

The Role and Value of the Emergency Department in an Accountable Care Organization

An Information Paper

Reviewed by the ACEP Board of Directors, November 2015

Introduction

With more than 354 million unscheduled acute care visits annually in the United States, emergency departments (EDs) and emergency physicians (EPs) are critical to the care and cost of care provided to patients. Since the passage of the Affordable Care Act (ACA) and the piloting of Accountable Care Organizations (ACOs), EDs and more specifically, emergency physicians will have an even greater role and responsibility in the coordination and cost of care for millions of patients. Additionally, in 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act (MACRA) which effectively repealed the troubled Medicare Sustainable Growth Rate (SGR). Under the law, by 2019 5-9% of physician payments will be tied to the value-based purchasing MIPS program (merit-based payment system)—a replacement for the PQRS (physician quality reporting system). With the passage of MACRA and the affirmation by the courts of the ACA, alternative payment models (APM) including ACOs are here to stay. Therefore, understanding the themes, goals and challenges of development and implementation of an ACO will be important due to significant shifts in reimbursement.

To assist members of the American College of Emergency Physicians (ACEP) to navigate the rapidly changing healthcare landscape, the Emergency Medicine Practice Committee has developed a reference tool and guide to define the role emergency physicians can take with the development and implementation of ACOs. In effect, this resource guide will:

1. Summarize what an ACO is and how it is developed
2. Give emergency medicine (EM) providers an understanding of the general themes and goals of an ACO; and
3. Discuss current strategies in ACO implementation and how emergency physicians can or should be involved.

Due to the length of the document, the paper has been divided into the following sections for ease of reference:

- An Overview of The Affordable Care Act and Accountable Care Organizations (ACO)
- The Structure of an ACO
- Requirements for Developing a Medicare-Shared Savings Program ACO (MSSP ACO)
- The Medicare Pioneer ACO Program
- Best-Practice Themes for Developing an ACO
- Role of Population Health Management
- Groups Participating in ACOs
- Role of the ED in Payment Reform
- Physician Pay and Incentives
- ACOs and APMs in Emergency Care
- Challenges for ED Physician Leaders
- Current State of ACOs
- Conclusions
- References
- Glossary of Terms

The methods used to create this document consisted of both literature searches and interviews with key stakeholders. The initial academic literature search was later expanded to include publications outside of conventional academic journals such as business case reviews, health policy articles, and even blogs. Also, the subcommittee conducted interviews with health policy experts, non-emergency physician and emergency physician leaders who were currently involved with ACOs to help develop an understanding of the complex APM world.

There were a number of limitations that may have impacted the methods utilized to formulate this guide. Unlike many policy or resource guides concerning clinical practice, few peer-reviewed papers have been published on ACOs. Most of the information for this document utilized Centers for Medicaid and Medicare Services (CMS) website information and reports, expert interviews, blog posts and white papers from health policy institutes, and publically released corporate information. While much of this information has been extremely helpful, it became clear there are no prescriptive methods for creating an ACO and further, the guidance given by CMS is limited. While many ACOs are currently in development, it will take years after an ACO's implementation to determine its efficacy and financial cost or benefit. Fortunately, there have been some groups that have reported on the strengths or weaknesses of their ACOs, which was a requirement of their participation, including the Medicare Pioneer ACO Program. Policy experts and researchers have been able to glean some understanding from reports released by Pioneer. Outside of this group, however, few financial models exist – other than corporate proprietary data. In addition, with the exception of salaried, hospital employee-based emergency physicians, emergency medicine practice management groups have complex, proprietary negotiations and contracts that limit the understanding of the financial structures of ACOs for the general body of medicine. When and if that information becomes available, future ACOs will have the benefit of structuring businesses based upon the successes or failures of those models.

An Overview of the Affordable Care Act and Accountable Care Organizations

In 2010, the year of the ACA's passage, the Institute of Medicine released a report, [Regionalizing Emergency Care](#), describing the United States healthcare system as highly fragmented, poorly coordinated, inefficient, and expensive, with poor quality outcomes when compared with other industrialized national health systems. To address this worsening problem, the report advocated for more regionalized, coordinated care with better aligned incentives or “accountable” care delivery.¹ With this in mind, since the adoption and implementation of the ACA, the United States healthcare system has continued to undergo a significant transformation with the hope of stemming the rise of healthcare costs. While many consider decreasing the number of uninsured patients and improving patients' access to care as the only goals of the ACA, another equally important goal was to improve healthcare value by reducing overall healthcare spending while improving quality. One such method of improving value is the creation of ACOs.

ACOs are defined as a collection of “ACO participants” who agree to assume collective responsibility for the care delivered to a population. The population is typically all individuals treated by the ACO who are insured by Medicare, Medicaid, or the commercial insurer contracting with the ACO. A “participant” can be a hospital, a community health center, a group or solo physician practice, or any other entity that bills Medicare for services under a unique federal tax ID number or CMS certification number. Within an ACO, its leaders, who may be individual physicians and/or hospitals, are responsible for leading initiatives to improve the quality of care for a defined group of individuals, while at the same time reducing costs. The benchmark for costs is fee-for-service (FFS) charges, and quality is defined by pay-for-performance initiatives. In effect, ACOs are a type of APM where physicians, hospitals, and other healthcare providers voluntarily work together to coordinate the care of a defined population.² Providers are also responsible for identifying and better managing high-risk patients within a population.³ In return, these providers share any savings and (potentially) any losses. Furthermore, in many cases, these

providers may be responsible for meeting a set of quality standards and can have withholdings or reimbursements based upon those quality metrics.

The Structure of an ACO

Presently, there are five ACO models that participate with Medicare:

1. Medicare Shared Savings Program (MSSP)
2. Advanced Payment ACO
3. Medicare Pioneer ACO Program
4. Next Generation ACO Program
5. Comprehensive ESRD Initiative

The **MSSP ACOs** are groups of doctors and other healthcare providers who voluntarily work together with CMS to provide improved healthcare at lower costs for Medicare fee-for-service beneficiaries. There are three main goals of Medicare ACO programs: improve individual health, improve the health of populations, and decrease the cost of health expenditures. In the MSSP shared savings model, the amount of money shared depends upon the risk model adopted. With the MSSP there are 2 types of risk that an ACO can choose. In one model, the savings are shared completely with no penalty for losses. In the other model, there is a risk-reward component where losses must be paid to CMS if the ACO underperforms financially. In addition to these two models, MSSPs also participate in the pay-for-performance schedule, which has increasing payments and/or penalties that change from year to year. For example, in year 1 of an MSSP ACO, the ACO is paid for reporting on all 33 performance-based metrics. In year 2, more money is tied to the quality performance of the ACO by tying payments to meeting certain quality benchmarks on 7 of the 33 performance metrics. By year 3, 32 of the quality metrics are pay-for-performance metrics, which means that the ACO must not only report out on all 33 metrics, but must also meet benchmark guidelines for 32 of the 33 metrics.

