Emergency Department EDPMA Practice Management Association

September 29, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–5519–P
P.O. Box 8013
Baltimore, Maryland 21244–1850.

Submitted electronically

Re. Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Proposed Rule

Dear Acting Administrator Slavitt:

The Emergency Department Practice Management Association (EDPMA) is one of the nation's largest professional physician trade associations focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups, as well as billing, coding, and other professional support organizations that assist healthcare providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 136 million patients that visit U.S. emergency departments each year. We work collectively and collaboratively to deliver essential healthcare services, often unmet elsewhere, to an underserved patient population who often has nowhere else to turn.

We appreciate the Centers for Medicare and Medicaid Services' (CMS') work in the development of alternative payment models (APMs), and EDPMA continues to support health system efforts to develop alternate forms of payment based on delivering better care for better value. As CMS engages in these efforts, we ask CMS to remember that that the delivery of emergency medical services is unique in the health care system and, in some instances, warrants special consideration particularly with regard to the implementation of programs such as those contemplated in the EPM proposed rule. In addition, we continue to stress that CMS, to this point, has offered little guidance on how certain hospital-based specialties – especially emergency physicians – can develop and secure approval from CMS on acceptable forms of specialty specific APMs that meet the intent contemplated by CMS to qualify for APM incentive bonuses. Finally, throughout CMS' ongoing APM development efforts, EDPMA requests that CMS recognize the importance and value and delivery of emergency care as a critical component to a cost effective delivery system.

ADVANCED ALTERNATIVE PAYMENT MODEL (APM) CONSIDERATIONS

As part of the referenced Proposed Rule, CMS proposes to create a track under each EPM in which the models would meet the criteria to be designated as an Advanced APM, thereby creating eligibility for the APM Incentive Payment created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). ***EDPMA appreciates CMS' effort to expand the Advanced APM participation opportunities for practitioners. However, in practice, we remain concerned that the EPM models, as currently proscribed, will be of limited utility to emergency physicians in providing access to the Advanced APM bonus payments and potential exemption from the Merit-Based Incentive Payment System (MIPS) payment updates***.

First, because of the emergency department's role as initial point of access for patients entering the hospital, and in many instances the identifying source of a selected EPM, but also simultaneously, the least likely cost element associated with the treating that EPM, we believe that it is unlikely hospitals will frequently pursue Sharing Arrangements with emergency medicine practices in the context of the proposed EPM models (Comprehensive Care for Joint Replacement (CJR), Surgical Hip/Femur Fracture Treatment (SHFFT), Acute Myocardial Infarction (AMI), and Coronary Artery Bypass Graft (CABG) Models,) and do so in such a way, to meaningfully expand emergency medicine access to Advanced APMs. While we appreciate that may not be CMS' intent in crafting these proposals, ***EDPMA encourages CMS to work further, along with emergency physicians, to support models that meaningfully incorporate emergency medicine's role as the first responder and initial point of access for the patient, the provider most likely to identify and trigger the EPM, but also a marginal element of the overall costs. Instead, we request for the design of Advanced APMs, which will likely include the implementation of models that are not focused only on expensive MS-DRGs***. It is no coincidence that, generally, larger-sized health care systems to date have carved out the emergency department from more innovative payment models because it is extremely complicated to administer, report, and accurately determine attribution. The fact that most private payers have been reluctant to collaborate on APMs with the emergency department setting, despite repeated attempts and despite our notable position in the health care delivery system, is also a testament to the difficulties inherent in this issue. As a result of this reality, it will be extremely challenging for emergency department practices to be sought out to serve as participants in APMs. We strongly urge CMS to keep these considerations in mind going forward and to allow for 'out-of-the-box' thinking which accommodates unique specialties, such as emergency medicine, the opportunity to fully engage in the contemplated Advanced APM policy design.

Second, even in those situations where emergency medicine (and other specialty specific, generally hospital-based physicians) are included on the list of participants associated with each of these EPMs, we are very concerned that it will be near impossible for any one group of EPM participants to become a Qualified Participant (QP) under the proposed QP thresholds that CMS has included in the MIPS and Advanced APM proposed rule. The current construction of these models creates Advanced APM siloes that limit the model to certain conditions even if the APM Entity is engaged in the EPM initiative more broadly. For example, the assessment of an APM Entity at only the level of the CABG Model is near certain to fall short of the QP thresholds. Certainly for emergency medicine participants, the contribution to calculating the QP threshold under only one of these models will be minimal given the diversity of conditions, symptoms, and diagnoses treated in the emergency department. In order to design these models in a manner that truly provides expanded access to the Advanced APM incentive payment, ***EDPMA recommends that CMS calculate an APM Entity's QP threshold across all EPM models in which the APM Entity is engaged rather than just under the siloes of the CJR, SHFFT, AMI, or CABG models individually.***

