



 American College of  
Emergency Physicians®  
*ADVANCING EMERGENCY CARE* 

## The Acute Unscheduled Care Model: A Framework to Support Contract-Negotiations

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# Leveraging ACEP's AUCM Framework to Advance Value-Based Arrangements in Emergency Medicine



An alternative payment model (APM) focused on emergency medicine could help systems move towards value and encourage physician engagement to improve quality of care and lower health system costs.



The Acute Unscheduled Care Model (AUCM) represents the best opportunity for the adoption of a data-driven, emergency department model that rewards cost containment and quality outcomes and allows the specialty to be integrated into value-based care.

# Barriers to Delivering Quality and Cost Efficient Acute Unscheduled Care

ED physicians face increasing risk as hospitals, other medical specialists and insurers curb inpatient admissions and observation stays to decrease the costs associated with acute unscheduled care. In addition, changes to out-of-network billing creates economic instability forcing many systems to seek out new sources of revenue.

Existing payment and care delivery models:

View ED care as something to be avoided, rather than a solution for many patients in need

Do not help manage the risk associated with the practice of emergency medicine

Do not reward good patient outcomes nor “fix” ED crowding concerns

Relative Value Unit (RVU)-driven reimbursement models value efficiency over effectiveness

Contribute to burnout among physician and other healthcare professionals

# Commercial and Managed Care Markets Starting to Embrace Value-Based Arrangements

Many alternative payment models (APMs) such as bundled payments or episodes of care are still in their early phases, but initial results show reduced financial strain and improved quality of life.



As direct contracting continues to increase, commercial payors are making concerted efforts to implement **APMs such as episodic or bundled payment models**. **20%** of commercial payor efforts are aligned with **existing bundled payments, case rates and MS-DRGs**.



States face mounting pressure to control their Medicaid budgets despite the increase in covered lives and utilization rates. In 2019, among the 40 states who utilize Medicaid managed care, **28 require plans to engage in some form of value-based reimbursement**.

**Bundled payment or episode of care (EOC) models** are a form of APM that provides reimbursement for a set of services that occur over time and across settings. This payment model can be focused on a: **setting** (such as a hospital or a hospital stay); **procedure** (such as elective surgery); or **condition** (such as diabetes).

# Commercial Payors Negotiate Contracts With Healthcare Systems and Managed Care Organizations

Negotiations for alternative payment contracts occur at the **executive-level** but the **process varies** by insurance company or healthcare system.

Alternative payment contracts require **legal authorities** to develop and review the arrangement.



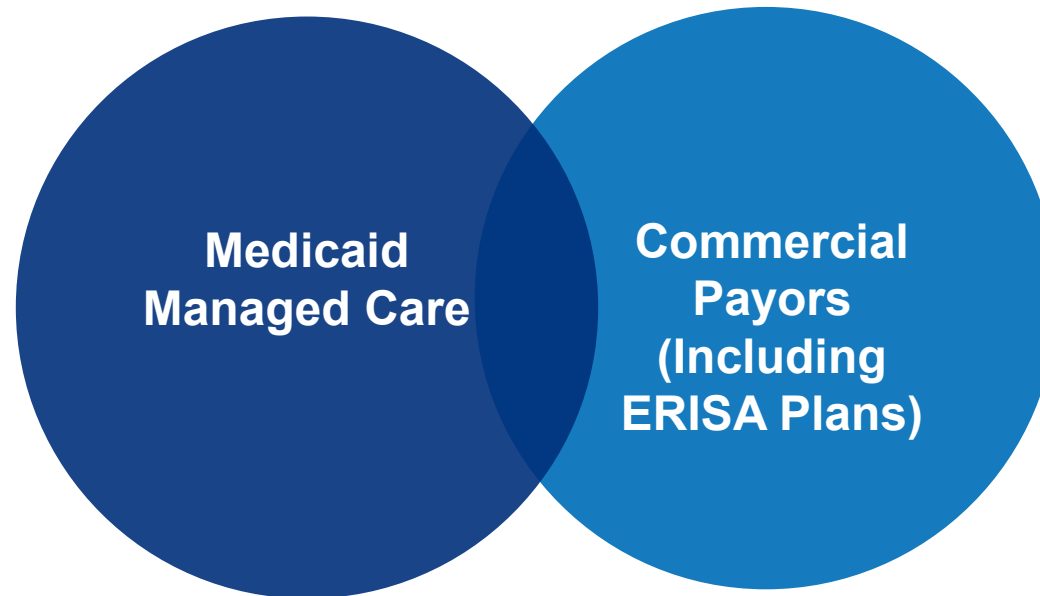
Commercial  
Payors

Private insurers adopt programs that allow them to generate **cost of care savings**.

Medicaid managed care operate under an agreement between the **State and a private payer/managed care organization** to help reduce state Medicaid budgets.

# Medicaid Managed Care and Private Payors Struggle to Contain Costs in the Emergency Department

- Medicaid beneficiaries are likely to visit the **ED** and often lack effective hand offs to the primary care system or federally qualified health centers (FQHCs).
- Medicaid dollars for **ED visits represent a significant cost** to health plans.



- Approximately **27 million annual ED visits** from privately insured patients.
- Reducing avoidable inpatient admission to the ED **could save an annual \$32 billion.**

# Leveraging the AUCM Framework to Advance Value-Based Arrangements in Emergency Medicine



EM physicians can **significantly impact overall healthcare spending** as they are responsible for determining if a patient should be kept for observation, admitted to the hospital, or discharged.



Given the proper tools, EM physicians could play a critical role in reducing Medicaid managed care and commercial insurance inpatient and outpatient costs through enhanced **care coordination process, a safe transition home** and a **warm hand-off** back to the patient's primary care physician or specialist.