The [Advanced Payment ACO](#) model is a Medicare program designed for rural, physician-based ACOs who voluntarily decide to receive upfront monthly fixed or variable payments for the care of a group of patients. This model was developed for those ACO providers with little available capital to develop the infrastructure necessary to care for defined populations.

Finally, the [Medicare Pioneer ACO Program](#) is a program designed for the early pilot ACO programs. As of August 2015, there were 19 participants in the Medicare Pioneer ACO program (down from 32). Of the 13 that left the program, most were losing money.⁴ Despite leaving the Pioneer program, most of those that left joined an MSSP ACO program. ACOs can receive a higher percentage return of shared savings in return for agreeing to also share in potential losses. Under Medicare's payment rules for the Pioneer ACO Program, providers continue to be paid Medicare FFS rates for providing services. A Pioneer ACO can earn payments for achieving savings or may have to repay money to Medicare if its losses are outside of a specified benchmark.

According to CMS.gov, starting at the end of 2015 and in 2016, Medicare will offer 2 other new programs called the [Next Generation ACO](#) with the hopes of enrolling 15-20 ACOs and the [Comprehensive ESRD \(end-stage renal disease\) Initiative](#), a disease specific ACO. The Next Generation ACO will build off of the MSSP and the Pioneer ACO programs with the goals of attracting those entities with well-developed, coordinated care efforts. Under this model, the ACOs will have greater financial risk and reward than then those ACOs in the MSSP. The Comprehensive ESRD Initiative is the first ACO of its kind to target a specific disease. The government chose this initiative because, while only 1.3% of Medicare beneficiaries have ESRD, [7.5% of Medicare costs](#) are tied to ESRD care.

Requirements for Developing an MSSP ACO

Unlike the development of a corporation, an ACO has no legally defined or legally mandated organizational form. There are key requirements, however, to be a participant in the MSSP. (The MSSP is the most common Medicare ACO with the largest number of participants.) These requirements include the following:

1. Providers must establish structures for reporting quality metrics and the cost of healthcare;
2. Leadership and governance of an ACO must include clinical and administrative entities that share in receiving and distributing savings;
3. Providers in the ACO must be “accountable” for the overall cost and quality of the Medicare beneficiaries enrolled in an ACO;
4. A minimum of 5,000 Medicare beneficiaries must be enrolled with an adequate number of primary care providers;
5. The ACO must commit to participating for a minimum of three years;
6. The ACO must include a process to promote evidenced-based medicine; and
7. The ACO must focus on patient-centered activities.

Best-Practice Themes for Developing an ACO

The structure of ACOs varies in contracting, governance, scope, and scale. Leaders, especially those in the ED, will need to be ever mindful of the basic principles of APMs where the underlying goal is to shift from volume to value. ACOs fall within the APM framework. The following is a list of general recommendations and themes to consider when developing an ACO.¹

- **Identify effective mechanisms that provide incentives to successfully develop and sustain integrated systems of emergency care, with the goal of reducing cost and increasing access to quality care.** As an integrated system, cooperation across service lines and practices must trump competition with information sharing as a vital component of sustaining systems and increasing access to care. A part of this integrated model will involve cost reduction and quality reporting to reduce costs and identify opportunities for improvement. Incentives for the ACO and more specifically for the physician, must be aligned to meet these goals.
- **Identify medical-legal frameworks that support and facilitate sustainable networks of regionalized emergency care.** The themes underpinning this recommendation are rooted in malpractice. The current malpractice system does not improve outcomes, may not offer compensation for negligent care, fosters defensive medicine, and discourages resource stewardship. For example, defensive medicine practices increase utilization of medical services without improving individual patient outcomes. This increased utilization and cost is counterproductive to the goals of an ACO. Therefore, leaders will need to balance the goals of an ACO and defensive medicine in the hopes of limiting liability while developing community standards of care and decreasing unnecessary interventions.
- **Identify mechanisms for reporting quality measures that differentiate high-performing systems of regionalized emergency care.** The goals emphasized within this recommendation include improving and standardizing quality data capture and reporting mechanisms.
- **Identify efficient, cost-effective, regionalized systems for licensure, credentialing, and accreditation that facilitate timely delivery of quality emergency care.** Following this

recommendation can help ACOs eliminate barriers to integration, including state licensure, state laws, hospital specific credentialing, institutional accreditation, or certification issues.

Role of Population Health Management

In the ACO implementation toolkit designed for providers, Colbert et al³ describes the importance of recognizing opportunities for improvement in the delivery of care, especially in terms of population health management. This information will become critical to emergency physicians interested in becoming involved with an ACO. The authors stress the importance of determining how to appropriately stratify risk and how to further classify high-risk patients. They suggest classifying patients into four distinct groups: (1) high-cost over-utilizers, (2) patients with multiple chronic conditions, (3) those who are considered at-risk for multiple chronic conditions, and (4) healthy patients with a small number of acute medical needs.

They describe how the high-cost patients can account for as much as 20% of total costs within the ACO, and stress the need to stratify these patients and intervene through focused care coordination. Patients with multiple chronic conditions can benefit from further stratification according to chronic disease type, followed by the appropriate allocation of care management resources. Patients who have a single chronic condition, and are thereby considered “at-risk,” can benefit from active primary care to decrease their likelihood of moving into a more costly stratum. Finally, healthy patients can still reap the benefits of receiving continual patient education, regular wellness checks, and online tools for health management. While many studies are being conducted to address these issues, it is clear that care coordination and transition of care are crucial. Emergency physicians and primary care physicians will be required to collaborate closely to improve the overall health of a defined population.

