

October 16, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8013
Baltimore, MD 21244-1850

Re: CMS-1701-P

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success

Dear Administrator Verma:

On behalf of over 39,000 members of the American College of Emergency Physicians (ACEP), we greatly appreciate the opportunity to provide our comments on the Medicare Shared Savings Program (Shared Savings Program) proposed rule.

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). 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. Anecdotally, we have heard that a limited number of emergency physicians participate indirectly in the Shared Savings Program. While emergency physicians could possibly be part of a larger physician group or hospital participating in the Shared Savings Program or another accountable care organization (ACO) model, emergency physicians do not play an active role in these initiatives.

Transition to Downside Risk

Even though the participation of emergency physicians in the Shared Savings Program is currently limited, we do wish to comment on a few issues, including CMS' proposal to transition ACOs to downside risk on a more aggressive timeline. Under CMS' proposal, ACOs that choose to participate in the BASIC Track would not be exposed to any downside risk for only two years (in the current program, ACOs can be in Track 1 for up to six years). These ACOs would also have limited risk for the remainder of their five-year agreement period. CMS also creates the concept of "low-revenue" ACOs, which would likely primarily be physician-based ACOs. These low-revenue ACOs could spend up to two 5-year agreement periods in the BASIC Track before proceeding to the ENHANCED Track.

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As we attempt to shift our health care system to one that rewards value over volume, ACEP believes that physicians, along with other providers, can start to become more accountable for the cost and quality of care they furnish. On September 6, ACEP presented a physician-focused payment model called the Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for consideration. The PTAC voted in favor of recommending the model to the HHS Secretary for full implementation. Structured as a bundled payment model, the AUCM will improve quality and reduce costs in Medicare by allowing emergency physicians to accept some financial risk for the decisions they make around discharges for certain episodes of acute unscheduled care. One of the core principals we adopted as we developed the model was that it had to include an element of downside financial risk and be considered an Advanced APM if implemented. However, we also understood that some emergency physicians might not have experience taking on risk, and therefore we provided an option that allowed participants to transition over a period of time into downside risk. The proposed changes to the Shared Savings Program take on the same overall approach to transitioning participants to downside risk that the AUCM does.

If CMS were to finalize this proposal, there is one adjustment that we urge CMS to make in the final rule. In the first two levels of the BASIC Track, which is shared savings only, CMS is proposing that ACOs only be eligible for 25 percent of the savings. Under the proposal, this percentage increases to 30 percent at the third level, 40 percent at the fourth level, and 50 percent at the fifth and final level of the Track. We believe that CMS should increase the maximum shared savings percentage in the first two levels to at least 40 to 50 percent and make corresponding increases in the third and fourth levels as well. Although ACOs in the first two levels are not subject to any downside risk, they still must make significant investments in information technology and care coordination processes to be successful in the program and get ready to take on downside risk. A maximum shared savings percentage of 25 percent may be too low for some ACOs to cover their initial investment and therefore may be a barrier for these ACOs to participate.

Use of Waivers

In the proposed rule, CMS is expanding the use and availability of the telehealth and skilled nursing facility (SNF) three-day waivers.

Telehealth Waiver

To comply with the Balanced Budget Act (BBA) of 2018, CMS is proposing to waive the telehealth originating site requirement for ACOs that take on downside risk and choose prospective assignment. CMS is also seeking comment on applying this waiver to ACOs that have downside risk but choose preliminary prospective assignment with retrospective reconciliation. ACEP believes that telehealth services have clear benefits to patients and provide an opportunity for savings by payers such as CMS. Therefore, we thoroughly support CMS providing this additional flexibility in the coverage of telehealth services. However, beyond the scope of the ACO waiver, we believe that telehealth can also be an effective tool for emergency physicians to use to serve their patients. We have included a telehealth waiver in the AUCM that allows emergency physicians to provide telehealth services into the beneficiary's home or residence. There are also established examples of high quality, cost-effective telehealth programs in the emergency department (ED) setting that allow greater access to an emergency physician in the inner city or rural emergency departments that would not normally be able to economically support that level of provider. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and time patients spend boarded in the ED. As more and more small and rural hospitals close, EDs consequently close too, leaving a gap in unscheduled acute care in that region. To fill these gaps, emergency physicians housed in what may be a state's only large or teaching hospital provide telemedicine services to patients in smaller rural or community hospitals that are staffed by RNs and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the academic medical center before a decision is made to transfer, admit locally, or release.

SNF Three-Day Waiver

CMS is proposing to allow ACOs that take on downside risk to use the existing SNF 3-day waiver regardless of their choice of prospective assignment or preliminary prospective assignment with retrospective reconciliation (currently the waiver is restricted to those downside risk ACOs that choose prospective assignment). CMS also proposes to amend the existing waiver to allow critical access hospitals and other small, rural hospitals operating under a swing bed agreement to be eligible to partner with eligible ACOs as SNF affiliates for purposes of the SNF 3-day rule waiver. ACEP supports this expansion of the three-day SNF rule waiver and agrees that all ACOs that take on downside risk should be able to take advantage of the waiver.

