

Medicaid Cost Saving Measures for Emergency Care *An Information Paper*

In response to rising healthcare costs, pressure is mounting for state leaders to develop cost containment initiatives for Medicaid programs. Although emergency care only accounts for less than 2% of healthcare costs, care provided in the emergency department (ED) is often a target for cost savings.¹ Some states have turned to using cost containment measures such as copays for use of the ED, which are questionably effective and almost impossible to implement safely.² Other states' Medicaid departments and contracted managed care organizations have attempted to contain costs by reducing or denying reimbursement for emergency care based on the encounter's final diagnoses rather than the patient's presenting symptoms and concerns, a process that violates the federally mandated Prudent Layperson Standard.³ It is especially concerning that these measures are often accompanied by a narrative that emergency departments are grossly misused since, contrastingly, data from the Centers for Disease Control and Prevention recorded only 4.3% of emergency department visits in 2016 as nonurgent.⁴

On the other hand, several very effective mechanisms for costs savings exist that can be expected to truly benefit patients, hospitals, physicians, and payors alike: **increasing access to primary care, care coordination, health information exchanges, and alternative payment models.** These tools improve efficiency of healthcare dollars spent by encouraging appropriate use of the healthcare system before, during, and after an ED visit. Increasing access to primary care and care coordination have shown to decrease costs by helping patients stay healthier, thus avoiding the need for an ED visit, rather than turning patients away from the ED once an emergency exists. Health information exchanges (HIE) decrease the cost of care once a patient is in the ED by decreasing utilization and duplication of healthcare resources. Seeing as the most expensive decision in healthcare is whether or not to hospitalize a patient from the ED, alternative payment models for emergency physicians are a very powerful tool for cost savings, allowing the safe use of outpatient resources after an ED encounter rather than hospitalization. The growing number of examples of these effective mechanisms for cost savings at the state level further demonstrate the keys to successful implementation in the future. States looking to contain Medicaid costs should use these examples to inform future health policy decisions.

Improving Access to Primary Care

It has long been accepted that a lack of access to primary care causes individuals to go to the ED. More

¹ "Medical Expenditure Panel Survey," Department of Health and Human Services, Agency for Healthcare Research and Quality, 2008, <http://tinyurl.com/489fa06>.

² Siddiqui M, Roberts ET, Pollack CE. (2015, May). The effect of emergency department copayments for Medicaid beneficiaries following the Deficit Reduction Act of 2005. *JAMA Intern Med.* 2015 Mar;175(3):393-8. doi:10.1001/jamainternmed.2014.7582.

³ Managed care emergency services coverage. (2000, April 5). Federal Policy Guidance to State Medical Directors. Retrieved from <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd040500.pdf>.

⁴ National Center for Health Statistics. National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Tables. https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf.

recently, literature now also goes a bit further than this and clearly supports the fact that improved access to meaningful primary care actually decreases utilization of the ED.

Michigan is a prime example, where Patient Centered Medical Homes (PCMHs) have a 19% lower rate of ED visits for adults and a 23% lower rate of primary care-sensitive ED visits for adults, and a 25% lower rate of ambulatory-care sensitive inpatient stays for adults.⁵ This study also showed that ED per member per month costs were reduced by 9.4% for fully implemented PCMH's versus 3.6% for not fully implemented PCHM's.⁶ A specific program in Detroit, Gateway to Health, focused on improving access to primary care, decreased multiple ED visits for complex patients by 70%.⁷

This trend has been shown to be true in other states, such as California, where primary care continuity after the Affordable Care Act (ACA) was instituted led to decreased ED visits.⁸

Similarly, for the Department of Veterans Affairs (VA), 33 VA homeless medical homes and patient-aligned medical teams resulted in a 19.0% reduction in ED use and a 34.7% reduction in hospitalizations.⁹

Implementing or increasing co-pays for primary care impedes access to primary care and instead increases ED utilization.¹⁰ To improve adherence to primary care and thereby decrease ED visits, one may argue that the counterfactual approach, paying individuals to attend primary care appointments, may be beneficial. A study doing exactly this showed both improved adherence to primary care while decreasing ED visits.¹¹ They did not show a change in cost. However, they may have been looking at too short of a time horizon and did not account for "pent up demand" when individuals started using care appropriately.¹² Looking at longer time window is likely to show decreased costs.