# The AUCM Framework



# The AUCM Framework is Key for Value-Based Contract Negotiations that Align with Payer Priorities

ED groups can engage directly with payors to adopt **new contracting models built upon the AUCM framework** to address emergency department (ED) care delivery, improve care coordination and decrease cost. Contracts should address the **following four areas**:



**Patient  
Experience  
of Care**



**Care Delivery**



**Enhanced  
Payment**



**Data Transparency**



# The AUCM Framework at it's Core is a Quality Improvement Model

EM physicians can improve patient care experience by accounting for:

- Social determinants of health (SDH)
- Barriers to care coordination
- Patient and family preferences regarding hospitalization and follow-up care

EM-focused bundled payment models should have robust quality scoring methodologies that are tied to the quality of ED care delivered including:

<b>Patient Context</b>	Safe Discharge Assessment (SDA) Completed
<b>Patient Engagement</b>	Shared Decision Making in which the physician, patient and family participate.
<b>Post Discharge Outcomes</b>	Event-free Post-discharge Rate (based on EM best practices focus on post-discharge return visits for falls, adverse drug events, and post-ED procedure complications)



# Acute Unscheduled Care Encompasses an Episode of Care Based Upon ED Visit Outcomes

## Length of Episode:

- Includes cost and tracks events for a set time post-ED discharge.
- The AUCM episode is 30 days based on an analysis of Medicare claims data. Private payor data should be used to set the length of the episode.

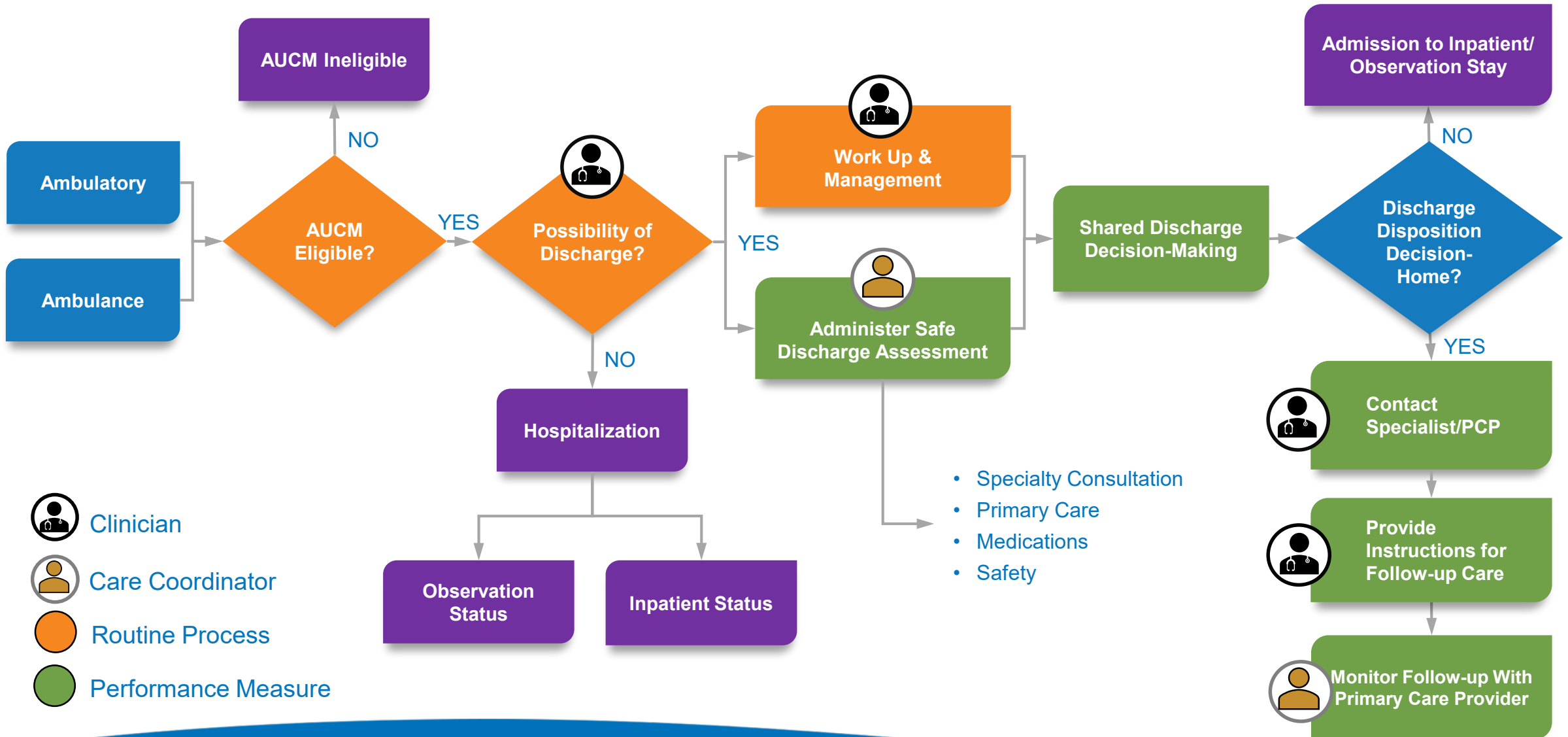
## Triggering Episodes:

- Begin with a few high-volume ED undifferentiated conditions (such as abdominal pain, altered mental status, chest pain, respiratory distress, or syncope).
- Potential to expand to more conditions over time.

## Qualifying ED Visit\*\*

- Ensure design captures most ED visits from patients with the select conditions.
- Include ED visits resulting in the following outcomes:
  - Discharge to home or the community
  - Inpatient admission
  - Observation stay

# The AUCM Care Delivery Process





# Focus on Safe Discharge Through Enhanced Patient Assessments and Improved System Communication

## Conduct Safe Discharge Assessment (SDA)

- Information collected during the SDA informs post-discharge care instructions, which provides valuable information for all patients, especially vulnerable population.
- The SDA helps identify socio-economic barriers to safe discharge, potential care coordination needs, and any additional assistance that may be needed.

