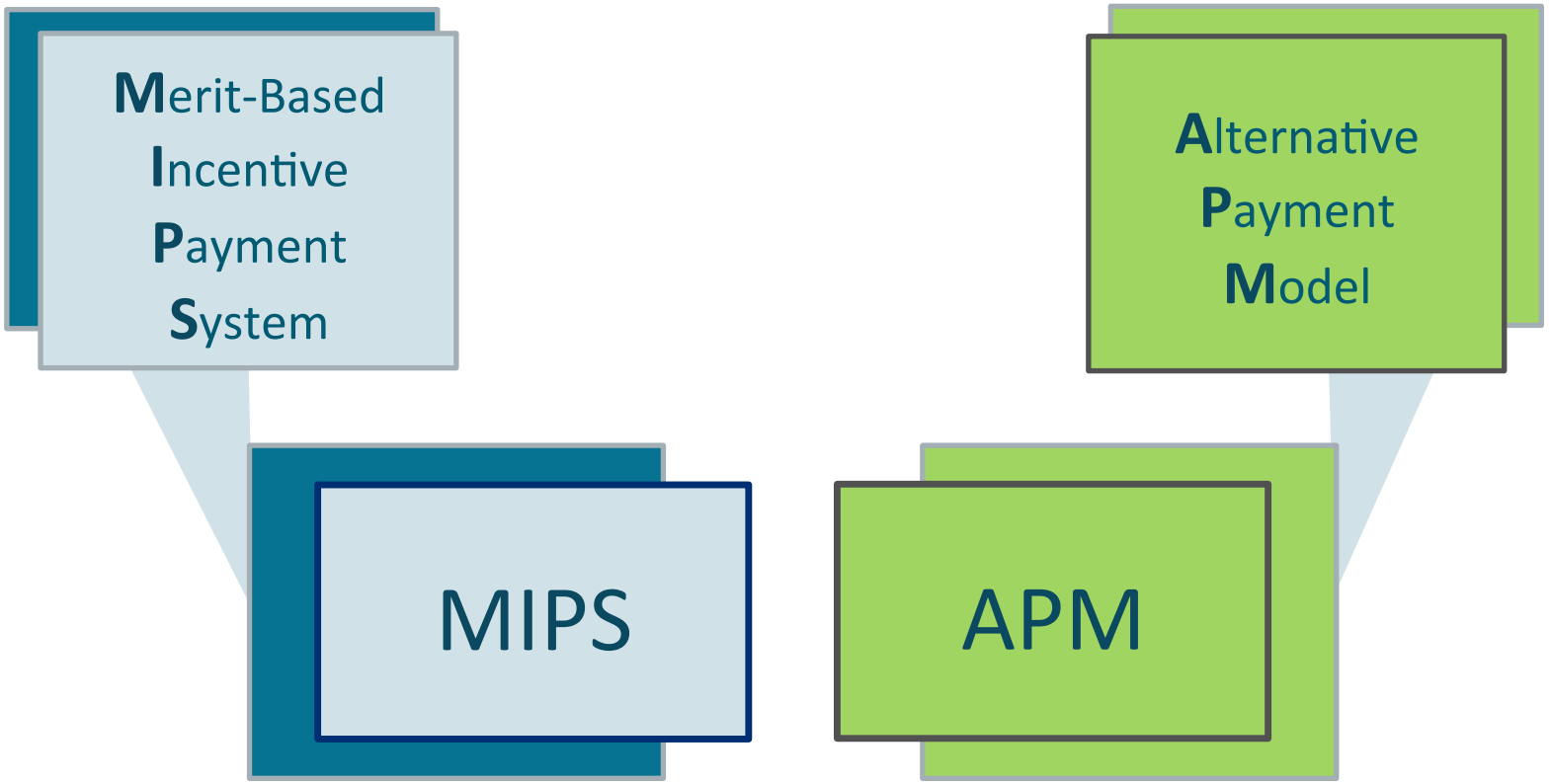
MACRA



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MIPS

- Merit-Based Incentive Payment System
- MIPS consolidates former performance incentives into one program.
    1. Medicare EHR incentive program
    2. The PQRS quality reporting program
    3. The Value-based Payment Modifier
- **Composite Score derived from 4 sub-categories**
    - **Quality**
    - **Cost**
    - **Clinical Practice Improvement**
    - **Advancing Care Information**