Groups Participating in ACOs

Emergency physicians may work directly with a physician-based, hospital-based, or insurance-based ACO, or may be indirectly affected by changing reimbursement from ACOs; however, understanding the nuances of each ACO model will be critical to navigating the new ACO world. Below is a description of each of the types of groups participating in an ACO:

- **Physician-Led ACOs.** According to the Brookings Institute, physician-led ACOs tend to have better cost savings and patient quality than ACOs that are hospital/system-based or insurance-based ACOs (Colbert 2014). There are various reasons for this observation. Physician-led ACOs are better at delivering primary care services, are more nimble, less bureaucratic, and create more efficient networks between specialists. Physicians must overcome many barriers, however, to develop a successful ACO. One such barrier is collaboration with other physicians across fiscal and administrative continuums. Physician-based ACOs will face other challenges as well. Some of these challenges are associated with the lack of scale and impact seen by individual physicians as compared to hospitals. Physicians will have to contract directly with systems and hospitals (and often competing hospitals) to care for the patients within their network. This idea is further complicated by the fact that more than 95% of physicians practice in offices with fewer than five physicians.⁵ Regardless, if physician-based ACOs dominate in a market, health policy experts believe there will be a decline in hospital admissions and potentially ED visits as care will be more tightly coordinated to avoid admissions and redirect patients making acute unscheduled care visits.
- **Hospital-Based ACOs.** ACOs developed within a hospital have clear benefits over insurance-based or physician-based ACOs.⁶ Hospitals (and to an even greater extent hospital systems) have both the scale and infrastructure required to address the needs of an ACO. For example, many health systems have invested millions in sophisticated information technology (IT) infrastructure

prior to even creating an ACO. Leveraging this IT infrastructure, hospitals and hospital systems have been able to report on quality and efficiency metrics and identify at-risk or high-risk patient populations, and, in effect, reduce redundant care. Hospitals and large practice management groups with economies of scale also have a strategic advantage with payer negotiations. While government-sponsored ACOs have no negotiation power over Medicaid and Medicare rates, hospital systems do have the ability to work with other payers to mitigate potential administrative expenses or financial losses incurred by a shared savings plan. Finally, hospitals also have some advantage in care coordination if the hospital has invested in outpatient plans for addressing acute care needs and continual care needs for at-risk populations.

Hospitals do face an interesting conundrum, however, when developing an ACO. Based upon a fee-for-service model, hospitals increase revenues by increasing appropriate admissions and services. In the ACO world, the hospital will need to trade short-term revenue for long-term cost savings. Hospitals may also have trouble designing ACOs for two reasons: one, the hospital is often inpatient focused (not outpatient focused) and two, aligning disparate physician groups across specialties may prove to be difficult.

- **Kaiser Permanente.** Similar to the cost constraints and rising costs experienced by the federal government, private payers have also seen astronomical growth in healthcare costs. One such payer, which perhaps was ahead of the ACO and APM curve, was Kaiser Permanente (KP). While not a participant in Medicare ACO models, KP is the largest integrated healthcare plan in the country, with eight regions stretching from the west coast to the east coast and serving almost 9 million patients. KP focuses on collaboration between the patient and professionals. Unlike other commercial or government payers, KP has dedicated access points for in-network patients and has a strong commitment to systematic accountability for all patients. Care coordination and transitional care are areas of focus, with tiered levels of care management based upon patient risk-stratification. In KP's integrated healthcare model, EDs and ED physicians interface with patients; however, patients are encouraged to interface with skilled nursing teams and clinic visits to avoid unnecessary visits to the ED. Similarly, once patients are seen within non-Kaiser EDs, physician access lines are available to non-KP providers to coordinate outpatient care.⁷
- **Private Payer ACOs.** With scenarios such as value-based "contracting," where participating physicians who contract with a payer are required to meet certain metrics and performance indicators in order to receive payments, other private payers have jumped into the ACO pool. In 2012, United Healthcare identified and pursued 8 to 12 pilot ACO programs across the country to identify value-based purchasing models as well as capitated payment models. One such model is the 220 physician ACO in Westchester County, NY. In this model, United Healthcare rewards physicians if the provider reduces costs, improves patient satisfaction scores, and improves quality outcomes for a defined group of United Healthcare beneficiaries. What remains unclear is how the savings are shared and how those shared savings are allocated to providers.⁸

By 2015, United Healthcare has planned for 250 accountable care contracts with 11 million beneficiaries or members benefiting from the value-based programs. By 2018, United Healthcare expects that more than \$65 billion in payments will be tied to value-based, accountable care programs.

Medicaid-based ACOs. Medicaid ACOs are also beginning to grow across the country. Presently, 19 states have decided to enter into Medicaid-based ACOs with varying levels of efficiencies and efficacies. In some states, the governance and structure is similar to that of an MSSP ACO; however, in other states, such as North Carolina, physicians participating in Medicaid ACOs assume the upside and downside financial risks of caring for these patients, with

capitated payment models for a defined population.⁹ As an aside, unlike Medicare ACOs, many of the state-based Medicaid programs also operate on a capitated model. In the state of Oregon, Medicaid has created 16 Coordinated Care Organizations (CCOs; ACO equivalents) covering 90% of Medicaid patients. Although each program has its own separate policies and procedures for caring for beneficiaries, there are some general trends, including capitated payments for Medicaid enrollees and strong coordinated care efforts. Services in the CCOs often partner with mental health and public health resources, provide dental care, and even non-medical interventions such as air conditioning for at-risk patients. Irrespective of the form and policies associated with the Medicaid-based ACOs, the themes and goals are the same. States are taking a proactive approach with physicians in treating higher risk populations.¹⁰

The Role of the Emergency Department in Payment Reform

Emergency departments have been described as the safety net of the United States healthcare system with three roles: (1) fulfilling the mandate of the Emergency Medical Treatment and Labor Act (EMTALA), (2) providing around-the-clock unscheduled care, and (3) providing constant readiness for disasters and emerging pathogens. In the new ACO world, EDs will take on an even greater role in population health management and the continued delivery of high-quality, lower cost care.

Presently, the economic drivers for healthcare finance (fee-for-service) conflict with the accountable, coordinated care (fee-for-value) model in some respects. As payment reform progresses, EDs will not only be central to cost containment in the APM and ACO world, but will also serve as centers for quality improvement and coordinated care. At present, emergency medicine physicians within Medicare ACO programs are being paid in a fee-for-service manner. A question remains however—is the current structure of an ACO using FFS as payment mechanism directly conflicting with the desire for decreased utilization and costs? Shortsighted goals of increasing revenues by increasing admissions and relative value unit (RVU) capture will ultimately be offset by reducing avoidable admissions, improving quality, and decreasing unnecessary RVUs. Here lies the conundrum for hospital executives and ED leaders—revenues may drop if the goals of ACOs and APMs are realized (eg, fewer admissions and fewer ED visits). In effect, reducing visits to the ED and improving outpatient, non-hospital-based care, and by extension the hospital, ultimately reduces hospital and ED revenues in the current FFS reimbursement environment.