First, given that hospitals engaged in an EPM model will be at least engaged in two of the models (AMI and CABG or CJR and SHFFT), this could alleviate an administrative burden on CMS of having to then calculate the individual QP determination of every participant under the (at least two) EPMs in which the APM Entity is engaged (assuming the APM Entity executes Sharing Arrangements with the same sets of providers under each of the two related models). Second, we believe that implementing a QP threshold methodology that incorporates all of the conditions and patients in which an APM Entity is engaged increases the likelihood that a hospital APM Entity would seek to engage with a group of physicians, such as a group of emergency physicians. We trust this would occur if the particular APM was structured in a way to capture multiple conditions rather than just SHFFTs or just CABG. We believe this will be especially true for those sites that are engaged in all four EPM models currently under consideration. We also believe that structuring the EPM program in this way is an approach that is more conducive to expanding participation access to Advanced APMs as CMS by adding conditions or diagnoses to the EPM program in the future. We believe that emergency medicine can play an important role in all four models. For instance, the emergency department will serve as the entry point for most patients with acute myocardial infarctions and acute femur/hip fractures. Some patients admitted through the emergency department may also eventually undergo coronary artery bypass grafting. However, if assessed separately among the four designated EPMs, as currently contemplated, EDPMA is concerned that emergency physicians could be viewed as influencing too small a portion of the costs and care to be viewed as partners in the program. ***We believe that restructuring the QP assessment methodology will make a large impact on the physicians and facilities with which hospital APM Entities seek to engage for these programs***.

FUTURE DIRECTIONS FOR EPISODE PAYMENT MODELS

In the Proposed Rule, CMS requests input on how it might expand episode payment models in the future. In particular, CMS asks for feedback on future condition-specific episode payment models that could focus on an acute event or procedure or longer-term care management as well as features for EPMs targeting procedures that could be inpatient or outpatient as well as hospitalizations for acute medical conditions which could overlap.

While EDPMA acknowledges that the emergency department is a unique setting and APMs as currently structured do not yield well formulated proposals for an emergency medicine, we continue to explore options internally on the design of an optimal emergency medicine specific APM and do expect to be able offer our findings to CMS in the near future as a means to work cooperatively with CMS on this long term initiative. Chief among those unique characteristics is that Medicare APMs to-date, including those in the current proposed rule, have focused on *diagnoses* whereas emergency department care is *symptom*- and *complaint*-driven. In addition, the models currently under consideration are premised on coding triggers that involve inpatient hospitalizations. Under the current model, there would be nothing to incorporate the involvement of the emergency department in preventing a hospitalization or need for other services due to the value of the care derived from the ED. As CMS seeks to develop episode payment models that focus on conditions rather than diagnoses, ***EDPMA believes that CMS must shift its focus to reliable quality measures and cost utilization that is more specific to the care delivered by emergency providers***. For instance, measuring resource utilization for symptom-driven care must allow for much more variation than diagnosis-driven models. This will require CMS to share more utilization data and launch pilot projects so that stakeholders have the necessary information to assist in the development of costs savings models. Additionally, the relationship between emergency physician providers and their groups are dynamic, meaning it will require from CMS unique tracking mechanisms to appropriately assess physician attributions which remains a critical component of accurate reporting and distributions. As CMS engages in this work, however, ***we also caution against the promotion of APMs that result in***

gatekeeper scenarios that contradict the goals of the national "prudent layperson" standard by placing barriers on patients in accessing the emergency department while ensuring all patients, irrespective of payer source, have unencumbered access to the emergency department at all times. This standard has very much benefited the nation and its patients and to undo it would be a great disservice to our healthcare system.