Improvements in Medicaid reimbursement to primary care physicians increase access to primary care as well. New evidence shows a clear relationship between increasing Medicaid physician reimbursement and ability for Medicaid enrollees to make an appointment with a new physician.¹³ Due to low Medicaid reimbursement levels, primary care physicians had a harder time taking on new Medicaid patients than other specialists, such as surgeons or obstetricians.

Lastly, it is important to understand that some studies have evaluated the effects of health care *insurance* rather than true *access* to primary care, leading to misinterpreted data and mixed conclusions in the literature

⁵ Value Partnerships: Leading the way to better health. Blue Cross Blue Shield 2017 Value partnerships annual report. Retrieved from <https://www.bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/partners-report.pdf>.

⁶ Green LA, Chang HC, Markovitz AR, et al. The reduction in ED and hospital admissions in medical home practices is specific to primary care-sensitive chronic conditions. *Health Serv Res.* 2018 Apr;53(2):1163-79. doi:10.1111/1475-6773.12674.

⁷ Greene J. (2017, June 26). DMC Gateway program reduces ER visits, admissions, improves primary care. Modern Healthcare. Retrieved from <https://www.modernhealthcare.com/article/20170626/NEWS/170629924/dmc-gateway-program-reduces-er-visits-admissions-improves-primary-care>.

⁸ Pourat N, Davis AC, Chen X, et al. In California, primary care continuity was associated with reduced emergency department use and fewer hospitalizations. *Health Aff.* 2015 Jul;34(7):1113-20. doi: 10.1377/hlthaff.2014.1165.

⁹ O'Toole TP, Johnson EE, Aiello R, et al. Tailoring care to vulnerable populations by incorporating social determinants of health: the Veterans Health Administration's "Homeless Patient Aligned Care Team" Program. *Prev Chronic Dis.* 2016 Mar 31; 13:E44. <http://dx.doi.org/10.5888/pcd13.150567>.

¹⁰ Kangovi S, Barg FK, Carter T, et al. Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care. *Health Aff.* 2013 Jul;32(7):1196-1203. doi: 10.1377/hlthaff.2012.0825.

¹¹ Bradley CJ, Neumark D, Walker LS. (2018, March 14). The effect of primary care visits on health care utilization: findings from a randomized controlled trial. CATO Institute 104.

¹² Aron-Dine A. (2017, September 12). Health Care: Issues impacting cost and coverage. Testimony before the Senate Finance Committee. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/health/health-care-issues-impacting-cost-and-coverage>.

¹³ Holgash K, Heberlein M. (2019, April 10). Physicians acceptance of new Medicaid patients: what matters and what doesn't. Health Affairs Blog. Retrieved from 10.1377/hblog20190401.678690.

as to whether improving access to care increases or decreases ED visits and cost of care.¹⁴ This is especially true of the studies about the ACA and its effects. The ACA immediately increased insurance coverage. However, it only more slowly increased true access to care. This was due to several reasons, including 1) initial limited primary care capacity and 2) high use of healthcare resources for those newly insured patients who previously had no healthcare and therefore initially had disproportionately complex illnesses. Both trends took around five years after ACA implementation to catch up to the sudden increase in insurance coverage. Therefore, it is inaccurate to draw conclusions of the effect of access to primary care based on trends in the two to three years after the passage of the ACA. Many studies of this time period showed increased visits to the ED. However, as primary care infrastructure caught up, access to primary care has improved.^{15 16} Not surprisingly, as more individuals are engaged in meaningful primary care, ED visits are decreasing, cost is decreasing, and overall health is improving.¹⁷ These same trends were clearly demonstrated in Massachusetts prior to the implementation of the ACA.¹⁸