MIPS Composite Performance Score (CPS)

50	+	10	+	25	+	15	=	100
Quality		Resource Use		Advancing Care Information		Clinical Practice Improvement Activities		MIPS Composite Performance Score

- CPS is calculated from 4 MIPS performance metrics
- Payment adjustment is based on CPS & MIPS performance threshold
  - CPS below: negative adjustment
  - CPS above: neutral or positive adjustment

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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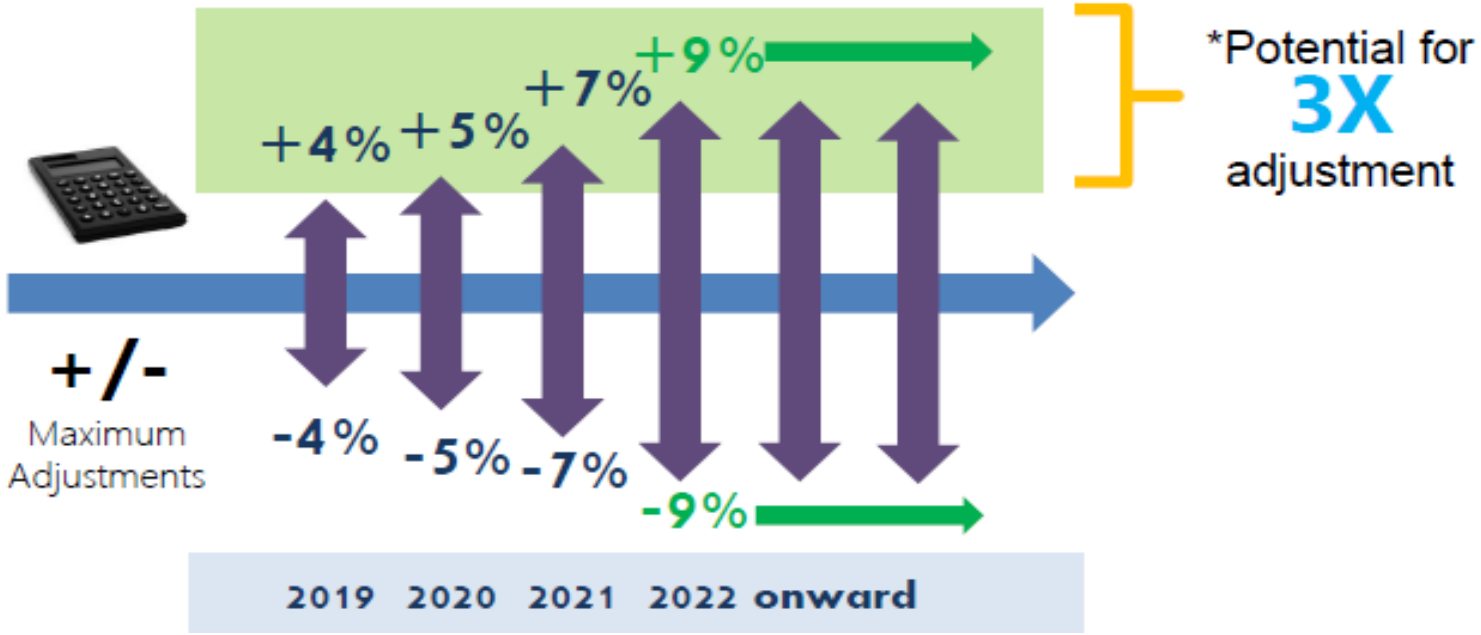
MIPS Payment Adjustment Timeline



- MIPS is budget neutral
- Positive payment adjustments are a redistribution of negative adjustments
  - Potential for more penalties than positive adjustments
  - May multiply positive adjustments up to 3X

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

Advanced Alternative Payment Models (APMs)

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What is an APM?

A payment method in which **providers take responsibility for patient care performance on cost and quality**.

Providers receive payments to support interventions that deliver high value.

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An "Advanced" APM?