EPM QUALITY MEASURES

While EDPMA supports that the quality measures selected for the four models (CJR, SHFFT, AMI, and CABG,) CMS did not include measures specifically directed at counting return visits to the emergency department; therefore, we urge that CMS ensure resource utilization measurement does not deter appropriate care delivered in the emergency department. EDPMA has previously expressed concern with certain CMS-sponsored metrics that suggest to the untrained eye that emergency department services reflect care that should be avoided. Consequently, we point to the RAND Corporation, which in 2013, released a study entitled "The Evolving Role of Emergency Departments in the United States," which effectively stated, among other things, that the emergency department is often the most appropriate venue for many patients. It found further that emergency department physicians are the major decision makers in over half of an average hospital's admissions and are critical in helping hospitals fulfill their statutory obligation to provide emergency care without regard to the ability to pay (i.e., EMTALA). Primary care physicians increasingly rely on the emergency department to evaluate complex patients with potentially serious problems, conduct workups, and provide overflow and after-hours primary care. Increasingly, the emergency department is seen not as a health care resource to be avoided, but a key stabilization and decision point for patient disposition, which increasingly involves finding alternatives to hospital admission or even potentially costly observation stays for high-focus patient populations. The RAND report found that "an average inpatient admission costs ten times more than an ED visit." In many cases, a visit to the emergency department is not only appropriate – but the least costly alternative. And increasingly, emergency department providers are finding alternatives to hospitalization (either inpatient or observation stays).

Therefore, we reiterate our past statements to CMS that the emergency department is a critical point of access to patients, by serving patients 24 hours per day, 7 days per week, and 365 days per year (24/7/365), it is often the most efficient location to receive the in-depth work-ups and tests many patients need. It would be a costly mistake to discourage APM Entities from making appropriate use of the emergency department ***EDPMA believes that the emergency department plays a critical role in the delivery of cost-effective care and can continue to do so as a participant of APM and risk-based models of care by providing timely, cost-saving care, resulting in decreasing costly hospital admissions and preventing further complications and the exacerbation of complex and ultimately costly cases***.

RECONCILIATION PAYMENTS

Under the EPM proposed rule, in the situations where an APM Entity achieves savings relative to the APM Entity's quality performance-adjusted target price, CMS proposes (as it finalized under the previous iteration of the CJR model) to share the savings with the APM Entity. While we understand the administrative simplicity this provides CMS, ***EDPMA is concerned that this ignores the fact CMS has made this a mandatory program in which hospitals are forced into the role of APM Entity***. Under voluntary models, we appreciate the operational rationale for providing the funds directly to the APM Entity. However, under this mandatory model where other providers are relegated, at best, to the role of

EPM Collaborator, hospitals will maintain an outsized influence over the distribution of funds and potentially marginalize the contributions of those providers on whom the success of the APM Entity rests. While it would be difficult for CMS to micromanage the distribution of reconciliation payments, we believe that CMS policy should better reflect the mandatory nature of this program and better position hospital partners for success under the model. Therefore, ***EDPMA recommends that CMS require EPM APM Entities (i.e. hospitals) that execute Sharing Arrangements with providers to establish a third party entity to receive and distribute reconciliation payments according to the terms articulated in the Sharing Arrangement.*** We believe that one of the overarching policy objectives to CMS promotion of APMs, and particularly episode-based payment models, should be the alignment of incentives among hospitals, physicians, non-physician practitioners, and post-acute care providers. A proposal that unnecessarily designates the hospital as the referee of the financial incentives undermines this policy objective and threatens to marginalize the contributions of the professionals on whom the success of the model hinge.

COMPLIANCE WITH FRAUD AND ABUSE LAWS

As was done in past rulemaking related to the development of APMs, CMS' deferred to a later date whether waivers of certain fraud and abuse laws were necessary to test the models under consideration. We understand also that many such waivers would need to be promulgated by the HHS Office of the Inspector General and therefore be conducted through separate rulemaking. However, ***EDPMA urges the assessment of the need for these waivers and the issuance of a proposed rule as soon as possible***. Not only will it be important relative to this proposed rule, but the HHS and OIG assessment will be a critical component to the development of physician-focused payment models (PFPMs). As the activities at the PFPM Technical Advisory Committee (PTAC) begin to ramp up, the pace at which specialty-developed models are developed will increase. Given the tremendous amount of resources being directed at these activities, we believe it is incumbent on CMS, HHS, and the OIG to address fraud and abuse laws sooner rather than later, and the degree to which they might interfere with otherwise appropriate APMs and PFPM. To this extent, we believe that our ability to submit APM and PFPM models to the Center for Medicare and Medicaid Innovation (CMMI) and the PTAC will have a greater likelihood of being implemented

The EDPMA appreciates the opportunity to provide input on the proposed rule. If you have any questions, please contact Elizabeth Mundinger, Executive Director of EDPMA, at emundinger@edpma.org if we can be of further assistance.

Sincerely,

Timothy Seay, MD, FACEP
Chairman, EDPMA Board of Directors