## Increase Accountability for Shared-Decision Making

- The discharging physician is held accountable for reviewing the case and to re-examine the patient prior to discharge.
- EM physicians require tools and support to actively engage in shared decision making about discharge disposition.

## Promote Continuity of Care

- At time of discharge, EM physician contacts primary care provider/ specialists assuming care.
- Hospitals, care coordinators and ED groups must work together to improve post-hospitalization coordination and shared accountability.

Patients are attributed to physician making the discharge decision.



# Requirements for ED Value-Based-Care Contracts

Payors should accept key requirements in developing new contractual models that include risk for post-discharge outcomes.

## Voluntary Participation

ED's provide service for differentiated and unique communities across the country. EM physicians' ability to successfully participate in an APM depends on current system infrastructure, case-mix and experience in risk contracting.

## EM Physician Participation

Flexible for employment models independent group, regional group, national group, employed physicians, and faculty practice plan) and geographic variation (urban and rural) is vital to ensure all EM physicians can successfully participate.

## A Focus on Quality

Data-sharing of post-discharge events is necessary to ensure that the quality of care is maintained and enhanced.



# Tying ED Physician Reimbursement to Value for Acute Unscheduled Care Delivery

## Facility-Specific Target Price or Benchmark

- Target price should be based on individual hospital historical spending, which best reflects the impact of patient comorbidities and social determinants of health in the population.
- 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.

## Built-in Discount

- The target price can include a small discount guaranteeing savings.
- 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).

## Reconciliation Payments

- Participants are eligible to receive positive or negative reconciliation payments based on performance metrics and quality scores.



# Provide Necessary Flexibility and Tools to Improve Patient Care Coordination and Delivery

Payment incentives such as waiver authorities facilitate health care practitioner's care coordination efforts and bridge the gap until primary care or specialty referral is available

## Telehealth Services

EM physicians should be allowed to provide telehealth services into the beneficiary's home or residence and to bill one of the in-home visits under the same waiver that was put in place in the Next Generation ACO Model and other APMs.

## Post Discharge Home Visit

Licensed clinical staff may provide home visits under the general supervision of an emergency physician to eligible patients. The providers may bill these services utilizing the same G-codes utilized in other APMs.

## Acute Care Transition Services

Authorize EM physicians to bill for a transitional care management code. This could be done utilizing the current CPT codes (99494 and 99496) or any code developed for specific types of care transition services.





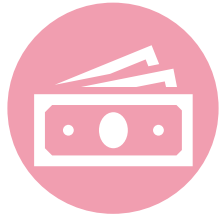
## Foster a New Dynamic Between Payors and ED Groups

ED groups working with payors to negotiate value-based contracts and collaborating with stakeholders across the healthcare ecosystem can create new partnerships dynamics.



Payors and ED groups seeking to implement value-based arrangements may forge improved relationships with the potential to positively impact reimbursement rates.





# Shared-Savings or Gain Sharing Helps Positively Position Systems to Participate in Value-Based Arrangements

Financial incentives included in contracts should reward cost-savings when compared to previous facility-based episode cost

Physician engagement in the behaviors that generate cost savings is critical for the success of an EM-focused APM

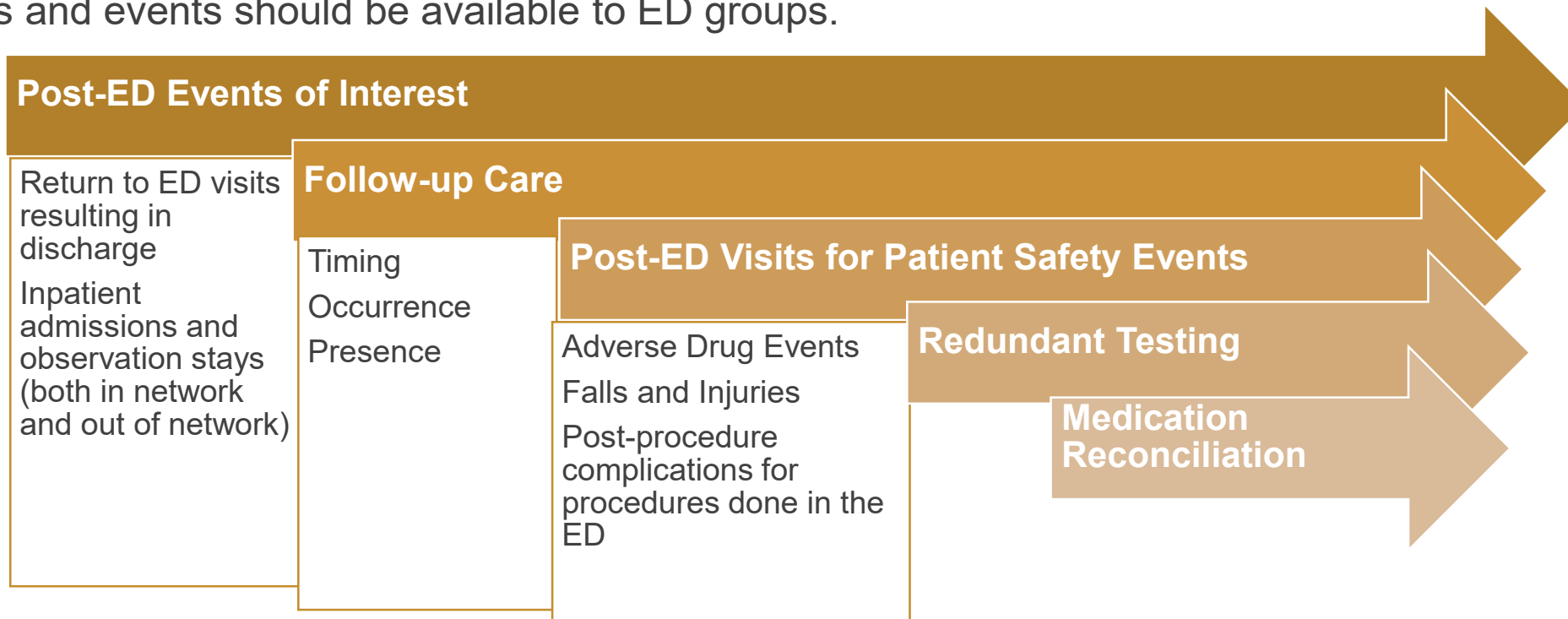
ED groups should involve physicians in the development of shared-savings distribution methodology to ensure transparency