The Patient Centered Primary Care Collaborative has released a 2018 Evidence Paper on the interaction between PCMHs and accountable care organizations, which further explores the effect primary care has on decreasing cost of care, including emergency care.¹⁹

Care Coordination

Care coordination is widely considered to be one of the leading strategies for achieving savings. Care coordination refers to efforts by Medicaid programs to ensure that patients get the right care at the right time and in the right setting by creating a bridge across our fragmented healthcare system. States have implemented separate care coordination entities, managed care contracting strategies, and multi-faceted interventions to improve how clinical and psycho-social care is care coordinated for Medicaid recipients. Care coordination must address traditional medical issues, such as chronic medical conditions, as well as psychiatric and dependency issues. In addition, care coordination services can include non-traditional medical services that affect health such as transportation, nutrition and housing.

One approach that states can take to enhance care coordination is to connect Medicaid beneficiaries with a medical home. In a medical home, a primary care provider takes the lead in coordinating an individual's care. This includes coordinating with other physicians and support services to improve patient compliance and outcomes. An added benefit to health homes is the availability of enhanced federal matching funds for

¹⁴ Sommers BD, Simon K. (2017, Oct 18). Health insurance and emergency department use - a complex relationship. NEJM Catalyst. Retrieved from <https://catalyst.nejm.org/health-insurance-ed-use/>.

¹⁵ Wishner J, Burton R. (2017, November 1). How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act? U.S. Health Reform - Monitoring and Impact. Published by the Urban Institute.

¹⁶ Alexander D, Schnell M. (2017, April 21). Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health. Working paper of the Federal Reserve Bank of Chicago.

¹⁷ Aron-Dine A. (2017, September 12). Health Care: Issues impacting cost and coverage. Testimony before the Senate Finance Committee. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/health/health-care-issues-impacting-cost-and-coverage>.

¹⁸ Miller S. The effect of the Massachusetts reform on health care utilization. *Inquiry*. 2012-2013 Winter;49(4):317-26.

¹⁹ Patient-Centered Primary Care Collaborative. (2018, August). Advanced primary care: A key contributor to successful ACOs. Annual PCPCC Evidence Report. Retrieved from https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_08-1-17%20FINAL.pdf.

states — they receive a 90% match for health home expenditures for the first two years of a state’s health home initiative.^{20 21 22}

States can also improve care coordination by focusing their efforts on people who use a disproportionate amount healthcare resources. In Medicaid, these are usually people with one or more chronic conditions, such as asthma, diabetes, and congestive heart failure. While this group is only about 1% of total Medicaid beneficiaries, it accounts for 25% of Medicaid spending. Some states are addressing this population by implementing health homes programs. Distinct from medical homes, health homes specifically target individuals with chronic conditions and coordinate, through an interdisciplinary team of health care providers, all primary, acute, and behavioral health and home care services.^{23 24 25 26}

Keys to Care Coordination:

- Must enhance collaboration with providers and/or provider networks to engage in patient-centered care coordination, reduce barriers to timely and appropriate care, and minimize duplication of care efforts and associated costs;
- Should connect members to outreach services that include transportation planning, respite and community resources to prevent additional ED visits and repeat trauma;
- Must frequently analyze the financial and quality impact of various discretionary services provided; and
- Should identify chronic, co-occurring conditions that have the biggest impact on health care quality and cost of care.^{27 28 29 30 31}

²⁰ Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children; Adolescents. Center for Medicare and Medicaid Services. Sept 2014. <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf>. Accessed Feb 12, 2019.

²¹ Srinivasan S. Care Coordinators Cut Costs, Improve Health Outcomes, But Are Underused. Connecticut Health Investigative Team. October 24, 2017. <http://c-hit.org/2017/10/24/care-coordinators-cut-costs-improve-health-outcomes-but-are-underused/>. Accessed Feb 13, 2019.