Dr. Mark McClellan, past administrator of CMS, explained there is no “prescriptive” way for emergency medicine physicians and providers to develop or work with an ACO. Nonetheless, there are fairly clear themes as emergency physicians navigate ACOs. According to Dr. Steven Farmer, cardiologist and health care policy expert with the Brookings Institution, primary care physicians and emergency physicians must develop strong collaborative relationships with other primary care providers and specialists in the ACO world. Because emergency physicians often control the decision to admit and decisions on interventions and treatment, extensive collaboration and trust with the primary care physician network is critical. Despite the lack of a clear path for the emergency physician’s role within payment reform, emergency physicians will be required to be cost-conscious and collaborative while delivering the highest quality care.

Without engaging emergency providers, ACOs will struggle to manage costs. Emergency physicians are poised to be important partners with accountable care organizations and other APMs and are critical to the success or failure of savings through avoidable admissions and coordinated care. Why? Around 70% of admissions arise from the emergency department, with 80% of primary care physicians sending their patients to the ED for acute care visits. A white paper released by the Rand Corporation, titled [The Evolving Role of Emergency Departments in the United States](#), highlights the importance of the ED in supporting hospital revenue through its ability to (1) facilitate admissions, (2) provide speedy and

complex diagnostic evaluations, and (3) serve as a safety net for individuals with poor access to primary care, as well as those with a perception of an urgent medical condition. The authors note that this study challenges the notion that we should reduce unnecessary ED visits and instead emphasizes the potential of the ED to reduce fragmented care. The ED model *could be expanded* to offer more population health management through partnership with primary care physicians and case managers within the department to better address the needs of the community, which could then lead to reduced costs and expanded access to care.¹¹

Physician Pay and Incentives within an ACO

When developing the incentive and contract structure for physicians in APMs or ACOs, the goal is two-fold: compensate the physician fairly and incentivize physicians in such a way as to drive improvements to the quality of care delivered and the financial goals of the practice. While most physicians are paid either by salaries or on an hourly basis, some hospitals and physician groups have chosen to incentivize physicians based upon certain operational and quality-based metrics. How much of a physician's salary should be incentivized remains a difficult question the medical community has yet to answer. Current research will answer these questions.

Irrespective of the individual contract or incentive compensation for ED providers, more complexity exists when considering how a physician group or, more specifically an ED physician management group, is compensated within an ACO. Two main ED physician contracting themes have emerged from interviews with ACO leaders and ED leaders who are currently working with hospital-based ACOs.

1. Hospital employee models

If the ED physician or provider is a hospital-based ED employee, working with the ACO is fairly straightforward. Most ED physicians are paid via salary with perhaps a small percentage of the salary being incentives based upon quality, throughput metrics, patients per hour, or citizenship-based metrics (ie, meeting attendance, on-call requirements). If the hospital ACO saves baseline ACO beneficiary dollars, the hospital adds those funds back to the hospital's operating revenues and the hospital chooses how or whether to distribute those savings among emergency physicians and other providers. One question which arises is how ED physicians would be compensated or penalized in an academic environment. Will emergency medicine attending physicians be penalized for the care rendered by resident staff? Those governing the ACO will need to determine how savings or penalties are allocated based upon these considerations.

2. Hospital contractors

Small, medium and large; or local, regional and national contract groups working with client hospitals are more complex. Unlike in a hospital-employee based model, contract groups must negotiate the "piece of the pie" and the "claw-back" of the shared savings or the shared risk. Defining the percentage of shared savings will be critical to maintaining the financial stability of the contract group. Consider the following example:

Hospital AB has developed an ACO for which emergency medicine practice management Group A has a three year contract with the hospital. As a part of the agreement, the hospital has required all physicians (including contracted physicians) be enrolled in the ACO. The hospital has also contracted with CMS to provide services to a defined population. CMS has agreed to split the shared savings with Hospital AB. In 2013, the hospital spent \$7 million dollars in expenditures for the defined population, but since the start of the ACO in 2014, the hospital spent only \$3 million dollars on the same population. CMS has agreed to "share" the savings by giving the hospital ACO \$1.5 million dollars. The hospital ACO has now received \$1.5 million dollars back from Medicare for the savings generated by the ACO.

Key questions:

1. Of the shared savings that goes to the hospital, how much is allocated to the emergency medicine practice management group, the primary care team, the hospital, or the other physician members of the ACO team?
2. Of the money allocated to the emergency physicians or the contract group, how is the money divided among the providers?
3. Is the money allocated to the emergency physicians divided among the providers based upon full-time equivalence (ie, 1 FTE versus ½ time FTE), or is the money divided on RVU capture, patient encounters, or some other metric?
4. Do you penalize those with greater RVU capture in the practices since in effect, these providers are costing the ACO more money?
5. Do the providers have incentives that are based upon quality metrics such as readmissions rates or other quality indicators as defined by the government for the specialty?
6. How will payments based upon quality initiatives shift as the governments reporting system shifts from PQRS to MIPS (merit-based initiative payment system)?

Clearly, emergency medicine leadership and physicians must be engaged early in the process of ACO development, especially if portions of the emergency physician's financial wellbeing are tied to the activity within the ACO. Furthermore, although a lack of clarity exists regarding the type or amount of incentives, as well as the portion of savings allocations that should be given to each emergency physician, emergency medicine leadership must have the tools to understand the APM environment, the business acumen to navigate hospital/business corporate structures, and the skillset to negotiate effectively for emergency medicine providers and their group's interests.

Although many questions remain regarding emergency physician compensation within the ACO model, lack of coordination and inclusion of the voice of emergency physicians and other specialists would negatively affect the overall success of the ACO. Because the largest savings in healthcare will be derived from decreasing avoidable admissions, emergency physicians are well positioned to impact the financial decisions made by the ACO. For example, in the fee-for-service model, emergency physicians are paid by the service rendered. The economic driver in the current model is a do-more, paid-more plan. However, in APMs, the more an emergency physician does (eg, diagnostics, testing, admissions) the *less* the ACO will save and ultimately, the less the physician may be paid and may even be penalized. Clearly, these payment arrangements will be determined by the ACO governing body. Having emergency physician leaders at the table when these decisions are made will be critical to an ACO's success.

ACOs and APMs in Emergency Care

For EDs to survive financially and best serve patients, ACOs and other APMs must encourage more appropriate use of the ED, strong care coordination within and outside of the walls of the ED to decrease avoidable admissions, and more efficient care during the ED stay. Since the ED is the proverbial "front-door" to the hospital, and admissions to the hospital drive costs, emergency physicians play a significant role in population health management.

