American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 24, 2018

Mr. Adam Boehler
Deputy Administrator for Innovation and Quality and Director, Center for Medicare & Medicaid Innovation
Center for Medicare & Medicaid Innovation
2810 Lord Baltimore Drive
Windsor Mill, MD, 21244

Re: Request for Information on Direct Provider Contracting Models

Dear Mr. Boehler,

On behalf of nearly 38,000 members of the American College of Emergency Physicians (ACEP), we greatly appreciate the opportunity to provide our comments on potential models that focus on direct provider contracting and the effects the models could have on emergency physicians and the patients we serve.

Emergency physicians play a vital role in their communities, serving as safety net providers who care for people at their greatest time of need. As they treat each patient, emergency physicians must make the critical decision about whether the patient should be kept for observation, admitted to the hospital, or discharged. Fundamentally, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in alternative payment models (APMs) that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on downside risk and participate in Advanced APMs, there simply are not any opportunities to do so. We therefore strongly encourage CMMI to consider developing models geared towards emergency physicians. ACEP has developed its own proposed physician-focused payment model that is currently being considered by the Physician-Focused Payment Model Technical Advisory Committee (PTAC), called the Acute Unscheduled Care Model (AUCM). We are willing and eager to discuss this model with you as it continues to go through the PTAC process.

With respect to potential direct contracting models, it appears that emergency physicians will likely be excluded from direct participation. These models are targeted at primary care or multi-specialty physician groups that provide the main source of care to patients—not emergency care. However, ACEP still believes that it is important that any model be designed in a way that will ensure that emergency care is adequately covered, so that patients who experience emergencies have access to high-quality and affordable care. Therefore, with that overarching theme in mind, ACEP would like to provide comments on the following questions listed in the Request for Information:

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8. The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?

ACEP strongly believes that any direct contracting model should not be structured in such a way as to discourage patients from visiting the emergency department if they believe they are having an emergency. Emergencies happen; and these models should account for participating primary care physicians or other specialists telling their patients that they need to go to the emergency department or for patients experiencing emergencies going to the emergency department out of their own volition.

Any potential model should maintain current coverage and cost-sharing requirements for emergency services. Adjusting these parameters may have the undesirable outcome of deterring some beneficiaries from going to the emergency department even when they truly need immediate care. Recent studies have shown that only a small percentage of emergency department visits are avoidable.[1] In many cases, people cannot tell whether their pain is life threatening or not. Regardless of the final diagnosis, if they believe that they are having a medical emergency, they are entitled to go to the emergency department, be treated, and have the services they receive covered by their insurance.

9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating practice be included? Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?

While it is unlikely that emergency services will end up being included in the per-beneficiary-per month payment made to the DPC-participating practice, we still think it is important for the participating practice to work with emergency physicians to make sure the care for participating patients who experience emergencies is coordinated. For example, participating practices could use some of the per-beneficiary-per month payment to invest in an information technology (IT) system that would allow them to share data with surrounding emergency departments. That way, if a participating Medicare beneficiary goes to the emergency department, there is a seamless way for emergency physicians to access the beneficiary's medical record.

11. Should practices be at risk financially ("upside and downside risk") for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what services should be included and

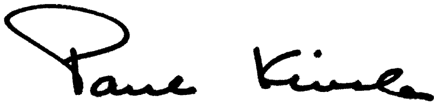
[1] "Avoidable Emergency Department Visits: A Starting Point." *International Journal for Quality in Health Care*, Volume 29, Issue 5, 1 October 2017, Pages 642–645; Available at https://doi.org/10.1093/intqhc/mzx081

how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?

As stated earlier, ACEP supports more opportunities for physicians, especially emergency physicians, to participate in Advanced APMs. If participating practices are held accountable for the total cost of care for a Medicare beneficiary, it may be useful to allow these practices to set up gainsharing relationships with some physicians in the area, including emergency physicians, to ensure that everyone has the same incentives to reduce overall Medicare expenditures and improve quality of care.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,



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