

# Empowering Emergency Medicine Through the Acute Unscheduled Care Model

## Understanding Public and Private Payors' Arrangements is Key for Uptake and Implementation

Novel structures for payment and care delivery help move our healthcare system away from incentivizing volume and towards prioritizing value. Recent efforts within Medicare (federally operated), Medicaid (state-based) and commercial markets signify payors are committed to creating a system that rewards quality and efficient patient-centric care.<sup>1,2,3</sup>

Payors are optimistic about alternative payment models (APMs) as a strategy for lowering health costs and improving quality.<sup>4</sup> Value-based efforts are hindered in many cases by stakeholders being split over who is ultimately responsible for driving reform efforts.<sup>5</sup> Physicians and other healthcare practitioners need the appropriate tools to support APM uptake and implementation and flexible financial arrangements to account for their position within the healthcare transformation continuum.<sup>6</sup>

## The Role of Emergency Medicines (EMs) in Physician Driven Health Reform

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) stipulates that Medicare rewards physician services using a rate setting method focused on value.<sup>7</sup> MACRA also created the Quality Payment Program (QPP), a new Medicare physician performance program.<sup>8</sup> The QPP includes two tracks: the Merit-based Incentive Payment System (MIPS) and Advanced APMs (AAPMs). Physicians who meaningfully participate in AAPMs are exempt from MIPS and potentially eligible additional Medicare payments.<sup>8</sup> Entities may benefit financially through AAPM participation due to increased shared savings, additional access to waiver payments and potential Medicare bonus payments after reaching specific thresholds. However, participating in an AAPM can be challenging as it requires physicians to take on a nominal amount of financial risk.<sup>9</sup> In addition, health systems vary in their ability to engage in transformation efforts and significant infrastructure barriers exist.

### Alternative Payment Models Definition

- Centers for Medicare & Medicaid Services (CMS) defines Alternative Payment Models (APMs) as the rules and structures outlining the payments made to physicians and other clinicians that incentivize delivering high-quality and cost-efficient care.
- Participation in any form of payment model requires a payor to offer a financial agreement that is different from the traditional fee-for-service (FFS) reimbursement structure.

Sources: Centers for Medicare and Medicaid Services (CMS). QPP Program Overview. (2019). <https://qpp.cms.gov/apms/overview>

<sup>1</sup> Nursing Center. GEDI WISE Model Feasible for Geriatric Emergency Care. (2015). [https://www.nursingcenter.com/healthdayarticle?Article\\_id=699162](https://www.nursingcenter.com/healthdayarticle?Article_id=699162)

<sup>2</sup> Center for Improving Value in Healthcare (CIVHC). Colorado's Accountable Care Collaborative. <https://www.civhc.org/change-agent-gallery/colorados-accountable-care-collaborative/>

<sup>3</sup> Modern Healthcare. Highmark Health to deliver hospital care at home. (2019). [https://www.modernhealthcare.com/home-health/highmark-health-deliver-hospital-care-home?utm\\_source=modern-healthcare-daily-dose-wednesday&utm\\_medium=email&utm\\_campaign=20191113&utm\\_content=article2-readmore](https://www.modernhealthcare.com/home-health/highmark-health-deliver-hospital-care-home?utm_source=modern-healthcare-daily-dose-wednesday&utm_medium=email&utm_campaign=20191113&utm_content=article2-readmore)

<sup>4</sup> Centers for Medicare and Medicaid Services (CMS). Advanced APMs Overview. (2019). <https://qpp.cms.gov/apms/advanced-apms>: APMs can apply to a specific clinical condition, a care episode, or a population. Examples of APMs include accountable care organizations (ACOs), medical homes, and bundled payment models. Payors include traditional Medicare, Medicare Advantage, Medicaid or Commercial insurers

<sup>5</sup> Jacqueline LaPointe. Doctors, Employers Disagree on Healthcare Payment Reform Strategy. (2018). <https://revcycleintelligence.com/news/doctors-employers-disagree-on-healthcare-payment-reform-strategy>

<sup>6</sup> Health Care Payment Learning & Action Network (HCP-LAN). APM Framework. (2017). <https://hcp-lan.org/apm-refresh-white-paper/>

<sup>7</sup> Centers for Medicare and Medicaid Services (CMS). MACRA About. (2019). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs>

