American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 5, 2021

Re: MACRA Episode-Based Cost Measures: Wave 4 Measure Development

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to provide feedback to Acumen on the development of episode-based cost measures in "Wave 4." As emergency physicians, we provide acute, unscheduled care to patients with a broad range of healthcare conditions. Therefore, we first want to provide brief comments on a couple of topics being considered in Wave 4 before moving to emergency medicine-specific comments.

4.1 Heart Failure

Question 3: We aim to capture care provided by clinicians for the chronic management of Heart Failure. Are there different roles in providing care that we should consider (e.g., do internal medicine and cardiology specialists play distinct roles)?

ACEP notes that emergency physicians working in the emergency department (ED) play a distinct role in providing care for exacerbations of heart failure in the target conditions. It is not unusual in mild cases for patients to be evaluated and treated for an entire exacerbation in the ED or ED observation unit. The consideration of measuring these mini-episodes for the management of acute exacerbations that is attributed to an emergency physician might be a valuable undertaking in any efforts to improve the overall care for patients with chronic heart failure.

4.2 Mental and Behavioral Health

Question 3: Are there any other concerns that may be present with assessing the chronic care for patients with these conditions? If so, what are some potential approaches to address these concerns for a cost measure?

The disposition of patients to the ED who present for new onset or previously diagnosed mental and behavioral health conditions is complex and not always driven by clinical condition but availability of inpatient mental health services, availability of community mental health services, or local models for allocating inpatient treatment for those without insurance.

This results not only in difficulty at a macro level but may be dependent on time of day or day of the week when they receive initial care. In some cases, medical admissions may occur that are due not to the management of the underlying mental or behavioral health diagnosis but to the inability of a patient to care for themselves for a diagnosis that would normally be treated in the outpatient setting. It may be

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

BOARD OF DIRECTORS
Mark S. Rosenberg, DO, MBA, FACEP
President
Gillian R. Schmitz, MD, FACEP
President-Elect
Christopher S. Kang, MD, FACEP
Chair of the Board
Alison J. Haddock, MD, FACEP
Vice President
Aisha T. Terry, MD, MPH, FACEP
Secretary-Treasurer
William P. Jaquis, MD, MSHQS, FACEP
Immediate Past President
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Jeffrey M. Goodloe, MD, FACEP
Gabor D. Kelen, MD, FACEP
James L. Shoemaker, Jr., MD, FACEP
Ryan A. Stanton, MD, FACEP
Arvind Venkat, MD, FACEP

COUNCIL OFFICERS
Gary R. Katz, MD, MBA, FACEP
Speaker
Kelly Gray-Eurom, MD, MMM, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Susan E. Sedory, MA, CAE

unlikely that administrative data alone will provide adequate data to address these variations nor to be amenable to current risk-adjustment models. One approach to these scenarios would be to exclude certain acute care or inpatient episodes from the cost measure.

5.1 Cross-Cutting Questions for All Wave 4 Candidate Episode Groups

Question 3: Quality alignment for assessing value—We solicit comments regarding alignment of quality of care with cost measures as well as comments on any indicators of quality that would be valuable to assess alongside the cost performance for the candidate episode groups.

The current episodes that are triggered by an inpatient admission do not capture the quality of care that occurs in the ED and in many cases is the determinant of the clinical outcome for conditions as an acute myocardial infarction, gastrointestinal bleed, congestive heart failure, or acute abdominal conditions requiring surgery. Current methods for attribution are not designed to attribute quality or cost to the ED care. ACEP recommends using administrative claims data to study the contribution of this care to the cost of an episode.

5.2 Participating in Wave 4 Development

Question 1: Are you interested in participating in Wave 4?

ACEP is interested in participating in Wave 4 as its members participate in and contribute to the quality of the care of patients with congestive heart failure, mental and behavioral health, and rheumatoid arthritis.

5.3.3 Cost Measures for Emergency Room Clinicians

Before addressing specific questions, ACEP would first like to request that Acumen change the reference to "emergency room," to "emergency department," as that is the more appropriate term.

We want to highlight ACEP's ongoing work to evaluate the cost of emergency care. We have long understood that our health care system is moving away from fee-for-service towards more value-based care, where our work as clinicians will be evaluated based on both the quality and cost of care we provide. In order to help put emergency physicians in the driver's seat to help manage this transition to value, ACEP developed the first emergency medicine-specific alternative payment model (APM), the Acute Unscheduled Care Model (AUCM).