Pre-Emergency Department Redirection. Within the ACO or even outside of an ACO, redirection has become a common theme in reducing inappropriate ED admissions and by extension, inpatient admissions. Various ACOs and APMs have tackled this problem in a multitude of manners:

- Educating outpatient physicians regarding appropriate referrals;
- Developing referral management protocols;
- Creating inter-hospital information exchange programs;

- Skilled-nursing and nursing home facility redirection;
- Identifying appropriate housing for the homeless;
- Working with emergency medical services (EMS) and city government to identify alcohol detox facilities;
- Identifying alternative access points to emergency physicians (such as mobile and video interface with providers, urgent cares and after-hours physician office visits); and
- Educating patients regarding appropriate ED use.

An interesting initiative by Washington State Medicaid helps address inappropriate ED use. The “ER is for Emergencies” Campaign addresses solutions for reducing ED use among Medicaid patients. These practices of reducing ED visits could cause increased financial pressures on an emergency physician group or hospital. The cost and acuity of patients within the ED could also rise for individual episodes of care.

Efficient, High-Quality ED Care. Once a patient arrives at the hospital or ED campus and requests care (irrespective of appropriateness or not), the federal government mandates that qualified medical personnel provide a medical screening exam to those patients under EMTALA. Nonetheless, ED leaders can design efficient, best-practice EDs to reduce the time patients remain within the department and obtain efficient, appropriate care in the appropriate place. Quality improvement is also a focus in value-based care. Developing protocols and standards of care to reduce variability will be another area of continued focus in the APM world. Some of the examples of best practices include the following:

1. **Split-Flow Management.** Identifying low acuity, ambulatory patients seen by appropriately licensed practitioners can improve throughput times and reduce the cost to the healthcare system.
2. **Use of Physician Assistants, Nurse-Practitioners and Scribes.** Because practice expense costs have risen and revenues have decreased, profit margins have been squeezed. To mitigate the cost to the practice, emergency medicine leaders should consider the use of physician extenders to work to their highest level of licensure. Scribes have also been used with great success to improve workforce efficiencies.
3. **Integrated IT.** Having a robust IT infrastructure is one of the strongest methods for improving the quality of care delivered while reducing unnecessary interventions. Some of the goals of an integrated IT infrastructure and regional health information exchanges are as follows:
 - Improve patient safety by reducing medication and medical errors
 - Increase efficiency by eliminating unnecessary paperwork and handling
 - Provide caregivers with clinical decision support tools for more effective care and treatment
 - Eliminate redundant or unnecessary testing
 - Improve public health reporting and monitoring
 - Engage healthcare consumers regarding their own personal health information
 - Improve healthcare quality and outcomes
 - Reduce health related costs
4. **Standardized Clinical Pathways.** Hospitals that have identified pathways for conditions such as heart failure, pneumonia, sepsis, and stroke have seen improvements not only in the quality of patient care delivered, but reduction in costs.
5. **Focusing on Appropriate Metrics.** ED leaders should identify appropriate metrics for tracking the care of patients. More importantly, they should identify which metrics align closely with the interests of their ACO and the needs to drive change in physician practice.
6. **Care Management.** Care management or patient navigation is perhaps one of the greatest areas of opportunity for reducing inappropriate admissions, improving outcomes, and decreasing avoidable ED presentations. For at-risk and high-risk patients, care coordination that invests in

transitions of care, either out of the ED or observation unit, will be critical for avoiding readmissions.

7. **Opioid and Pain Management Protocols.** Opioid prescriptions have increased by a factor of 10 between 1990 and 2007, with a significant increase in related ED visits.¹² With improved protocols and management of non-cancer opioid prescribing practices, EDs can expect to see a reduction in opioid-related visits.¹³ Refer to ACEPs’ “[Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department](#).”
8. **Develop care plans for frequent users.** Some EDs have developed specific treatment plans for ED super-users, limiting unnecessary studies and redundant, low-value interventions.
9. **Palliative Care and End-of-Life Care.** Founded in Rockford, Illinois, OSF Healthcare was one of the first ACOs within the Medicare Pioneer ACO Program. OSF Healthcare utilizes both emergency physicians and ED nurses for delivering end-of-life and palliative care. Central to their mission, emergency-trained palliative care physicians and nurses interact closely with ED patients to start the conversation about end-of-life decision-making. To better serve their population, OSF Healthcare, with the support of the ED, introduced a supportive care initiative within the surrounding community to promote advance care planning. Palliative care team members, including emergency physicians, address individual patients’ illnesses while simultaneously working to address the needs of both patients and their families. The involvement of emergency physicians in the advance care planning process ensures that open discussions regarding care preferences lead to the fulfillment of patients’ wishes regarding end of life care.¹⁴
10. **Development of Observation Units.** More hospitals are using emergency medicine leaders to develop highly efficient, focused observation units. Ultimately these units, many of which are staffed by emergency physicians, have been demonstrated to save money. In a study released in 2013, patients falling within defined protocols, who were observed, versus admitted, experienced between 23 and 28% reduction in length of stay. Similar savings on a national level could reach nearly \$1 billion dollars. Furthermore, these researchers predicted savings could reach as much as \$5 billion dollars annually if observation medicine were expanded nationally to other short-stay inpatients.¹⁵
11. **Tracking Quality Metrics.** Provider-based measures focus primarily on the clinical care of specific medical conditions. On the other hand, hospital-specific quality measures – such as ED throughput, timeliness of care, utilization of imaging resources, and system-based factors – have a substantial impact on the practice and reimbursement methods of emergency-based care.¹⁶ Although the United States Department of Health and Human Services (DHHS) has designed specific measures within emergency medicine, ED leaders should consider developing quality metrics internally to align with their ACO.¹⁶
12. **Continual Education and Process Improvement.** As gaps are identified with providers and the department structure in the APM world, leaders will have to recognize opportunities and strategies for continual education and system improvement.