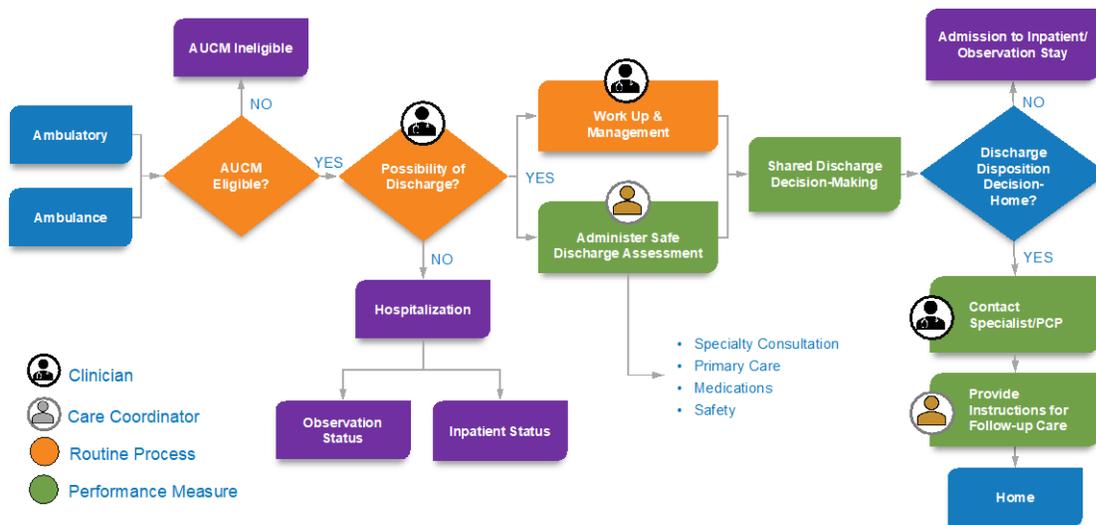
<sup>8</sup> Centers for Medicare and Medicaid Services (CMS). MACRA About. (2019). <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs>

<sup>9</sup> American College of Emergency Physicians. Emergency Medicine Alternative Payment Models: Frequently Asked Questions. (2019). <https://www.acep.org/federal-advocacy/federal-advocacy-overview/APM/apm-faqs/#FAQ4>

Currently, EM physicians are not eligible to participate directly in the AAPM track of the QPP.<sup>10</sup> Existing AAPMs establish episodes of care that begin at inpatient admission and exclude services provided in the ED. Also, many of CMS' models rely on metrics such as reducing ED return visits or readmissions. Yet, ED initiated episodes of care represent a significant expenditure across the health system. Medicaid dollars account for the majority of payments made to the ED (37%), 32% of ED payments from private insurance, and Medicare accounts for approximately 18%.<sup>11</sup> In 2016, there were 145.6 million ED visits and about 31.4 million visits were attributable to Medicare beneficiaries.<sup>12</sup> Among Medicare beneficiaries' visits, 22.4% of patients between ages 65-74 and 25.9% of patients over age 75 were admitted.<sup>12</sup> Thus, findings demonstrate significant opportunity to lower costs and improve quality of acute unscheduled care delivered in the ED.

To fill the void in EM-focused value-based payment arrangements, ACEP developed the Acute Unscheduled Care Model (AUCM) and submitted the proposal to the Physician Technical Advisory Committee (PTAC) for consideration in 2017.<sup>13</sup> In September 2019, Secretary Azar formally responded to PTAC's recommendation, acknowledging EM physicians' ability to influence the cost and quality of care transitions and the necessity to engage EM physicians in healthcare reform efforts.<sup>14</sup> The Secretary also stated that he was interested in exploring how the concepts in the AUCM model could be incorporated into models under development at CMS' Center for Medicare and Medicaid Innovation (CMMI).<sup>14</sup>

## Exploring the AUCM's Framework:



As originally constructed, the AUCM is a voluntary model that seeks to address ED care and engage EM physicians directly by supporting their efforts to reduce hospital inpatient admissions or observation stays, ensure safe discharge decisions, foster effective care coordination, reduce adverse post-ED patient safety events, and decrease overall system costs. The model is built upon the traditional fee-for-service reimbursement model. It allows EM groups or hospitals to accept financial risk directly attributable to discharge decisions within qualifying episodes of acute unscheduled care while reimbursing for services to support post-discharge care coordination. EM physicians and groups can participate regardless of employment model, and incentives are linked to same-hospital performance due to variations in population health, infrastructure and facility capabilities.

<sup>10</sup> Emergency physicians as a provider category have “no avenues to participate in a Medicare APM”. Leavitt Partners. Medicare Alternative Payment Models: Not Every Provider Has a Path Forward. (2017). <https://leavittpartners.com/whitepaper/medicare-alternative-payment-models-not-every-provider-path-forward/>

<sup>11</sup> Centers for Disease Control (CDC). National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Summary Tables. (2016). [https://www.cdc.gov/nchs/data/nhamcs/web\\_tables/2016\\_ed\\_web\\_tables.pdf](https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf)

<sup>12</sup> Centers for Disease Control (CDC). Emergency Department Visits, Fast Facts. (2016). <https://www.cdc.gov/nchs/fastats/emergency-department.htm>

<sup>13</sup> The PTAC ultimately recommended the model to Secretary of the Department of Health and Human Services (HHS) Alex Azar, for full implementation in late 2018.