Criteria

- **EMR use**
  - ≥ 50% first year
  - ≥ 75% after first year
- **Payment based on quality measures**
  - Similar to MIPS measures
  - No minimum number of measures (except must have one outcome measure)
- **Must bear financial risk based on quality**
  - At a rate at least that of MIPS percentages
  - In excess of a nominal amount

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APM Examples

- Medical Home
- ACOs
- Shared savings models
- Bundled payments
- Capitated models
- Pay for performance models
- Risk pools
- Condition-based payments

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Advanced APM Incentive Payments

for Qualified Providers:

Excluded from MIPS

Receive a 5% lump sum bonus

Bonus applies in payment years 2019 – 2024;
then higher fee schedule updates apply - beginning 2026.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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Qualifying for Advanced APMs

Requirements for incentive payments

(Clinicians must meet payment or patient requirements)

Payment Year	2019	20120	2021	2022	2023 & beyond
% of Payments through an Advanced APM	25%	25%	50%	50%	75%
% of Patients through an Advanced APM	20%	20%	35%	35%	50%

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And of course, public reporting …..

Reporting through *Physician Compare*

- **Names of QPs in Advanced APMs**
- **Performance of Advanced APMs**
- **MIPS scores**
  - Individual and aggregate scores
  - 4 performance categories

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MIPS versus APMs

- **MIPS:**
  - Components are complex and changing
  - Virtually no “neutral” adjustment possible with 0-100 scoring
  - Less risk
- **APM :**
  - Excluded from MIPS
  - *Receive annual 5% lump sum bonus 2019-2024*
  - Receive higher fee schedule updates 2026 and beyond
  - Greater risk
- **The challenge**:
  - The percentage of patients treated under APMs must increase annually

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CHALLENGES
FOR EMERGENCY MEDICINE

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Key Elements of Alternative Models

- Goal
- Scope of service
- Defined population
- Access to the population
- Intervention(s)
- Quality measurements
- Outcomes
- Payment method
  - For what
  - When
  - Modifications
  - Risk

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Emergency Medicine: Facts & Realities

Emergency Departments treat a broad range of conditions*

- 130 – 140 million annual ED visits in the U.S.
  - Emergent care: 10 – 16% of visits
  - Intermediate / complex conditions: 31 – 57% of visits
  - Minor conditions: 12 – 40% of visits

* ***"A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department."***
Smulowitz, Peter B., et. al.
Health Policy/Concepts, Annals of Emergency Medicine. 2012

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Challenges for ED APMs

Presentations

- Unscheduled
- Bound by EMTALA
- Often undifferentiated

Clinical Care

- Episodic
- Chief complaint-driven
- Disposition-focused

Service

- Essential for hospital
- Essential benefit per ACA
- 24/7 availability

Patients

- Universal access
- No requirement to pay

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Framing an ED APM

Which "population"?

- Urgent / emergent conditions?
- Ambulatory care sensitive conditions?
- Disease-specific conditions?
- No final diagnosis?

- Patient preference or convenience
- Absence of other options
- Community physician request
- Patient economic advantages
  - Medicaid, Medicare, self-pay

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APMs for the ED?

- Lots of people
- Sick people
- High focus populations
- Frequent interface with the health care system
- Important things get started there
- Decisions that matter get made there
- Increasing dependence on the ED by community physicians
- All payor types use the ED
- Single hub for introducing and managing change
- You have to have one
- It's always open
- Market share and revenue driver for the hospital

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ED APMs: The Opportunities

- Admissions
- Readmissions
- ED Re-visits
- Utilization
  - Advanced imaging
  - Other imaging
  - Lab
  - Pharmacy

APMs for the ED

Reduce avoidable admissions

- ED Observation
- Intensive Case Management
- Home Health
- Palliative Care
- Advanced Care Planning
- Evidence Based Clinical Pathways
- And, and, and. . .

APMs for the ED

Reduce avoidable ED visits

- Prescription Drug Monitoring
- S.B.I.R.T.; Substance Abuse Screening, Brief
- Intervention, Referral to treatment
- Case Management
- Paramedicine
- Telemedicine
- Education
- Assertive Community Treatment
- Care coordination

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EMERGENCY DEPARTMENT

ALTERNATIVE PAYMENT MODELS

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The ACEP approach…..