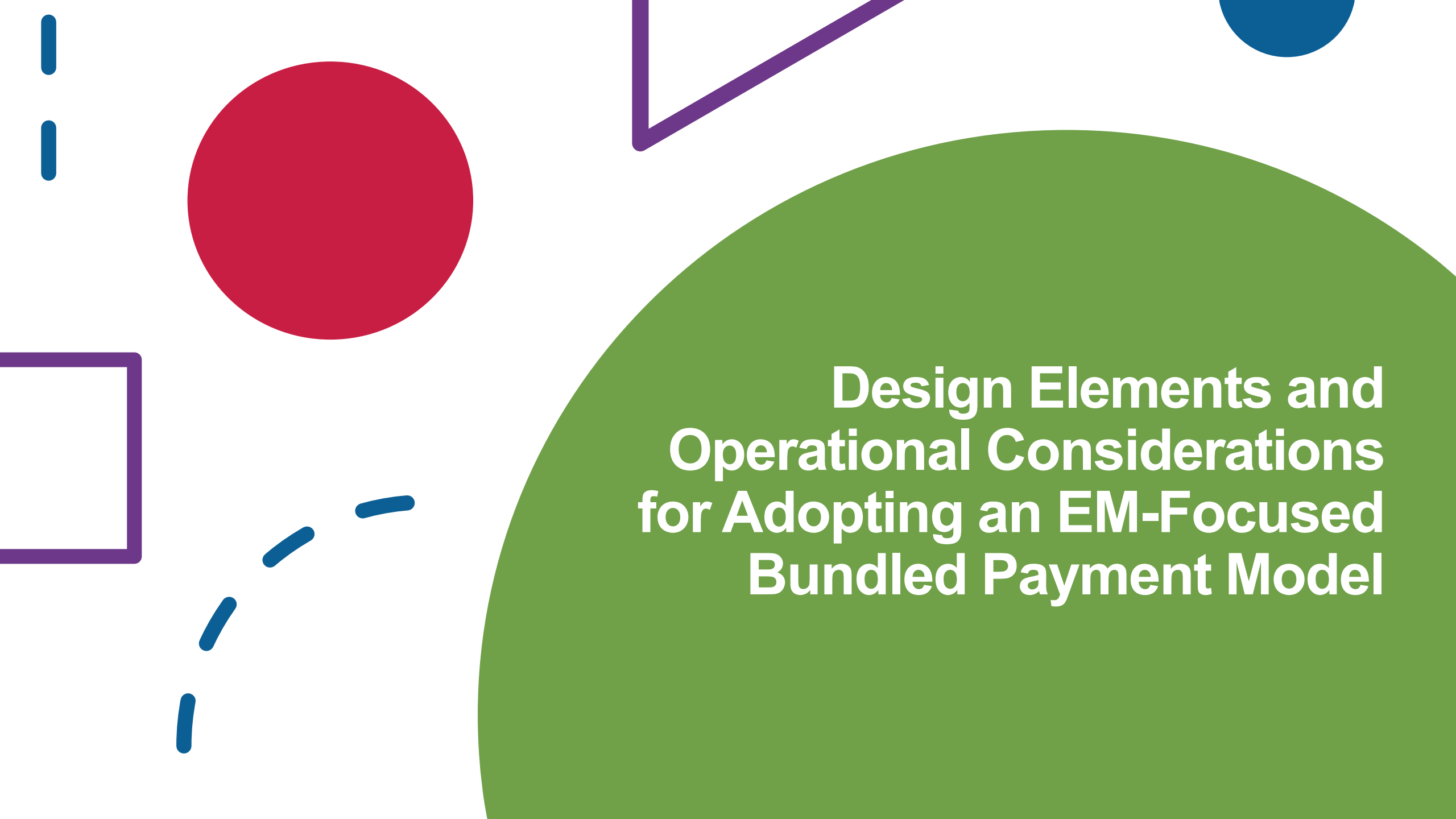
Shared-savings increase physician revenue by rewarding cost-savings associated with safe discharge, decreased post-discharge events, in-network follow-up and the elimination of redundant testing.



# Determine Cost Saving Opportunities Through Safe Discharge or Post-ED Care Coordination

Payor claims and electronic health records (EHR) data regarding frequency and types of post-ED services and events should be available to ED groups.





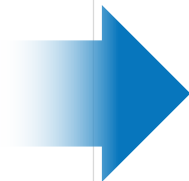
**Design Elements and  
Operational Considerations  
for Adopting an EM-Focused  
Bundled Payment Model**

# Tailoring the AUCM Framework to Meet the Needs of Individual Systems

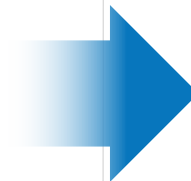
The AUCM can be integrated into existing physician-focused, population health, and hospital value-based care reimbursement models. Working together, health systems and physicians can begin advancing efforts to drive patient-centric care transformations within the ED by customizing the AUCM to best suit the needs of their patients.