<sup>14</sup> Health and Human Services Secretary Response to the PTAC. (2019). <https://downloads.cms.gov/files/ptac-hhsresponse-sep18-dec18.pdf>

## ED Care Process Under The AUCM:

**Payor and Model Alignment:** The AUCM could be an ideal APM construct to incorporate into existing and future bundled payment or population-based models being adopted in both urban and rural communities. Medicaid and private payors are encouraged to incorporate core concepts of the AUCM to empower EM-participation in APMs.<sup>15</sup>

Existing CMS Model Alignment		
Current CMS Model	Focus	The AUCM Focus
Readmission Reduction Program	Reduce acute care readmissions	Reduce post-ED visit admissions or observation stays
Hospital Acquired Condition Reduction Program	Reduce HACs	Reduce post-ED Patient Safety Events
Transitional Care Payment	Improve post-hospitalization care transitions	Improve post-ED care transitions
CJR and BPCI Advanced	Incentivize telehealth and post-discharge visits by non- HHA providers	Incentivize telehealth and post- discharge visits by non HHA providers
MACRA Cost of Care Measures	30-day post-inpatient discharge costs	30-day post-ED discharge costs

**Bundled Payment and Episodes:** The AUCM is structured as bundled payment focused on specific episodes of acute unscheduled care. The episode of care begins when a Medicare patient arrives at the ED presenting symptoms associated with one of the four qualifying high-volume ED undifferentiated conditions including abdominal pain, altered mental status, chest pain, or syncope.<sup>16</sup> ED visits that result in a discharge home, inpatient admission and visits resulting in observation services are considered qualifying or anchor events for the AUCM.<sup>17</sup>

**Patient Centered Care Re-Design:** The AUCM stipulates payment waivers for ED acute care transition services, telehealth services, and post discharge home visits. The waivers provide EM physicians with the necessary tools to better coordinate care and promote improved patient outcomes. The model does not involve any changes to ED clinical guidelines. Concurrent to clinical care provided during the patients ED visit, an EM healthcare professional will administer a safe discharge assessment (SDA) to identify socio-economic factors and potential barriers to safe discharge, needs related to care coordination, and additional assistance that may be necessary.<sup>18</sup> Information captured in the SDA informs unique patient care instructions provided at the time of discharge.<sup>19</sup> The EM physician participates in shared decision-making by coordinating with the primary care physician or specialist assuming care of the patient after ED discharge. Finally, the ED organization arranges follow-up services by telephone, in-person visits, or telehealth outreach.

Support Waivers Included in the AUCM	
Telehealth	EM physicians can provide telehealth services in the beneficiary's home or residence and bill one of the in-home visits under the same waiver that was put in place in the Next Generation ACO Model and other APMs.
Post Discharge Home Visit	Licensed clinical staff can provide home visits under the general supervision of an EM physician to eligible Medicare beneficiaries. The providers may bill these services utilizing the same G-codes utilized in other APMs.
Transitional Care Management	Authorize EM physicians to bill for a transitional care management code potentially by utilizing the current CPT codes (99494 and 99496) or the ED specific Acute Care Transition codes submitted to the CPT Editorial panel in 2016.

<sup>15</sup> Payors will likely need to alter some features of the AUCM to make the model more impactful to their specific patient population, giving rise to even more innovative efforts to transform EM care across payors.

<sup>16</sup> Beneficiaries receiving hospice, with end-stage renal disease, or with an admission in the previous 90 days are excluded, as are episodes of care that result in death in the ED.

<sup>17</sup> The episode effectively ends at 30 days post-ED visit regardless of discharge disposition. All services provided during the 30-day post-ED visit are included in the episode of care.

<sup>18</sup> Carpenter C. Risk Factors and Screening Instruments to Predict Adverse Outcomes for Undifferentiated Older Emergency Department Patients: A Systematic Review and Meta-analysis. (2015). <https://www.ncbi.nlm.nih.gov/pubmed/25565487>

<sup>19</sup> The SDA supports patient and family engagement by laying the groundwork for shared decision-making at discharge.

**Cost Savings and Quality Measures:** Savings are generated when the cost of ED and 30-days post-discharge services for a Medicare patient with one of the four qualifying conditions is below the target price for that 30-day episode. The target or pre-determined price is facility-based for each qualifying symptom.<sup>20</sup> Performance on the AUCM's quality measures determines eligibility for CMS reconciliation payments.<sup>21</sup> The model includes three options for risk-sharing that balance the needs of small groups who may not initially have the infrastructure to effect care redesign or the cash reserves to take on risk, with those of larger groups who would like accept downside risk immediately.