²² Schubel J. Better Care Coordination Can Cut Medicaid Spending and Improve Health Outcomes. Center on Budget and Policy Priorities. April 23, 2015. <https://www.cbpp.org/blog/better-care-coordination-can-cut-medicaid-spending-and-improve-health-outcomes>. Accessed Feb 12, 2019.

²³ Center for Medicare and Medicaid data. National Health Expenditure data, NHE Fact Sheet 2016. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>. Accessed June 13, 2018.

²⁴ Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (AHRQ Publication No. 12-0010). January 2012. www.ahrq.gov. Accessed Feb 12, 2019.

²⁵ Srinivasan S. Care Coordinators Cut Costs, Improve Health Outcomes, But Are Underused. Connecticut Health Investigative Team. October 24, 2017. <http://c-hit.org/2017/10/24/care-coordinators-cut-costs-improve-health-outcomes-but-are-underused/>. Accessed Feb 13, 2019.

²⁶ Schubel J. Better Care Coordination Can Cut Medicaid Spending and Improve Health Outcomes. Center on Budget and Policy Priorities. April 23, 2015. <https://www.cbpp.org/blog/better-care-coordination-can-cut-medicaid-spending-and-improve-health-outcomes>. Accessed Feb 12, 2019.

²⁷ Coordinating Care for Adults with Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (AHRQ Publication No. 12-0010). January 2012. www.ahrq.gov. Accessed Feb 12, 2019.

²⁸ Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children; Adolescents. Center for Medicare and Medicaid Services. Sept 2014. <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf>. Accessed Feb 12, 2019.

²⁹ Song Z, Rose S, Safran DG, et al. Changes in health care spending and quality 4 years into global payment. *N Engl J Med*. 2014 Oct 30;371(18):1704-14.

³⁰ Srinivasan S. Care Coordinators Cut Costs, Improve Health Outcomes, But Are Underused. Connecticut Health Investigative Team. October 24, 2017. <http://c-hit.org/2017/10/24/care-coordinators-cut-costs-improve-health-outcomes-but-are-underused/>. Accessed Feb 13, 2019.

³¹ Schubel J. Better Care Coordination Can Cut Medicaid Spending and Improve Health Outcomes. Center on Budget and Policy Priorities. April 23, 2015. <https://www.cbpp.org/blog/better-care-coordination-can-cut-medicaid-spending-and-improve-health-outcomes>. Accessed Feb 12, 2019.

Successful Programs:

North Carolina has used the medical home strategy. About 80 percent of the state's Medicaid population is enrolled in a medical home. In its first year, North Carolina's program cut the number of ED visits for children enrolled in Medicaid who have asthma by 8% and the number of inpatient hospitalizations among the same group by 34%. The state projects that the program will help it save about \$160 million each year.³²

Missouri uses a health home model. For those enrolled in Missouri's Community Mental Health Center (CMHC) health home, hospitalizations dropped from 33.7% in 2011 to 24.6% in 2012. The CMHC saved Missouri \$15.7 million in its first 18 months of operation.³³

Colorado's The Bridges to Care (B2C) program provides help to Medicaid patients who use the emergency department frequently. It steers them to primary care providers, assists them in getting prescriptions filled, and even tries to find them transportation and housing, if needed. The program was developed by the Camden Coalition of Healthcare Providers, a multidisciplinary, community-based primary care program. When applied in Colorado, the program led to 30% fewer hospitalizations, a similar reduction in ED visits, and a 123% increase in primary care visits in six months compared to a control group, according to a study published in Health Affairs.³⁴

Future programs are also anticipated to be successful in Ohio and New York, focusing on care coordination for beneficiaries with serious mental illness and intellectual or developmental disabilities. For more information on these programs and others, the National Academy for State Health Policy lists programs on care coordination by each state.^{35 36 37}

Health Information Exchange

The Affordable Care Act has led to the investment and development of HIEs to transfer medical records between physicians. The goals of the exchanges are to reduce testing duplication, decrease the length of stay, avoid admissions and to reduce costs. Recent studies have shown HIEs have been successful in reaching these goals. What's more, HIE's have been an impactful tool for physicians to employ safe practices for administering and prescribing opioids and other high-risk medications.