Consider **operational factors** relating to implementation

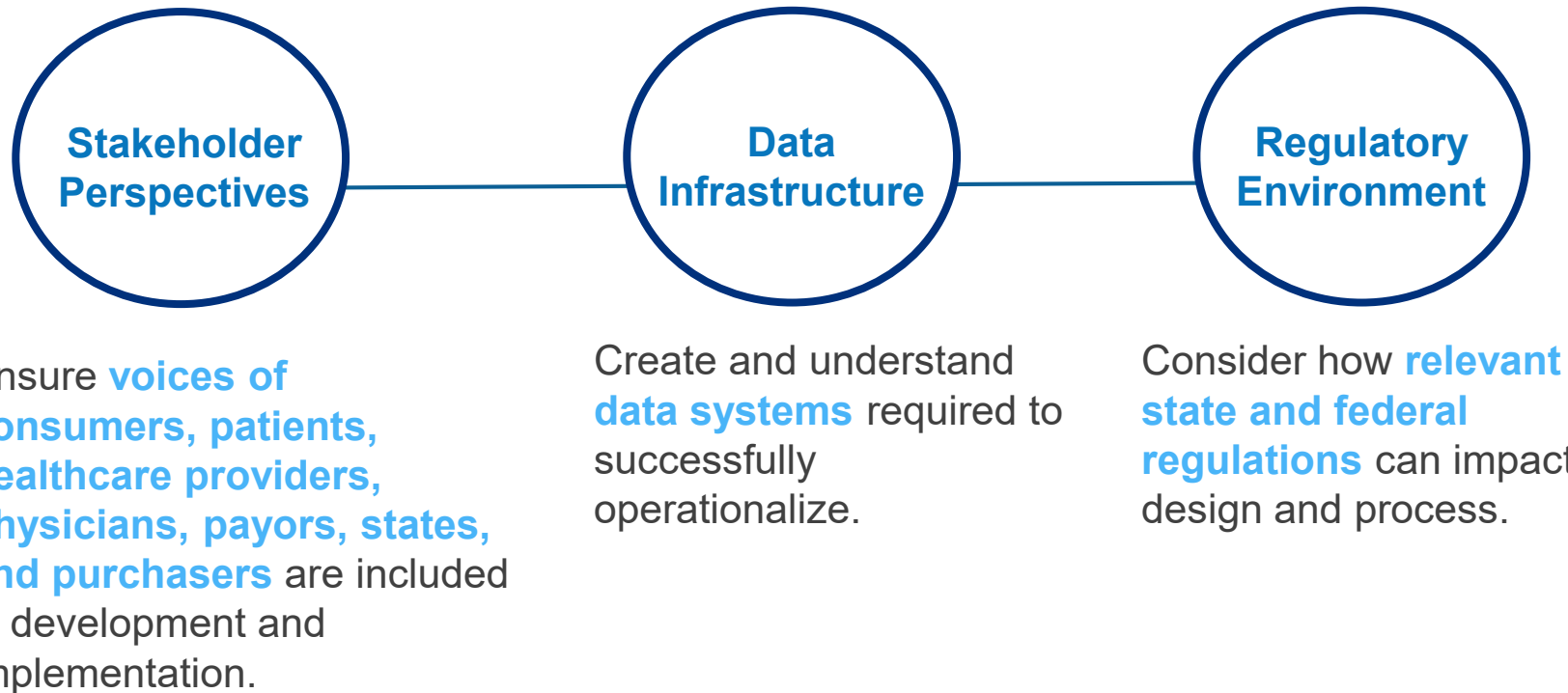


Identify **opportunity to increase value** in EM care and align on **bundle design**



Review and prepare for the **negotiation process**

# Operational Considerations When Creating an EM-Focused Bundled Payment Model



# Initial Steps to Develop an EM-Focused Alternative Payment Model Using the AUCM Framework

## Identify

Opportunity to improve quality and lower costs by selecting a target population for intervention and gauge payor interest in pursuing a financial arrangement.

## Analyze

Claims data and EHR information determine types of post-ED events and glean patient's post-ED (i.e. discharge or inpatient).

## Develop

Value-based model that adopts ED care delivery best practices such as the use of a safe discharge assessment, shared decision making, and fall assessment.

## Measure

Quality improvement opportunity to ensure continuous feedback and account for any adjustments required.

## Approach Payors

Regarding negotiations for instituting pilot projects.

# Design Recommendations for an EM-Focused Bundled Payment Model

Identify target population

Finalize the trigger events and codes associated with the trigger event (ICD diagnosis, ICD procedure, HCPCS/CPT, and DRG classifications).

Define episode length and timing

Work with the clinicians, purchasers and data to determine the final episode length for targeted bundles. Ensure the care process matches the management needs of the patients.

Identify criteria to support patient inclusion and exclusion in episodes

Broad inclusion criteria will create large, statistically significant programs and spread risk across the patient pool.



# Analyze Claims and Electronic Health Records Data to Determine Relevant Quality Measures

Identify best practices for improving care delivered in the ED through interventions that meet the needs of target population selected.

## The AUCM Framework Quality Improvement Measurements:

<b>Patient Engagement</b>	Safe Discharge Assessment (SDA)
<b>Process of Care Coordination</b>	Shared Decision Making
<b>Post Discharge Outcomes</b>	Post-discharge event rates
<b>Patient Safety Events</b>	Injuries, Adverse drug events (ADE), Post-procedure complications

# Recommendations for Pricing in an EM-Focused Bundled Payment Model

## Episode Pricing Structure Should:

### Generate Savings Across Stakeholders

- Payor should see savings compared to average historical costs.
- Patient savings generated from lowering deductibles and co-pays.
- Physician should see increased savings and additional revenue from efficient service utilization and innovative clinical care process design.

### The AUCM Framework

- Target price for the episode should be based on individual hospital historical spending, which best reflects the impact of patient comorbidities and social determinants of health in the population.
- The target price can include a small discount guaranteeing savings.