- ACEP is actively seeking strategic paths to successfully transition to alternative payment methodologies, using:
  - CEDR
  - APM Task Force and
  - the expertise of members and staff
- ACEP is working on developing performance measures for the ED
- ACEP is focusing on fair payment for ED services
- ACEP is creating a registry
- ACEP is exploring resources such as CMMI grants to develop APM or episode models that will work in the ED setting

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ACEP
APM Task Force

Project Status

ACEP: APM Task Force

Phase I

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Who:	• Federal Government / CMS
When Initiated:	• April 2015
Action:	• Legislative imperative (MACRA; APMs)

ACEP: APM Task Force

Phase 2

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Who:	• ACEP Board & Staff
When Initiated:	• Summer 2015
Actions:	• ACEP evaluation & response • Presidential appointment of APM Task Force • Engagement of staff and consultant (Harold Miller)

ACEP: APM Task Force

Phase 3

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Who:	• APM Task Force
When Initiated:	• Fall 2015
Actions:	• Initial assessment • Ideation/brainstorming • Selection of initial APM frameworks

ACEP: APM Task Force

Phase 4

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Who:	• APM Technical Workgroups
When Initiated:	• Spring 2016
Action:	• Appointment of Workgroup chairs & members • Detailed build out of 3 APMs (objectives, mechanisms, and operational detail) • Refinement, vetting, risk/ benefits • Articulate needs for data, analytics, and modeling

ACEP: APM Task Force

Phase 5

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Who:	⇨	• ACEP Board of Directors Report
When:	⇨	• October 2016; at ACEP 2016
Action:	⇨	• Status update from Task Force co-chairs • Consideration of timeline and trajectory • Resources

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ACEP APM Task Force

Co-Chairs: Dr. Jeff Bettinger
Dr. Randy Pilgrim

APM # 1	• **ED Disposition Planning** • Chair: Dr. Heather Marshall
APM # 2	• **Case Rates for ED Services** • Chair: Dr. Sue Nedza
APM # 3	• **Population Management of Ambulatory Care** • Chair: Dr. Tony Cirillo

APM # 1

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Payment for services to support safely discharging ED patients without hospital admission.

The emergency physician has the flexibility to use augmented payments to support

- additional physician time or
- additional staff

to help appropriate patients return home (or return to their facility) rather than being admitted to the hospital.

APM # 1

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Payment for services to support safely discharging ED patients without hospital admission.

The rate at which the patients are admitted to the hospital is measured and compared to a target level.

Additional indicators, such as the rate of returns to the ED or readmissions would also be measured.

All rates are risk-adjusted based on clinical and other patient characteristics.

APM # 1

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Payment for services to support safely discharging ED patients without hospital admission.

The amounts paid to the emergency physicians for discharge planning and coordination:

- adjusted up or down
- based on performance on these measures

APM # 2

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Case rates for ED services

Hypothesis:

The adoption of *risk-adjusted case-based rates*
for patients that are seen in the ED, and *discharged or admitted to observation*

for 80 prevalent conditions that present to the ED

will generate enough savings to enable physicians to become Qualified Providers under MACRA.

APM # 2

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Case rates for ED services

An emergency physician group and hospital would agree to jointly manage the total costs associated with ED visits:

within pre-defined ED Case Rate budgets/payments

for each eligible patient who presents to the ED.

Mini-bundles were considered -> not enough savings, and

More patient groupings will assist in meeting future targets

APM # 2

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Case rates for ED services

Performance Metrics:

- Repeat ED visits within 72 hours
- Admission to the hospital within 72 hours
- Outpatient imaging within 72 hours
- Death within 72 hours

APM # 2

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Case rates for ED services

Analysis:

- 80 potential presenting conditions that cover the majority of ED visits have been identified.
- Focus is on discharged and Observation patients, since average admissions have dropped
  - readmission policies,
  - 2 midnight rule

Data Needs:

- Risk-adjustment models that consider the type of facility, population risk, and socio-economic factors
- A multi-year, national data set that included both Part A and Part B claims that could be matched to ED records (to test the use of presenting condition) would be required.
- (Potential CMMI grant)

APM # 3

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Population Management of Ambulatory Acute Care

- Participating physicians charge a pre-defined, risk-adjusted payment each month for each individual in the population being managed.

- Risk adjustment results in higher payments for populations more likely to need acute care services
  - Elderly
  - Chronic conditions
  - Etc.

APM # 3

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Population Management of Ambulatory Acute Care

Defined population:

- Primary care patients
- Nursing home residents
- Health plan members
- Attributed members of an ACO
- Assigned members of an IPA
- Employees of a self-insured business
- Etc.