The University of Michigan showed using Epic's HIE Care Everywhere reduced ED stays by 26.9 minutes, patients were 2.5% less likely to receive a CT, 1.6% less likely to receive an MRI, 2.4% less likely to receive a radiograph, and 2.4% less likely to be admitted. Charges were 6.3% lower than average, resulting in savings of \$1187 per visit.³⁸

³² Care Coordination. NASHP. December 10, 2013. <https://nashp.org/care-coordination>. Accessed Feb 12, 2019.

³³ Care Coordination. NASHP. December 10, 2013. <https://nashp.org/care-coordination>. Accessed Feb 12, 2019.

³⁴ Care Coordination. NASHP. December 10, 2013. <https://nashp.org/care-coordination>. Accessed Feb 12, 2019.

³⁵ Care Coordination. NASHP. December 10, 2013. <https://nashp.org/care-coordination>. Accessed Feb 12, 2019.

³⁶ Ohio Medicaid launching new behavioral health care coordination program for high-needs members (2018, April 2). Retrieved from: <https://www.openminds.com/market-intelligence/news/ohio-medicaid-targets-92000-members-new-behavioral-health-care-coordination-program/>.

³⁷ New York announces six care coordination organizations for people with I/DD. (2018, March 18). Retrieved from: <https://www.openminds.com/market-intelligence/news/new-york-announces-six-care-coordination-organizations-for-people-with-i-dd/>.

³⁸ Everson J, Kocher KE, Adler-Milstein J. Health information exchange associated with improved emergency department care through faster accessing of patient information from outside organizations. *J Am Med Inform Assoc*. 2017 Apr 1;24(e1):e103-e110.

The Carolina eHealth Alliance, a South Carolina based private federated HIE that provides ED alert system within four hospitals in Charleston, reported a \$1 million dollar decrease in charges during its first year of implementation in 2015.³⁹

HealthlinkNY, which operates the HIE connecting providers and patients across the Hudson Valley and Southern Tier of New York, reports a reduced average length of stay by more than 7%, reduced rates of 30-day readmission by 4.5%, and reduced the odds of a patient being seen by multiple physicians (specialists) by 12%.⁴⁰

HIEs have also been shown to reduce repeat imaging. A study evaluating 20,000 patient visits at 37 EDs linked by HIEs, compared to a control group of 401 EDs that were not linked by an HIE, showed reduced repeat imaging for computed tomography (8.7%), ultrasound (9.1%) and chest X-rays (13%).⁴¹

Washington, Oregon, New Mexico and Alaska have all legislatively mandated the use of an HIE system and have implemented the Collective Medical Network

- In the first year of use, Washington State saw a 10% drop in Medicaid ED visits, 11% reduction in ED use by high utilizers, 14% reduction in low acuity visits, and a 24% reduction in opiate prescriptions from the ED. This HIE use and other components of a statewide program call “ER is for Emergencies” resulted in \$34 million dollars in savings for the state in the first year of implementation.⁴²
- Catholic Health Initiatives St. Anthony’s Hospital, a critical access hospital located in Pendleton, Oregon, was able to reduce unnecessary ED visits from identified frequent ED users from 17 percent of overall visits to nine percent within six months of implementing the Collective platform. Within one year, the hospital reduced narcotic prepack prescriptions coming out of the ED by 60 percent and realized hospital cost savings of \$200,000.⁴³
- The Northwest Physicians Network collaborated with Pierce County Fire and Rescue using Collective Medical Software and realized a 44% decrease in unnecessary EMS calls, 47% decrease in EMS transports, 36% decrease in ED visits, 42% decrease in hospital admissions, and a 31% decrease in hospital observation stays.⁴⁴

³⁹ Carolina eHealth Alliance. Information retrieved from <https://www.healthsciencessc.org/initiative/carolina-ehealth-alliance-ceha/238>.