## Payment Flow Suggestions:

### Initial Reconciliation Model

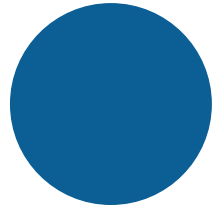
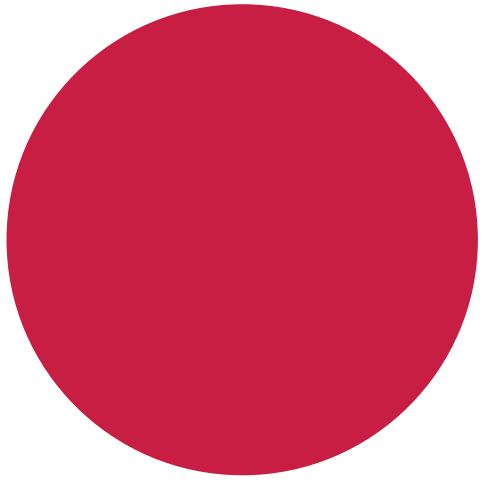
- Easier to structure program initially as a retrospective reconciliation model but once program is in full swing and physicians gain a better understanding of the payment process, it is possible to move toward a prospective model.
- Potential to leverage payors prevailing physician rate schedule.

### The AUCM Framework

- Participants should be eligible to receive positive or negative reconciliation payments based on performance metrics and quality scores.

# Step-wise Approach for Negotiating Value-based Arrangements Between Organizations and Payors

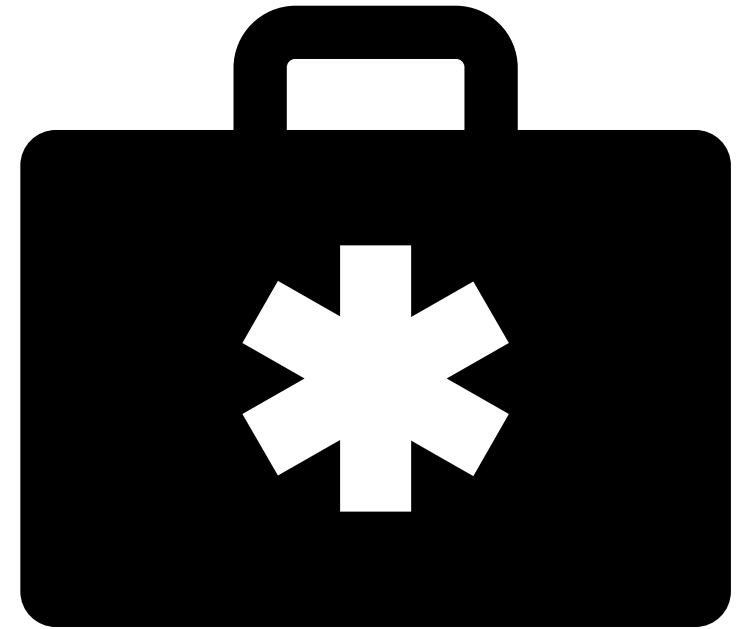
1. Select **targets** (local payors, regional employers, statewide employers, unions)
2. Identify other contractual relationships between the payor, ED group and other entities such as the hospital **to ensure stakeholder alignment**
3. Develop **value proposition** to share with payors and employers during initial meetings
4. Outline **program parameters**, ensuring specifications regarding service inclusions and exclusions
5. Create a **pricing strategy based on specific payor/employer** volume and geographic coverage
6. Determine a **claims adjudication process**
7. Finalize **agreement**



# Appendix



# Medicaid Managed Care Alternative Payment Model Landscape



# Medicaid Coverage is a Critical for the Health of Vulnerable and Low-Income Patients

## Medicaid is Grounded in Entitlement and State-Federal Partnerships

### Medicaid is jointly funded by federal and state government

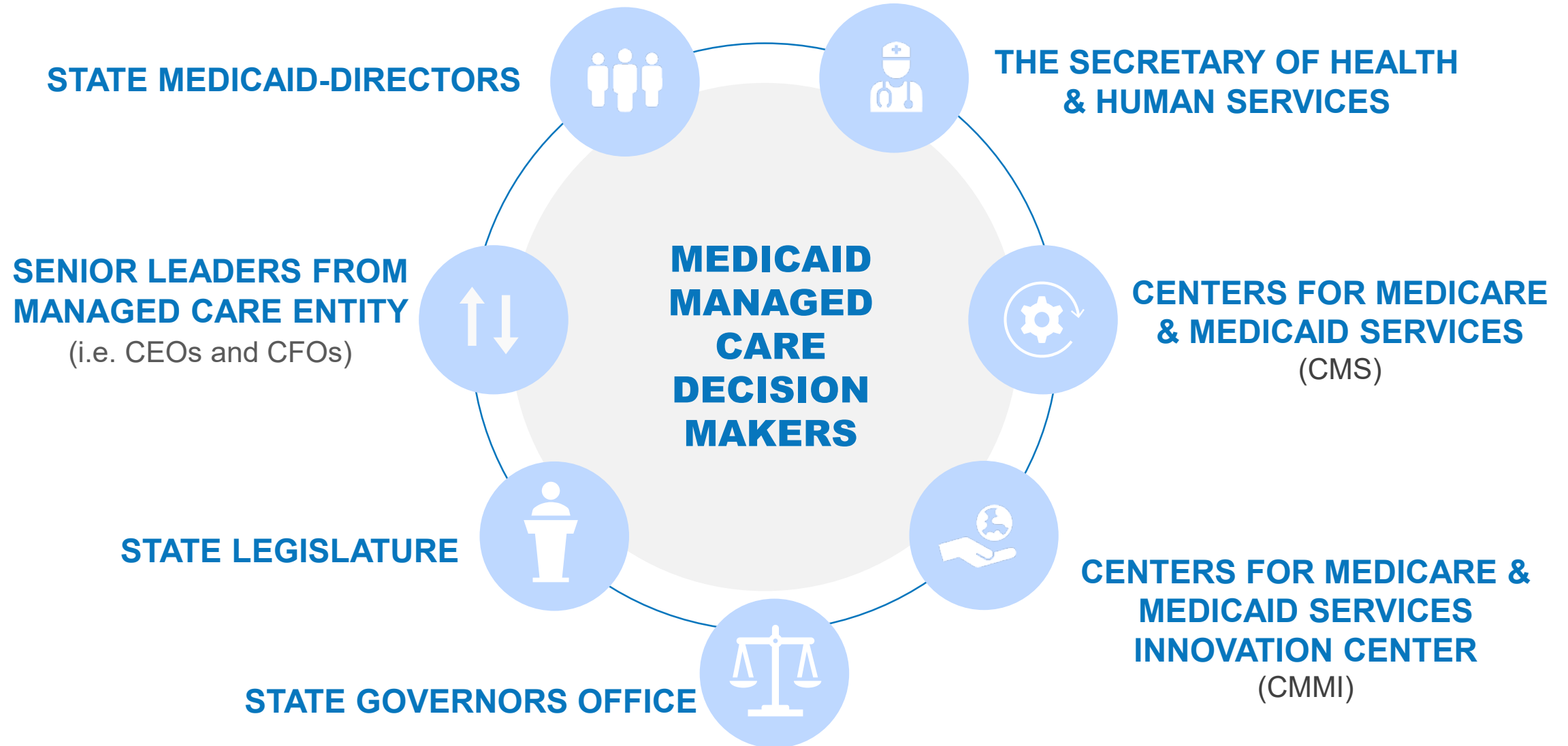
- Total Medicaid spending in 2017 accounted for \$577 billion.
- Eligible individuals are entitled to a defined set of benefits and states are entitled to federal matching funds.