ACEP: APM Task Force

Phase 6

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Who:	• Data, Modeling, & Analytics Workgroups
When:	• Winter 2016
Actions:	• Obtain access to necessary data • Obtain modeling and analytic resources • Obtain dedicated project management resource • Detailed analytics & testing of APMs • Final results & recommendation to full Task force • ACEP Board review & approval

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YESTERDAY

FOR IMMEDIATE RELEASE
October 14, 2016

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS finalizes streamlined Medicare payment system that rewards clinicians for quality patient care

MACRA rule will accelerate health care system's shift toward value

Today, the Department of Health & Human Services (HHS) finalized a landmark new payment system for Medicare clinicians that will continue the Administration's progress in reforming how the health care system pays for care. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program, which replaces the flawed Sustainable Growth Rate (SGR), will equip clinicians with

ACEP: APM Task Force

Phase 7

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Who: ⇒ CMS Process

When: ⇒ 2017

Actions: ⇒ **Presentation of APMs to PTAC / CMMI**
Approval & refinement process

ACEP: APM Task Force

Phase 8

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Who:	⇒	EM Community
When:	⇒	2017
Actions:	⇒	Rollout to ACEP members Implementation and utilization Further action / development as indicated

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ALTERNATIVE PAYMENT MODELS

STRUCTURE AND TAXONOMY

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American Journal of Managed Care
August 2016

COMMENTARY

Aligning Payment Reform and Delivery Innovation in Emergency Care

Jesse M. Pines, MD, MBA; Frank McStay, MPA; Meaghan George, MPP; Jennifer L. Wiler, MD, MBA; and Mark McClellan, MD, PhD

Hospital-based emergency departments (EDs) play a central role in US healthcare delivery, with 136 million visits in 2011.[1] For decades, increases in ED visit rates have outtion-level payments, increasing financial risk and accountability, and aggregating payments across providers.

Category 2. Category 2 links FFS payments with quality. In

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HHS Payment Model Taxonomy

Category 1: FFS (no link to quality)

Category 2: FFS (with link to quality)

Category 3: APMs with FFS architecture

Category 4: Population-based payment

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HHS Payment Model Framework

Fee for Service

No Link to Quality & Value

- **Fee-for-Service**
  - Traditional payment model
  - DRGs
    - Example: DRG without link to quality

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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HHS Payment Model Framework

Fee for Service

No Link to Quality & Value

- **Payments**
  - Based on volume and acuity of services
  - No dependency on
    - Quality
    - Efficiency
    - Outcomes

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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HHS Payment Model Framework

Category 2

Fee for Service

Link to Quality & Value

- **Foundational Payments for Infrastructure & Operations**
- **Pay for Reporting**
- **Rewards For Performance**
- **Rewards & Penalties For Performance**

Examples:

PQRS bonus payments & penalties for quality performance

DRGs with rewards & penalties for quality performance

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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HHS Payment Model Framework

Category 2

Fee for Service

Link to Quality & Value

- **Payments**
  - *Some* portion is dependent on
    - Quality
    - Efficiency
    - Outcomes
  - Essentially still FFS

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

HHS Payment Model Framework

Category 3

Fee for Service

Link to Quality & Value

- **APMs with Upside Gainsharing**
  - Bundled payment with upside risk only
  - Episode- based payments for procedure-based clinical episodes with shared savings only
  - Primary care PCMHs with shared savings only

- **APMs with Upside Gainsharing / Downside Risk**
  - Bundled payment with up and downside risk
  - Episode- based payments for procedure-based clinical episodes with shared savings & losses
  - Primary care PCMHs with shared savings & losses

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

HHS Payment Model Framework

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Category 3

Fee for Service

Link to Quality & Value

- **Payments**
  - Some amount dependent on management of
    - A population
    - Episode(s) of care
  - Triggered by delivery of service
  - May be shared savings, or
  - Upside/downside risk

Examples: Bundled payments
Shared savings models
ACOs

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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HHS Payment Model Classification

Category 4

APMs built on Fee-for-Service Architecture

- **Population-based Payment:**
  - Population-based payments for condition-specific care (e.g. via an ACO or PCMH)
  - Partial population-based payments for primary care
  - Episode-based, population payments for clinical conditions (diabetes, CHF, COPD)

- **Population-based Payment:**
  - Full or percent of premium population-based payment (e.g. via an ACO or PCMH)

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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HHS Payment Model Classification

Category 4

APMs built on Fee-for-Service Architecture

- **Payment:**
  - Not triggered by service delivery
  - Relates to a defined population
    - Condition-specific care
    - Episode-based payments for clinical conditions (diabetes, CHF, COPD)