⁴⁰ Janakiraman R, Park E, Demirezen E, et al. The Effects of Health Information Exchange Access on Healthcare Quality and Efficiency: An Empirical Investigation (2017, February 10). Mays Business School Research Paper No. 2915190. Retrieved from <https://ssrn.com/abstract=2915190> or <http://dx.doi.org/10.2139/ssrn.2915190>.

⁴¹ Lammers E, Ader-Milstein J, Kocher KE. Does health information exchanges reduce redundant imaging? Evidence from emergency departments. *Med Care*. 2014 Mar;52(3):227-34.

⁴² Pines J, Schlicher N, Presser E, et al. (2015, May 4). Washington State Medicaid: Implementation and Impact of “ER is for Emergencies” Program. The Brookings Institution. <https://www.brookings.edu/wp-content/uploads/2016/07/050415EmerMedCaseStudyWash.pdf>.

⁴³ Landi H. (2018, September 28). In Texas, healthcare leaders take a tech-enabled approach to combat the opioid crisis. Healthcare Innovation. <https://www.hcinovationgroup.com/interoperability-hie/article/13030753/in-texas-healthcare-leaders-take-a-Tech-enabled-approach-to-combat-the-opioid-crisis>.

⁴⁴ Perna G. (2017, December 29). How an IPA in Washington collaborates with the local EMS. Physicians Practice. <https://www.physicianspractice.com/population-health/how-ipa-washington-collaborates-local-ems>.

- Mat- Su Regional Hospital in Alaska saw a 79% percent decrease in opioid prescriptions from 2015-2018 and a 41% drop in the number of opioids given in the ED after joining Collective Medical.^{45 46}

Patient Ping is another successful commercially available HIE. National datasets from CMS show Accountable Care Organizations using PatientPing are saving money. One hundred percent of Next Generation accountable care organizations (ACOs) who use PatientPing earned shared savings, whereas just 61% of all Next Generation ACOs did. Also, ACOs in the Medicare Shared Savings Program using PatientPing saw nearly 20% higher success rate as compared those not using PatientPing. Altogether, PatientPing customers saved more than \$120 million in 2017.⁴⁷

Alternative Payment Models

Every day, emergency physicians must make critical decisions about whether their patients should be kept for observation, admitted to the hospital, or discharged. Fundamentally, we act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in value-based arrangements and alternative payment models (APMs). However, there are not many opportunities to do so. To address this gap in available models, ACEP developed an APM called the Acute Unscheduled Care Model (AUCM) that is focused on Medicare providers and beneficiaries. On September 6, 2018, a federal advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended the AUCM to the Secretary of the United States Department of Health and Human Services for full implementation.

The AUCM enhances the ability of emergency physicians to reduce inpatient admissions and observation stays, when appropriate, through processes that support care coordination and consider patient preference. Emergency physicians become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits. States can apply these same principles for payment reform and quality improvement into state-based or contracted Medicaid models. To help initiate state efforts to improve care and lower costs for this population, ACEP has developed principles for a successful emergency medicine APM (Appendix A).

In order to provide the necessary flexibility and tools to better coordinate care for patients, an APM should include additional payments for ED acute care transition services, telehealth services, and post discharge home visits to bridge the gap until primary care or specialty referral is available. Suggested CPT codes for ED transition services are in Appendix B; these same codes were submitted to the American Medical Association CPT Editorial Panel in June of 2016. Alternatively, a state could assign value to the pre-existing codes for transitional care, 99494 and 99495. Additionally, states would need to assign value to the preexisting codes for telehealth services and home visits as applicable for emergency physicians to perform after ED discharge.