Voluntary Assignment

In accordance with the BBA of 2018, CMS proposes modifications to the Shared Savings Program's existing policies on "voluntary" alignment. Voluntary alignment allows beneficiaries to choose the physician who is their primary doctor responsible for coordinating their overall care. CMS is proposing to allow beneficiaries to designate a physician regardless of specialty or a nurse practitioner, physician assistant or clinical nurse specialist as their primary clinician. CMS will count this voluntary alignment above the claims-based assignment process. CMS is also proposing to require that each ACO provide a standardized notice to each of its Medicare beneficiaries that informs them of their ability to identify or change the identification of a provider for purposes of voluntary alignment. ACEP supports this effort to strengthen the ACO beneficiary assignment process by increasing patient engagement and more accurately tying patients to the physician who has the most direct control over their care. We are particularly supportive of the proposal to allow beneficiaries to designate a physician regardless of specialty as their main doctor. In the past, we have expressed concern that the narrow focus on primary care in the beneficiary assignment process impeded the ability for specialists, such as emergency physicians, to actively participate in ACOs.

CMS is also seeking comment on creating an alternative assignment methodology that would allow beneficiaries to opt into the program. Such an opt-in methodology would be voluntary for ACOs. If ACOs did choose this option, CMS would use a hybrid approach that would be based on beneficiary opt-ins, supplemented by voluntary alignment and a modified claims-based methodology. While ACEP is supportive of the concept of involving patients more in the assignment process, we worry about the complexity of this alternative and the potential for gaming. CMS does state that ACOs would be prohibited from providing or offering gifts or other remuneration to Medicare beneficiaries as inducements to influence their decision to opt-in to assignment to the ACO. However, because they would have the option to choose this methodology or the traditional claims-based and voluntary alignment methodology, there is a clear incentive for ACOs to begin targeting beneficiaries who are more likely to bring the ACO better performance scores and higher shared savings. We therefore believe that if CMS were to finalize this alternative methodology, the agency would need to carefully monitor ACO behavior to ensure that patients who want to be part of an ACO are able to do so and that ACOs do not in any way impede the ability of certain high-cost beneficiaries to access the care they need.

Extreme and Uncontrollable Circumstances Policies

ACEP strongly supports CMS' proposal to permanently extend the policies that are currently in place that help mitigate the impact that extreme and uncontrollable circumstances can have on an ACO's performance. We agree that ACOs should not be punished for factors beyond their control, and believe that CMS' current policies effectively protect ACOs from either receiving less shared savings or being liable for more losses due to their inability to report quality measures and focus on their financial performance during an emergency.

Request for Comment on Quality Measures

CMS is seeking comments on new quality measures to add to the Shared Savings Program, including those related to opioid utilization. ACEP believes that one of the contributing factors leading to the paucity of emergency physicians actively participating in the Shared Savings Program is that there are not many measures in the program that are relevant to providers practicing in the ED setting. Therefore, we welcome the opportunity to recommend some measures that are meaningful to emergency medicine.

Found below is a list of emergency medicine-related Quality Payment Program (QPP) measures that could be applicable to the Shared Savings Program. These measures, which are used by ACEP’s Qualified Clinical Data Registry (QCDR), the Clinical Emergency Data Registry (CEDR), focus on the appropriate use of certain treatments. They correlate to some of the current overuse Shared Savings Program measures including ACO-44 (Use of Imaging Studies for Low Back Pain) and ACO-28 (Hypertension (HTN): Controlling High Blood Pressure).

ID	DESCRIPTION	NATIONAL QUALITY STRATEGY (NQS) DOMAIN
QPP76	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections	Patient Safety
QPP254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	Effective Clinical Care
QPP317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Community/Population Health
QPP331	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)	Efficiency and Cost Reduction
QPP332	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patient with Acute Bacterial Sinusitis (Appropriate Use)	Efficiency and Cost Reduction
QPP333	Adult Sinusitis: Computerized Tomography for Acute Sinusitis (Overuse)	Efficiency and Cost Reduction
QPP415	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	Efficiency & Cost Reduction

ID	DESCRIPTION	NATIONAL QUALITY STRATEGY (NQS) DOMAIN
QPP416	Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	Efficiency & Cost Reduction
QPP419	Overuse Of Neuroimaging For Patients With Primary Headache And A Normal Neurological Examination	Efficiency & Cost Reduction

Adding these QPP measures to the Shared Savings Program would make participation in the Shared Savings Program more consequential to many of these members, as it would allow them to report on quality measures that have direct impact on the patients they serve.

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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