### Significant variability among Medicaid programs

- Within federal guidelines, states determine the population covered, services provided, healthcare delivery models, and reimbursement for physicians and hospitals.

## Medicaid's Benefits are Designed to Reflect the Needs of the Population Covered

Low-Income Families	<ul style="list-style-type: none"> <li>•Pregnant Women: Pre-natal care and delivery costs</li> <li>•Children: Routine and specialized care for childhood development (immunizations, dental, vision, speech therapy)</li> <li>•Families: Affordable coverage to prepare for the unexpected (emergency dental, hospitalizations, antibiotics)</li> </ul>
Individuals with Disabilities	<ul style="list-style-type: none"> <li>•Child with Autism: In-home therapy, speech/occupational therapy</li> <li>•Cerebral Palsy: Assistance to gain independence (personal care, case management and assistive technology)</li> <li>•HIV/AIDS: Physician services, prescription drugs</li> <li>•Mental Illness: Prescription drugs, physicians services</li> </ul>
Elderly Individuals	<ul style="list-style-type: none"> <li>•Medicare beneficiary: help paying for Medicare premiums and cost sharing</li> <li>•Community Waiver Participant: community based care and personal care</li> <li>•Nursing Home Resident: care paid by Medicaid since Medicare does not cover institutional care</li> </ul>



# Contracting Through Medicaid Managed Care Helps Lower Program Costs

Both state and federal government face significant political and economic pressure to limit Medicaid spending and increase program efficiency.



- States can reduce program costs and better manage healthcare service utilization through contracted arrangements between a state Medicaid agency and a managed care organization (MCO).
- MCOs accept a set per member per month (capitated) payment and are at financial risk for the Medicaid services outlined in their contracts.



- Most Medicaid enrollees receive care through private managed care plans.
  - 40 states, including DC contract with comprehensive risk-based MCOs to provide care for some of their Medicaid beneficiaries.
  - Over two-thirds of all Medicaid patients receive their care through MCOs.



# Alternative Payment Models Are Changing the Way Managed Care Organizations Pay Provider

States require or encourage MCOs to increase implementation of value-based arraignments through a variety of efforts.

Medicaid agency can provide financial incentives for MCOs to use APMs already in existence.

Medicaid agency may contractually require MCOs to implement MCO-defined APMs.

Medicaid agency may design an APM and contractually require MCOs to implement it.

# Examples of Current Value Based Models



# Commercial Home Health Recovery LLC Model Leverages Bundled Payments



- Achieved through a joint venture between **Highmark Health and Contessa** in Western Pennsylvania.
- Designed to function within commercial markets as a **bundled payment model for specific episodes of care.**



- Proactively aligned with the broader shift in healthcare toward providing care in lower cost settings.
- **Delivers inpatient hospital care to patients in their homes** to provide safer healthcare services and help lower cost through a combination of **in-person home visits and telehealth.**



- Patients begin the **30-day episodes of care, once at home.**
- Initially the **nurses visit the home** twice a day to check on the patient and perform necessary treatments.
- For the rest of the period, the **patient is monitored via a telehealth kit.**

# Employer Sponsored Plan Establishes Centers of Excellence Networks and Utilizes Various Reimbursement Structures



- **Walmart and Emory Healthcare** developed the Emory Accountable Care Plan which combines an accountable care organization (ACO) with a bundled payment program.



- Members of the Walmart's employee sponsored health plan can **opt into the ACO and gain access to free preventive care/ pay standard copays** for primary, specialty and urgent care.



- **Bundled payment for care related to spine surgery and joint replacement** through **Centers of Excellence agreement** between Walmart and Emory University in Georgia.
- Members **don't pay out-of-pocket for procedures** at those locations.

# Arkansas Health Care Payment Improvement Initiative Includes Multiple Payors and Several Value-based Agreements



- **Multi-payor effort** including the Arkansas Medicaid, Arkansas BCxBS, Arkansas State and Public-School employees Health Plane, Centene, HealthSCOPE, QualChoice and Walmart.
- Initiative has **positioned AK as a national leader** in value-based innovation.