In summary, states that have increased access to primary care, improved care coordination from the ED, implemented health information exchanges, and moved towards alternative payments models for emergency physicians have demonstrated that significant cost of care savings can be realized. Therefore, there is no need for states to consider alternative attempts at cost savings, such as ED copays, which are

⁴⁵ Collective Medical helps providers identify and prevent opioid abuse. (2019, January 23). A case study: Mat-Su Regional Medical Center. Collective Medical press release.

⁴⁶ Zink A. Addressing the opioid crisis. Medical Economics. 2018 May 31;96(10). <https://www.medicaleconomics.com/business/addressing-opioid-crisis>.

⁴⁷ Lovett L. (2017 Nov). CMS data shows PatientPing's ACO users are saving more. Mobi Health News. <https://www.mobihealthnews.com/content/cms-data-shows-patientpings-aco-users-are-saving-more>.

less effective and pose a dangerous barrier to true emergency care. Emergency physicians look forward to working with state policy leaders to improve Medicaid program financial viability by reshaping the delivery and reimbursement of emergency care.

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Emergency Medicine Principles for Alternative Payment Models (APMs) for the Medicaid Population

Overall Model Structure

- **Voluntary Model:** Since each ED services a unique community, the ability of an emergency physician to successfully participate in an APM is dependent on current infrastructure, case-mix, and experience in risk-contracting. Therefore, any emergency medicine-focused APM should be voluntary and should not mandate participation.
- **Eligible Participants:** An APM should allow providers specializing in emergency medicine to participate regardless of employment model (independent group, regional group, national group, employed physicians, and faculty practice plan). The model should also be amenable to implementation in both urban and rural areas.
- **Bundled Payment Model:** Most patients come to the ED with episodes of acute unscheduled care. Therefore, ACEP believes that a bundled payment model that holds emergency physicians accountable for total costs over a post-ED discharge period is the most appropriate model structure.
- **Length of Episode:** The length of the episode should be between 7- and 30-days post-ED discharge. ACEP set an episode length of 30 days for the AUCM, based on an analysis of Medicare claims data, but a shorter period may be more appropriate for Medicaid recipients.
- **Triggering Episodes:** An APM should begin with a few high-volume ED undifferentiated conditions (such as abdominal pain, altered mental status, chest pain, and syncope) and then expand to more conditions over time. ACEP believes that diagnoses which result in greater than a 90 percent admission rate per condition should be excluded, as movement to a discharge model might harm patients.
- **Qualifying ED Visit:** An APM should capture most ED visits from patients with the select conditions. ED visits that should be included include those that: 1) result in a discharge to home or the community; 2) an inpatient admission; or 3) an observation stay. However, the APM should include appropriate exclusions, such as deaths in the ED, hospice patients, or individuals with an inpatient admission occurring up to 90 days prior to the ED visit.
- **Payment Incentives:** In order to provide the necessary flexibility and tools to better coordinate care for patients, an APM should include additional payments for ED acute care transition services, telehealth services, and post discharge home visits to bridge the gap until primary care or specialty referral is available.
- **Continuation of Existing Standard of Care:** The APM should not alter the basic practice standards for emergency care.

Payment Methodology

- **Reconciliation Payments:** Like a typical bundled payment model, spending for an episode should be compared to a benchmark or target price. If spending for episodes is less than the target price, a model participant would be eligible for a positive reconciliation payment. If spending for episodes exceeds the target, then the participant would be required to reimburse the Medicaid payer (subject to stop gain/stop loss requirements).
- **Determining the Target Price:** ACEP believes that an APM should include facility-specific target prices that are based upon individual hospital historical spending, as this best reflects the impact of patient comorbidities and social determinants of health in the population that they serve. National or regional benchmarks should not be incorporated initially but may be considered after participants have experience in the model. The target price can include a small discount to guarantee savings for the Medicaid program. The size of the discount can include a range that is dependent on a participant's quality score (the better the performance on quality, the lower the discount). Finally, the target prices should be updated annually, and risk adjusted using the CMS-HCC methodology or other methodology determined by the state. The original target price should always be factored into the updated target price calculation.