Post-ED Care. Once the patient leaves the ED, the ED can continue to serve patients by ensuring high quality, post-ED follow-up care. The following are best practices for improving such care:

1. **Care managers and navigators.** Care management can leverage IT by not only identifying super-users, but by alerting care management teams of the discharge of ACO patients to help outpatient care-coordination.
2. **Develop stronger relationships with hospitalist teams and primary care physicians.**
3. **Patient educators and 24 Hour Follow-Up Calls.** Once the ED team identifies high-risk patients, patient educators can be used both within and outside of the ED to help ensure that patients understand their discharge instructions, their prescriptions, and their follow-up plan.
4. **Community Care Navigation.** Once patients leave the ED, care navigators will need to liaise with high-risk patient populations to decrease readmissions and ultimately reduce avoidable care episodes. An article recently published by [the Brookings Institute](#) highlights the importance of

population health management in pediatric patient populations. In this article, the authors identified that the roots and treatment of asthma often lie outside of the healthcare world. Leveraging social services and investing in programs to address the underlying causes of asthma like reducing environmental triggers and second-hand smoke will ultimately improve outcomes, decrease costs and support stronger ACO financials.¹⁷

Challenges for ED Physician Leaders

Depending on the ACO model, emergency physicians may find hospital administrative support lacking or even absent. In hospitals with limited bandwidth financially and administratively, developing the required infrastructure to support an ACO can be difficult. Even outside of garnering support from the hospital, emergency physician leaders may also have the following challenges:

1. **Developing incentives for employees.** Developing meaningful incentives has been elusive in other industries. In medicine, financial incentives have been based upon productivity, acuity, and volume. In APMs, to ensure incentives are aligned, physician leaders will need to design incentives that promote collaboration and avoid unnecessary testing/visits.
2. **Negotiating for shared savings payouts.** As mentioned in a previous section, EM leaders will need to understand the financial implications of a shared savings program and have the skill set to negotiate with hospitals and/or physician group leaders.
3. **Working with care coordination.** In the past, hospitals have focused on care coordination at the point of discharge from an inpatient admission. Hospitals and EDs will now have to shift to coordinating care in the ED to reduce inappropriate or avoidable interventions such as re-admissions. EDs may have to consider alternatives to admission, observation or discharge and begin identifying other alternatives for patient placement such as skilled nursing facilities, rehabilitation units, home health entities or other options for the those patients who will likely need continued, outpatient-based care.
4. **Resource limitations.** Depending upon the hospital, resources may be significantly limited to accomplish many ACO goals. Unfortunately, one concern of the Medicare Pioneer ACO Program has been significant administrative cost (which would include resources to support care coordination, quality metrics tracking, IT infrastructure, and administrative assistance).
5. **Change in culture.** Most emergency physicians have practiced within a fee-for-service environment since emergency medicine's inception. As value-based purchasing/contracting and APMs expand, emergency medicine providers and leadership will need to understand the changing business model and adjust rapidly to the quickly shifting landscape.
6. **Liability and risk.** As with any change of care model, liability and risk must be considered and explored. Unlike in some states with HMOs that have liability exemptions, there will likely be few exemptions for participants in ACOs. Providers will also have increased duties to practice within the guidelines of evidence-based medicine, while facing heightened scrutiny with internal and publically reported metrics. Will "breaches" in protocol and failures to provide reasonable care, as deemed by that of a reasonably prudent doctor or the ACO, be used against clinicians in court? Will the paper trail used to assess the success of a specific physician fall outside of the normal peer review protections and become accessible documents of plaintiffs' attorneys? These questions presently have few answers. Conversely, improvements to documentation and the enhanced abilities of an integrated health record may *reduce* physician liability. Presently, ACOs may be too early in their infancy to appreciate the full effects of liability on ACO implementation.¹⁸

The Current State of ACOs

A 2014 article in *Health Affairs* found ACOs thus far to be more concentrated in the Southern United States.¹⁹ Furthermore, compared to non-ACO patients, patients participating in an ACO were more likely

to be over the age of 80, and were less likely to be Black or eligible to receive Medicaid benefits. Along those lines, they also had higher incomes than non-ACO patients. Total costs of care were nearly \$500 less for ACO patients compared to non-ACO patients, and both hospital and non-hospital costs were lower overall.

The quality of care provided at ACO hospitals did not differ greatly from the care delivered at non-participating hospitals; however, the characteristics of participating hospitals differed significantly from non-ACO hospitals. ACO-participating hospitals were larger, often located in the Northeast and Midwest, not-for-profit, and located in urban areas. Of interest, more than half of the ACOs examined in the study did not include a hospital participant.

Compared to hospital referral regions (HRR) that did not contain an ACO headquarters, total Medicare spending per beneficiary was higher in HRRs that did contain one or more ACO headquarters; however, based on prevention quality indicators (PQIs), the study found no significant difference in the rate of hospitalization for care-sensitive ambulatory conditions.

As for the Medicare Pioneer ACO Programs, the success has been mixed. Initially the Pioneer Program started with 33 ACOs. Now there are only 19. Nonetheless, collectively the Medicare Pioneer ACO Programs have demonstrated benefit. In year 1, the programs saved \$254 million. In year 2, the savings reached \$100 million. These savings translate into \$35.62 per beneficiary-per-month (PBPM) in 2012 and \$11.18 PBPM in 2013. When evaluating the Medicare Pioneer ACO Programs, researchers sought to ascertain if there would be a “spill-over” effect. The expectation was that care coordination would “spill-over” outside of the ACO to non-ACO beneficiaries. Thus far, the effect has been negligible and care coordination has only affected those patients who are enrolled in the ACO.²⁰

Conclusions

The Affordable Care Act and more recently the passage of the Medicare Access and CHIP Reauthorization Act have been designed to tackle the increasingly fragmented, poorly coordinated, inefficient, and costly healthcare system in the United States. Resulting incremental changes to the system, including the establishment of physician, hospital, state-based ACOs and other APMs, have begun to demonstrate the improved quality and reduced costs that can be obtained through incentivized, coordinated care designed to meet strict quality standards.

To succeed, an ACO must be efficient, cost-effective, sustainable, and consistently deliver quality care to patients while rewarding physicians financially for a job well-done. As the proverbial safety net for millions of patients in the United States, EDs are central to cost containment in the healthcare system. They must also be recognized as integral to the delivery of palliative care and for their ability to impact overall savings through avoiding admissions and coordinating care. However, despite the best intentions of health policy experts and the early designers of ACO organizations, emergency physicians (as well as other specialists) have been largely omitted from alternative payment plans. In addition to facilitating cost savings, EDs are ideal conduits for quality improvement and care coordination.

Increased involvement for EDs and emergency physicians within an alternative payment system does incur challenges. Incentive development, care coordination within the ED, resource limitations, and culture change must all be addressed in order for emergency medicine EM to contribute effectively within an ACO.

*Created by members of the ACEP Emergency Medicine Practice Committee
August 2015*

References

1. Pilgrim R, Hilton JA, Carrier E, et al. [Research priorities for administrative challenges of integrated networks of care](#). *Acad Emerg Med*. 2010;17(12):1330-1336.

This article discusses the multiple administrative systems currently in place to support the delivery of emergency care in the United States, while highlighting the administrative challenges that pose a threat to current efforts to integrate and coordinate regionalized accountable emergency care systems.
2. Centers for Medicare & Medicaid Services. [Accountable Care Organizations \(ACO\)](#). January 2015.