- **State-wide initiative** focused on shifting away from fee-for-service payments towards patient-centered delivery models including **patient-centered medical homes (PCMH) and Episodes of Care (EOC)**.
- AK practices assume full financial responsibility for the **total cost of care** for attributed patients.x

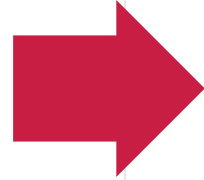


- For the EOC model, **quality and financial improvements are evident in targeted areas**.
- In 2017, AK was selected to participate in the **Comprehensive Primary Care Plus (CPC+)**, a CMMI demonstration program, extending Medicare participation in primary care medical homes throughout the state.

# TennCare Managed Care Organizations Reduce Overall System Costs at No Expense to Patient Care



- Achieved through an **1115 waiver**.
- TennCare is the only Medicaid program in the country that requires **all beneficiaries to be enrolled in managed care**.



- MCOs make bundled payments to providers for **75 different episodes of care**.



- In 2013, the program reduced costs for covered episodes by \$11.1 million and, **in 2016, the program reduced costs by \$14.5 million**.



# **Additional Resources**

# Commercial and Private Payor Related Resources

- Health Care Transformation Task Force, Clinical Episode Contracting for Commercial Payers. (2019)
  - [https://hcttf.org/wp-content/uploads/2019/01/HCTTF\\_Clinical-Episode-Contracting-for-Commercial-Payers.pdf](https://hcttf.org/wp-content/uploads/2019/01/HCTTF_Clinical-Episode-Contracting-for-Commercial-Payers.pdf)
- Health Payer Intelligence, Private Payers Follow CMS Lead, Adopt ValueBased Care Payment (2016)
  - ▶ <https://healthpayerintelligence.com/news/private-payers-follow-cms-lead-adopt-value-based-care-payment>
- Nixon Peabody LLP, Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context
  - ▶ [https://www.nixonpeabody.com/-/media/Files/Alerts/159464\\_bundled\\_payments\\_shared\\_savings\\_arrangements.ashx](https://www.nixonpeabody.com/-/media/Files/Alerts/159464_bundled_payments_shared_savings_arrangements.ashx)
- United Health Group. The High Cost of Avoidable Hospital Emergency Department Visits. (2019).  
<https://www.unitedhealthgroup.com/avoidable-ed-visits>
- American Hospital Association, Evolving Care Models: Aligning Care Delivery to Emerging Payment Models (2019)
  - ▶ [https://www.aha.org/system/files/media/file/2019/04/MarketInsights\\_CareModelsReport.pdf](https://www.aha.org/system/files/media/file/2019/04/MarketInsights_CareModelsReport.pdf)



# Medicaid Medicaid Managed Care Related Resources

- National Association of Medical Directors, Medicaid Value-based Purchasing: What Is It & Why Does It Matter? (2017)
  - [https://medicaiddirectors.org/wp-content/uploads/2017/01/Snapshot-2-VBP-101\\_FINAL.pdf](https://medicaiddirectors.org/wp-content/uploads/2017/01/Snapshot-2-VBP-101_FINAL.pdf)
- Georgetown Center for Children and Families/ National Association of Medical Directors, Medicaid Value-based Purchasing (2017)
  - [https://ccf.georgetown.edu/wp-content/uploads/2017/07/Browning-VBP-Medicaid\\_7\\_19\\_2017.pdf](https://ccf.georgetown.edu/wp-content/uploads/2017/07/Browning-VBP-Medicaid_7_19_2017.pdf)
- National Academy for State Health Policy, Toolkit: State Strategies to Develop Value-Based Payment Methodologies for Federally Qualified Health Centers
  - <https://nashp.org/toolkit-state-strategies-to-develop-value-based-alternative-payment-methodologies-for-fqhcs/>
- ECG Management Consultants, Bundled Payments in the Commercial Market: What You Need to Do to Be Prepared (2019)
  - <https://www.youtube.com/watch?v=4Z794xkjkyk&feature=youtu.be>
- Kaiser Family Foundation, 10 Things to Know about Medicaid Managed Care (2019)
  - <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>
- Kaiser Family Foundation, 10 Things to Know about Medicaid: Setting the Facts Straight (2019)
  - <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

# ACEP AUCM's Resources

- ACEP's the Acute Unscheduled Care Model Homepage: [www.acep.org/apm](http://www.acep.org/apm)
- PTAC Homepage: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>
- American College of Emergency Physicians. The AUCM Proposal. (2018)  
<https://aspe.hhs.gov/system/files/pdf/255906/ACEPResubmissionofAUCMtoPTAC.PDF>
  - ▶ Letter of Intent: <https://aspe.hhs.gov/system/files/pdf/255906/LoIACEP.PDF>
  - ▶ Public Comments: <https://aspe.hhs.gov/system/files/pdf/255906/ACEPPublicComment.pdf>
  - ▶ Preliminary Review Team (PRT) Report: [https://aspe.hhs.gov/system/files/pdf/259886/PRT\\_Report\\_ACEP\\_08-13-18\\_508.pdf](https://aspe.hhs.gov/system/files/pdf/259886/PRT_Report_ACEP_08-13-18_508.pdf)
  - ▶ Additional Information from Submitter:  
<https://aspe.hhs.gov/system/files/pdf/255906/AdditionalInformationfromSubmitterACEP.pdf>
  - ▶ Additional Information/Analyses: <https://aspe.hhs.gov/system/files/pdf/255906/AdditionalInformationorAnalysesACEP.pdf>
  - ▶ Additional Information/Analyses – Data Tables: <https://aspe.hhs.gov/system/files/pdf/255906/AddlInforAnalyses-DataTablesACEP.pdf>
  - ▶ Committee Member Disclosures: [https://aspe.hhs.gov/system/files/pdf/259886/ACEP\\_Disclosures\\_508.pdf](https://aspe.hhs.gov/system/files/pdf/259886/ACEP_Disclosures_508.pdf)
  - ▶ Report to the Secretary: [https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary\\_ACEP\\_10.20.18.pdf](https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary_ACEP_10.20.18.pdf)