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

Impact on Effective Discount Rate on the Target Discount Price		
Quality Performance Category	Effect on Discount Rate	Eligibility for Reconciliation Payment
Unacceptable	The effective discount is 3%	Not eligible
Acceptable	The effective discount is 3%	Meeting the minimum threshold in all three categories
Good	The effective discount is 2%	Meeting the minimum threshold in all three categories AND 1) having a combined rate ED visits without post-discharge events of at least 80% OR 2) meeting or surpassing the Participant's historical combined rate of clean cases* that is calibrated to each facility's historical performance.
Excellent	The effective discount is 1.5%	Meeting the minimum threshold in all three categories AND 1) having a combined rate of clean cases of at least 90% OR 2) meeting or surpassing a threshold rate of clean cases that is calibrated to each facility's historical performance.

## The AUCM Implemented in Any Capacity Benefits the Entire Health System

**Quality:** Through the adoption of patient-centric care redesign, physicians have the tools to enhance patients post-ED care by identifying patients at risk for adverse post-discharge events when they first enter the ED. The model acknowledges patients' socio-economic status and integrates that information into care decisions and post-discharge care instructions. Furthermore, the AUCM integrates telehealth services and care coordination efforts which have been shown to impact patients' outcomes after hospitalization. The model has built in patient protection through the monitoring of post-discharge events and ensures that attempts to decrease the cost of care do not result in harm to patients. Finally, ACEP's Clinical Emergency Data Registry (CEDR) registry and other qualified clinical data registries (QCDRs) can support participants as they utilize their data to define, implement, and measure quality improvement activities and care redesign to better performance in their EDs.

<sup>20</sup> Facility-specific episode benchmark is calculated using three years of historical CMS claims and a specified discount percentage for the initial ED visit plus all costs incurred for 30 days post discharge (including new services associated with waivers). The benchmark is risk adjusted and used to determine the facility-specific episode target price.

<sup>21</sup> The quality measures included in the AUCM focus on patient engagement through the SDA, the process of care coordination by engaging in shared decision making and actual patient post-discharge events. CMS makes positive or negative reconciliation payments to participants based on participating entities performance metrics and quality measure scores.

**Costs:** The AUCM effectively engages EM physicians in a value-based arrangement promoting improved patient outcomes and lower costs. Healthcare systems are guaranteed savings through the AUCM’s built-in metrics and penalties for readmissions and other excess days in acute care.<sup>22</sup>

**Access and Affordability:** Hospitals improve their scores in other existing CMS value-base programs as the AUCM is designed to be “turn-key” and aligns with existing CMMI demonstrations. Also, the AUCM may decrease ED boarding so hospitals can address high-occupancy concerns.<sup>23</sup> In addition, the model helps EM physicians directly address concerns over ED affordability and access to appropriate follow-up care by encouraging continuity of care. Limiting inpatient observation stays means patients are less likely to be surprised that these were outpatient services provided.

In conclusion, EM physicians provide vital care for all patients and often serve as the ‘gateway’ to the hospital. Through ACEP’s novel model, the AUCM, EM physicians are integrated into the value-based care continuum and empowered to make the right disposition decision for the right patient at the right time. The model guarantees savings for Medicare by building a discount into the target price for each episode and will produce additional savings by reducing hospital admissions and other post-discharge costs associated with each episode.<sup>22</sup> Although the AUCM was developed with the intention of functioning in Medicare, it is flexible enough for adoption by Medicaid and private payors. Other payors should incorporate the AUCM framework in various capacities to address ED care delivery and payment. Ultimately, EM physicians deserve and are eager to assume direct responsibility for the care they deliver. Empowering EM physician participation in health system transformation is required to achieve patient-centered, value-based healthcare.

## Additional Resources

Learn more about the AUCM and ACEP’s efforts to engage EM physicians in payment and delivery reform:

- The AUCM Overview (ACEP): <https://www.acep.org/federal-advocacy/federal-advocacy-overview/APM/>
- The AUCM Proposal: <https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDF>
- PTAC: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>
- CMS Innovation Center (CMMI): <https://innovation.cms.gov/>
- Innovation Models: <https://innovation.cms.gov/initiatives/#views=models>
- Quality Payment Program: <https://qpp.cms.gov/>
- HCP-LAN: <https://hcp-lan.org/>

<sup>22</sup> American College of Emergency Physicians. The AUCM Proposal. (2018). <https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDF>

<sup>23</sup> Safe discharge as an alternative will enhance EDs ability to address crowding that occurs when patients wait for admission to the hospital and offers additional patient-centered alternatives to care.