Structured as a bundled payment model, the AUCM would improve quality and reduce costs by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. Initial episodes focus on patients with the following symptoms: abdominal pain, altered mental status, chest pain, and syncope. The AUCM would enhance the ability of emergency physicians to reduce inpatient admissions, and observation stays when appropriate through processes that support care coordination. Emergency physicians would 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 or inpatient admissions.

ACEP submitted the AUCM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for consideration. We presented the AUCM proposal before the PTAC on September 6, 2018. The PTAC recommended the AUCM to the HHS Secretary for full implementation. The AUCM met all ten of the established criteria, and the PTAC gave one of the criteria ("Scope") a "Deserves Priority Consideration" designation since the PTAC felt that the model filled an enormous gap in terms of available APMs to emergency physicians and groups.

They did recognize the need for the development of cost measures to support the model. The PTAC submitted its report to the Secretary in October 2018. The HHS Secretary responded to the PTAC's recommendation in September 2019, requesting the "the CMS Innovation Center… assess how key mechanisms of action in this model could operate as a component in a larger model dedicated to improving population health."

We are still waiting for CMMI to act on the Secretary's request, and we look forward to working with the Center to improve emergency patient care through the implementation of the model.

Question A: How can a measure on emergency room care appropriately address the result of the visit (e.g., release to community versus transfer to hospital)? How should cases where the emergency room visit leads to an inpatient admission (or transfer to another facility for follow-up care) be handled by an emergency room episode group?

Our work on the AUCM shapes our understanding of how we should be attributing the cost of episodes of acute unscheduled care to ED clinicians. Most of the current cost measures focus on episodes of care for those patients admitted to the inpatient setting or observation status. However, we believe that, going forward, we should be creating cost measures specific for ED care that results in discharge. Administrative data could be utilized to assign a trigger code, attribute the care to one professional, and to group that care with claims that occur in a post-discharge period of accountability that is determined by the diagnosis/undifferentiated condition that is alignment with evidence-based literature. In ACEP's review of administrative data of visits by Medicare FFS beneficiaries, this period is most likely 7-10 days. These episodes would allow for the creation of cost measures that meet the "Criteria for Measure Prioritization" outlined in section 3.1 of the Acumen document and be aligned with the "Essential Features of Cost Measures" outlined in section 3.2. We would highlight the opportunity for such cost measures to improve ED clinicians' performance through the adoption of care coordination models, better shared decision-making, and use of telehealth services.

Question B: What would be clinically coherent scopes for candidate episode groups for emergency room care (e.g., visits for shortness of breath, chest pain, wounds)?

Clinically coherent scopes should include those for which there is sufficient volume, sufficient variations in episode costs, and admission rates of less than 90 percent (at the national level) for acute undifferentiated conditions frequently evaluated in the ED. In the Medicare population these might include shortness of breath, chest pain, abdominal pain, syncope, and altered mental status. Consideration might be given to those conditions that would be complete the continuum of care between outpatient chronic care and inpatient care for clinical conditions for which measures have been developed.

Question C: Based on the type of care provided in the emergency room setting, how should individual clinicians and clinician groups be attributed episodes?

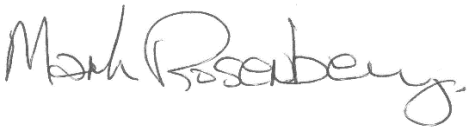
With respect to attribution, in the AUCM, the episode is attributed to the physician/practitioner who submits the Medicare Part B Claim for services. It is assumed that this will be the physician who makes the final determination of advisability of discharge and is most likely to be responsible for a final assessment of the patient, determining the discharge diagnosis, participating in shared decision-making and the hand off to the next provider as well as determining care coordination needs.

Question D: In terms of episode window, what are suitable timeframes that can assess care, treatment, and subsequent outcomes that may be reasonably influenced by attributed emergency room clinicians?

The episode window should be determined by a review of Medicare administrative data to identify the time frame in which re-admissions, death and return to ED care occur. Studies in the medical literature have defined these for a number of conditions. In general, a time frame from 7-11 days would be appropriate and end at the submission of the first claim for an evaluation and management service by a primary care or specialty practitioner.

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,



Mark S. Rosenberg, DO, MBA, FACEP

ACEP President