Quality Performance

- **Quality Scoring Methodology:** An APM should have a robust quality scoring methodology that appropriately awards emergency physicians who provide high quality care to their patients. ACEP believes that the quality measures included in the model should focus in three areas: patient engagement (Safe Discharge Assessment), the process of care coordination (Shared Decision Making), and post-discharge outcomes (Event-free Post-discharge rate). Performance on metrics within these three areas should determine a participant's eligibility for positive reconciliation payments, and, as described above, the size of the discount built into the target price.

Level of Financial Risk

- **Transition to Downside Risk:** Consistent with other APMs, the amount of savings and losses that participants would either receive or be liable for should be capped at certain percentages. An APM should include options for risk-sharing that balance the needs of groups who may not initially have the infrastructure to effect care redesign or the cash reserves to take on risk, with those of groups who would like to accept downside risk immediately.
- **Qualifying as an "Other Payer Advanced APM":** An APM should include a financial risk option that allows the model to count as an "Other-Payer Advanced APM" under the Center for Medicare & Medicaid Services (CMS) regulations governing the Quality Payment Program. Currently, physicians can become eligible for a five percent Medicare bonus and avoid reporting measures under the Merit-based Incentive Payment System (MIPS) by participating in a combination of Advanced APMs with Medicare and Other-Payer Advanced APMs. Other-Payer Advanced APMs are non-Medicare payment arrangements (including Medicaid models) that meet criteria that are similar to Advanced APMs under Medicare.

Proposed CPT Codes: ED Acute Care Transition for Predominantly Medical Complaints and Conditions Service

Axx1 – Medical decision making and/or care management plan of low to moderate complexity, services may typically include establishing new, time certain primary care within a short time frame in a patient previously unattached to any routine care, establishing time certain follow up for Medicare beneficiaries with medical problems requiring procedural action or reassessment (such as wound care), or reviewing and substantially revising an existing care plan. The plan of care, including such items as medication management, equipment/supply availability, treatment adherence and completion of scheduled appointments, will be monitored by follow up communication with either patient or follow-up provider to determine that the patient was able to execute the plan of care and/or received the services as scheduled.

Axx2 – Medical decision making and/or care management plan of moderate to high complexity, services may typically include establishing new, time certain specialist care for a problem identified in the emergency department visit and requiring specific, timely evaluation or action, coordinating the care of other professionals and agencies, addressing significant barriers to ongoing outpatient care such as mobility, transportation, or home safety, for example. The plan of care, including such items as medication management, equipment/supply availability, treatment adherence and completion of scheduled appointments, will be monitored by follow up communication with either patient or follow-up provider to determine that the patient was able to execute the plan of care and/or received the services as scheduled.

Axx3 – Medical decision making and or care management of high complexity such as that complicated by multiple or serious medical or psychiatric comorbidities, services may include establishing admission, arranging transport, and communicating the plan of acute care to inpatient sub-acute rehab, skilled nursing facility, inpatient psychiatric facility, inpatient substance abuse treatment facility, or establishing home health services including home hospice or similar alternative to acute hospital admission. The plan of care will be monitored for completion, by follow up communication with either patient or intended provider to determine that the patient received the services as scheduled. The site of service for the arranged admission must be distinct from the routine process of admission by being geographically and/or operationally distinct and must represent a more effective or appropriate site of service than acute hospitalization. (That is admission to a physically contiguous or otherwise closely associated facility or transfer to another acute care hospital such that it would be part of standard admission or transfer workflow, would be part of the ED evaluation and management (E&M) service and not eligible for this service).