This document provides healthcare providers a brief overview of accountable care organizations, including information regarding the impact on Medicare patients. Resources to obtain more information are also provided.
3. Colbert J, Kocot SL, Brenner R, et al. [Adopting Accountable Care: An Implementation Guide for Physician Practices](#). The Engleberg Center for Health Care Reform at Brookings. November 2014.

This toolkit is designed to illuminate the unique challenges and opportunities that relate to physician-led ACOs. It offers emerging physician-led ACOs important knowledge and tools to address the management of high-risk populations, aid in the development of high-value referral networks, and foster patient engagement.
4. Peterson M, Muhlestein, D. ACO Results: What we know so far. *Health Affairs Blog*. May 30, 2014.

This blog post summarizes the quality and financial results of the 32 Medicare Pioneer ACOs.
5. Hing E, Burt CW. [Office-based Medical Practices: Methods and Estimates from the National Ambulatory Medical Care Survey](#). Advance data from vital and health statistics; no. 383. Hyattsville, MD: National Center for health Statistics. 2007.

This report uses data collected through physician induction interviews for the 2003-04. National Ambulatory Medical Care Survey to estimate the number and characteristics of United States medical practices. Results revealed over 311,000 office-based physicians practiced in approximately 161,200 medical practices in the United States in 2003-04. Over 8% of medical practices involved multiple specialties and 15% of practices utilized electronic medical records.
6. Kocher R, Sahni NR. [Physicians versus hospitals as leaders of accountable care organizations](#) *New Engl J Med*. 2010;363(27):2579-2582.

Published in 2010, shortly after passage of the Affordable Care Act, this article outlines the aims of the Act and projected impact on the United States healthcare system. The authors discuss in detail the role that ACOs will play in the successful implementation of the Act, as well as the efforts that must be put forth by physicians and hospitals to ensure that ACOs function to the best of their design.
7. McCarthy D, Mueller K, Wrenn J. [Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology](#). The Commonwealth Fund. Case Study: Organizational Healthcare Delivery system. June 2009.

This case study examines the integrated healthcare delivery system of Kaiser Permanente, the largest nonprofit integrated healthcare delivery system in the United States. The success of Kaiser Permanente is rooted in both quality and efficiency and achieved through teamwork, provision of high-value care, continuing innovation, improved access to care, attainment of performance benchmarks, and the use of an integrated and multidisciplinary group practice.
8. [WESTMED Medical Group Launches Accountable Care Organization \(ACO\) in Collaboration with United Healthcare and Optum](#). March 20, 2012.

This press release announces the collaboration between UnitedHealthcare, Optum, and WESTMED Medical Group in order to reduce cost, improve quality outcomes, and increase patient satisfaction.

9. Hervey D. [What You Should Know About Medicaid ACOs.](#) Becker's Hospital Review. April 25, 2014.
This brief article discusses the disparities in state-initiated Medicaid ACOs, using ACO development in Oregon, North Carolina, and New Jersey as examples.
10. McConnell KJ, Chang AM, Cohen DJ, et al. [Oregon's Medicaid Transformation: An Innovative Approach to Holding a Health System Accountable For Spending Growth.](#) *Healthcare*. 2014;2(3):163-167.
This article describes Oregon's recent transformation of its Medicaid program via interaction with the Centers for Medicare and Medicaid Services, and describes how the program's resulting structure compares to Accountable Care Organizations and other payment models.
11. Morganti KG, Bauhoff S, Blanchard JC et al. [Research Report: The Evolving Role of Emergency Departments in the United States.](#) The Rand Corporation, Copyright 2013.
This Research Report from the Rand Corporation utilizes both quantitative and qualitative methods to investigate the changing role of hospital emergency departments and their staff in the evaluation and management of complex patients. This study presents a number of findings regarding the role of emergency departments in hospital admissions and diagnostic workups, as well as factors affecting patients' utilization of the emergency department.
12. Weiner SG, Perrone J, Nelson LS. [Centering the Pendulum: The Evolution of Emergency Medicine Opioid Prescribing Guidelines.](#) *Ann Emerg Med*. 2013;62(3):241-243.
The intent of this brief article is to clarify the intent of the New York City guidelines regarding emergency department opioid utilization. The authors stress that the prescribing guidelines announced by New York City mayor Michael Bloomberg are simply recommendations and not mandates.
13. Department of Health and Human Services (DHHS). [Addressing Prescription Drug Abuse in the United States. Current Activities and Future Opportunities.](#) 2013.
This comprehensive DHHS report describes current efforts to address the growing drug abuse problem in the United States. With a focus on opioids, the report details efforts underway with regard to surveillance, drug abuse prevention, education (public, patient, and provider), clinical practice tools, regulation and oversight activities, drug abuse treatment, and overdose prevention.
14. Kriz J, West S. [Value of an Emergency Physician on a Palliative Care Team.](#) May 14, 2014.
This blog post highlights the role that emergency medicine physicians play in a palliative care team by emphasizing their role in assisting patients and families in decision-making and facilitating care coordination between primary care physicians and specialists.
15. Ross MA, Hockenberry JM, Mutter R, et al. [Protocol-Driven Emergency Department Observation Unity Offer Savings, Shorter Stays, and Reduced Admissions.](#) *Health Aff (Millwood)*. 2013;32(12):2149-2156.
This study compared 2010 data from a case study in Georgia, statewide Georgia discharge data, and a national survey and discharge data to compare length-of-stay, probability of subsequent inpatient admission, and potential national cost savings annually.
16. Newell R, Slesinger T, Cheung D, et al. [The State of Emergency Medicine Quality Measures.](#) ACEP, 2011.
This article provides background on national quality measure reporting and includes information on financial incentives and penalties for reporting measures.
17. Farmer S, McStay F, George M, et al. [Community Based Approaches to for Optimal Asthma Outcomes and Accountable Population Health.](#) September 2015.
This article highlights community based initiatives across the country designed to improve the outcome of asthma in pediatric populations. Additionally, the authors identify various groups that can work collaboratively to improve the health of asthma patients.
18. DiGiancinto C, Rubin JD, Berkowski. [Potential Liability Risks and Solutions for Accountable Care Organizations.](#) *AHRMNY Risk Management Quarterly*. Summer 2013.

This paper discusses the potential for increased risks and liability for providers entering the ACO landscape. It discusses a number of potential defensive solutions that providers and their counsel can utilize to mitigate these increased risks.