Examples: Capitated payment models
Global contracting
Next Gen ACO models

Nussbaum, S, et al, https://hcp-lan.org/workproducts/apm-whitepaper.pdf - page 13

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Implementation Challenges

- Hard-wired payor systems, analytics, and data processes
- Provider attribution is a mess
- Total cost of care may not be calculated until it's spent
- Effect of ED facility fee on total cost

ACEP: APM Task Force

Phase 6

URGENT Matters

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Preparing for Alternative Payment Models

Tips for Success

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"MACRA to drive fear, care quality & consolidation in Physician Services space"

- MACRA will result in
  - increased data reporting requirements,
  - focus on quality,
  - likely rate cuts for smaller provider groups, and
  - bonus payments for larger, higher quality providers.

- 80% of large practices are expected to see increased reimbursements
  - Data warehouses
  - Evidence-based clinical pathways
- "MACRA will drive industry consolidation."

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How to Prepare NOW

- Education
- Data readiness
- Performance measurement and feedback
- Aligned structures
- Continuous study and improvement
- Manage well

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Preparing for Alternative Models

Provider performance feedback

1. **Provider-specific disposition profile:**
   - Admission – Observation – Transfer %
   - Home Health referral %
   - Observation – Clinical Decision Units %
   - Consultations (Hospitalist, Case Management, etc.)
2. **Primary care follow up percentages**
   - Yes/ no? Days since ED visit
3. **ED re-visit rates**
4. **Readmission rates**
5. **Utilization**
6. **Pharmacy utilization**
7. **Provider-specific cost of care (versus quality delivered)**

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Practical Alternatives to Hospital Inpatient Status

Solution	Objective
Rapid Decision Units	Rapid disposition with high diagnostic specificity
Rapid Treatment Units	Rapid-cycle treatment; reduced down time & reduced cost of care
Hospitalist Consultation in the ED	Early and accurate determination of optimal patient status and disposition (inpatient/ Obs/ SNF/home-based, etc.)
ED Observation Unit	Hospital-based short stay (in the ED) with less in-hospital transitions of care
Hospital Observation Status	Hospitalized care for less than 2 midnights

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Preparing for Alternative Models

Producing value and aligning provider payment

- **Determine a roadmap for increasing *Value***
  - Baseline:
    - What is your quality profile *per provider*?
    - What is your cost profile *per provider*?
    - Comparison to norms?
  - How can you impact both quality and cost?

CMS
QRUR
Profiles

- **Align pay and incentives with overall objectives**
  - Providers
  - Group

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Preparing for Alternative Models

1. Develop (or collaborate with) innovative solutions
   - Telemedicine
   - Post-acute services

2. Optimize EHR functionality
   - Interoperability
   - Accessibility
   - Data

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Preparing for Alternative Models

- Education
- Data readiness
- Performance measurement and feedback
- Aligned structures
- Continuous study and improvement
- Manage well

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Preparing for Alternative Models

Disruptive Innovation or ***Disaster***?

1. Reduced ED volume?
2. More work to *not* see patients?
3. Reduced productivity with reduced revenue?
4. Recruiting with bonus payments 2 years later?
5. Capital requirements?

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Relief: Pick Your Pace …

September 8 2016 announcement:

Andy Slavitt, Acting Administrator of CMS

These options ensure "Quality Payment Program" participation:

Option 1: Test the Program

- Submitting some data avoids negative adjustment in 2019

Option 2: Participate for *part* of 2017

- Qualify for small positive adjustment

Option 3: Participate for *all* of 2017

- Qualify for modest positive adjustment

Option 4: Participate with an *advanced APM*

- 5% incentive in 2019

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Rewarding Quality

- Define Quality
- Meet or exceed targets
- Top tier performance
  - With or without threshold
  - Without threshold
- Improvement
  - Degree
  - Pace

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Rewarding Cost Efficiency

- What costs?
- How is cost impacted?
- Targets?
- Improvement?
- Comparisons?

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FOCUS:

- Chips are down
- Payment Model types
- ACEP Models
- Getting Ready.

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Ouch

- Intro 3 min
- MACRA, MIPS, APMs 7 min
- APMs in the ED 10 min
- APM Task Force 10 min
- Succeeding 10 min
- Close / Questions 5 min