19. Epstein AM, Jha AK, Orav EJ, et al. [Analysis of early accountable care organizations defines patient, structural, cost, and quality-of-care characteristics.](#) *Health Aff (Millwood)*. 2014;33(1):95-102.

This study offers insight into the structural and market characteristics of early ACO programs for Medicare beneficiaries. The authors report that ACO patients in these early programs were more likely than non-ACO patients to be over the age of 80 and have higher incomes, while less likely to be Black, covered by Medicaid, or disabled. The costs of care for ACO patients were also found to be slightly lower.

20. Patel K, Lieberman S. [Taking Stock of Initial Year One Results For Pioneer ACOs.](#) Health Affairs Blog. July 25, 2013.

This blog post discusses five key results obtained by CMS at the conclusion of the first year following implementation of the Medicare Pioneer ACO Program. Results discussed include the following: (1) success of the program (as measured by continued participation of the initial ACOs); (2) quality of care delivered compared to industry benchmarks; (3) financial performance tied to savings bonus payments; (4) future challenges; and (5) program modifications moving forward.

Additional Reading

- Barnet S, Rosin T, Punke H. [ACO Manifesto: 75 Things to Know about Accountable Care Organizations.](#) *Becker's Hospital Review*. October 9, 2014.

This resource reviews the basics of ACOs, as well as ACO-related terminology, Medicare and Medicaid-based ACO specifics, and the essential relationship between health informatics and ACOs.

- [Evaluation of CMMI Accountable Care Organization Initiatives. Contract HHSM-500-2011-009i/HHSM-500-T0002. Pioneer ACO Evaluation Findings from Performance Years One and Two.](#) L&M Policy Research. March 10, 2015.

This comprehensive report regarding the evaluation of Pioneer ACOs during years one and two of implementation examines total savings and total spending, with a focus on the situations and factors contributing to both. Both patient- and expenditure-related factors were considered.

- Pines JM, Presser E, George M, et al. [Can Payment Reform Improve Emergency Care? The future of emergency department care costs, both for patients and hospitals.](#) April 28, 2015.

This brief article discusses how payment reforms impact the role of the emergency department in the healthcare system, and offers insight into the challenges faced when addressing payment reforms that impact emergency medicine.

Glossary

**Note: All definitions provided in this section were obtained from the CMS website (www.cms.gov and <https://www.healthcare.gov/glossary/>)*

Accountable Care Organization - A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Advanced Payment ACO Model - A supplementary incentive program for selected participants in the Shared Savings Program.

AHRQ - Agency for Healthcare Research and Quality - the Agency for Healthcare Research and Quality's (AHRQ) mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

Cost Sharing - The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Co-Op- A non-profit organization in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors, hospitals, and businesses as member-owners. Co-ops will offer insurance through the Marketplace.

Cost Sharing Reduction - A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category. If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

CMS - (Centers for Medicare and Medicaid Services) - The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.

DME - (Durable Medical Equipment) - Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

EPSDT - Early and Periodic Screening, Diagnostic and Treatment Services - A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

EPO - Exclusive Provider Organization - A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

ESRP - Employer Shared Responsibility Payment - The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

FQHC - Federally Qualified Health Center - Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

Fee-for-Service - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

HCUP - Healthcare Cost and Utilization Project- The Nation's most comprehensive source of hospital data, including information on in-patient care, ambulatory care, and emergency department visits. HCUP enables researchers, insurers, policymakers and others to study health care delivery and patient outcomes over time, and at the national, regional, State, and community levels.

HMO - Health Maintenance Organization - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

HCBS - Home and Community Based Services - Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

MACRA (Medicare Access and CHIP Reauthorization ACT) - MACRA was signed into law by President Obama in April 2015. Under the act, the SGR (Medicare Sustainable Growth Rate) was repealed and replaced by value-based purchasing initiatives.

Medicare Advantage (Medicare Part C) - A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Prescription Donut Hole - Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Medical Loss Ratio - MLR - A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medicare Part D - A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Shared Savings Program (MSSP) - A program that helps a Medicare fee-for-service program providers become an ACO

Minimum Essential Coverage - (MEC) - The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

MIPS - Merit-based Incentive Payment System - The proposal would replace the SGR with the Merit-based Incentive Payment System (MIPS), a process that combines existing Medicaid incentive programs

and creates a composite performance score that will inform a provider's reimbursement rates based on four performance categories:

- **Quality:** measures to be determined on an annual basis by the Department of Health and Human Services (HHS) with stakeholder input.
- **Resource use:** measures level of resources appropriate for specific care episodes.
- **Meaningful use:** this will follow current MU standards set in Electronic Health Record (EHR) policy.
- **Clinical practice improvement activities:** increased use of practices such as alternative payment methods (APM) and others as established with stakeholder input.

A provider's performance in these categories will be reflected in the Composite Performance Score, a 0-100 scale that informs the level of reimbursement. A threshold would be established annually that providers would have to meet or exceed in order to be eligible for enhanced rates. Those who fail to meet the threshold would be at risk of reduced rates. MIPS may replace the SGR in 2019.

Pioneer ACO Model - A program designed for early adopters of coordinated care. No longer accepting applications.

PQRS - Physician Quality Reporting System - A quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. Beginning in 2015, CMS will subject eligible professionals who are not successful reporters under Physician Quality Reporting to a payment adjustment. By way of background, this year CMS will stop issuing bonuses for PQRS and continue penalizing for not participating or failing the PQRS measures. The penalty is potentially 2-6% of your Medicare reimbursement in 2017 if you fail the measures or fail to report. The below tips should help you to pass for 2015 to avoid a 6% adjustment or penalty. The average doc stands to lose \$1500- \$4000 depending on their population (based on the 2012 Medicare database). While the Name will change from PQRS to MIPS after the SGR fix when through, the concepts, rewards and penalties will stay the same.

Qualified Health Plan - Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Skilled Nursing Facility - Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

State Health Insurance Assistance Program - (SHIP) - A state program that gets funding from the federal government to provide free local health coverage counseling to people with Medicare.

Value-Based Modifier (VM) - The Affordable Care Act requires that CMS apply a value-based modifier (VM) to Medicare physician fee schedule payments starting with select physicians in 2015 and all physicians by 2017. Unlike the Physician Quality Reporting System (PQRS), which is a pay-for-reporting program that focuses only on quality, the VM is tied to physician performance on a composite of quality and cost measures. Since 2017 VM adjustments are based on 2015 performance and apply to group practices of any size, as well as solo practitioners, it is critical that emergency physicians understand how they may be affected by this program.

Value-Based Purchasing (VBP) - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.