The Affordable Care Act and Emergency Care: The Impact of ACOs and other Shared Risk Models on the Quality, Cost, and Practice of Emergency Medicine

SAEM

May 15th, 2014

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Karin Rhodes, MD MS, University of Pennsylvania
Brent Asplin, MD MPH, Chief Clinical Officer for Catholic Health Partners
David Nilasena, MD, Chief Medical Officer, Region VI, CMS
Tim Peterson, MD MBA, Medical Director, University of Michigan Medicare ACO

sponsored by the Health Services and Outcomes Interest Group
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- Keith Kocher – investigator initiated research funding sponsored by NIA, occasional consultant for Magellan Health Services, Inc., a health management consulting firm
- Arjun Venkatesh – none
- Peter Smulowitz – none
- Adam Sharp – none
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- Brent Asplin – none
- David Nilasena – none
- Tim Peterson – none
Outline

- **Structure:**
  - Mini-lecture (5 min)
  - Moderated panelist discussion (15 min)
  - Directed audience question and answer (5 min)

- **4 topics:**
  - (1) Introduction to payment reform, shared risk models/ACOs
  - (2) ED quality measures under shared risk models
  - (3) Understanding the costs and financing of delivering emergency care
  - (4) Impact of shared risk models on the practice of emergency medicine
Outline

- Welcome, Topic #1 – 25 minutes
- Topic #2 – 20 minutes
- Topic #3 – 20 minutes
- Topic #4 – 20 minutes
- Additional audience directed questions and further discussion – 20 minutes
- Final thoughts and wrap up – 5 minutes

/ Total = 110 minutes
Objectives

- Understand the impact of shared risk models on the delivery of emergency care, specifically:
  - Define shared risk models, accountable care organizations, and payment reform
  - Conceptualize how quality and cost should be measured in emergency care
  - Explore the implications of shared-risk models on the practice of emergency medicine, including residency training programs and opportunities for researchers
State Medicaid program to stop paying for unneeded ER visits
Topic #1

- What is payment reform?
- What is a shared risk model?
- What is an accountable care organization (ACO)?
Payment Reform

- Affordable Care Act (aka, *Patient Protection and Affordable Care Act* or *Obamacare*)
  - Passed March 2010
  - 3 components:
    - Consumer protections (patient’s bill of rights)
    - Expansion of health insurance coverage (individual mandate, state insurance exchanges, state Medicaid expansion)
    - Payment reform for health care services (accountable care organizations, Hospital Readmission Reduction Program)
Payment Reform

- Fixing rising health care expenditures ("bending the cost curve")

- Better incentivizing value for what is spent
  - We have a value gap in the US health care system
  - We spend a lot and get a little, compared to other health systems

- Payment for outcomes (value), not volume (fee-for-service)
  - Value-based purchasing
  - Pay-for-performance
  - Episodes of care
  - Global payments
  - Bundled payments
Shared Risk Models

- **Definition**
  - Process by which two or more parties agree to share the risks associated with achieving a certain outcome

- **Within health care:**
  - Payer (insurer, government)
  - Provider(s) (health system, hospital, physician group)
  - Take many forms (upside risk, downside risk, loss of market share)

- **Goal is to align the payment incentives to slow expenditures while maintaining quality**
Shared Risk Models

- View this as a policy reaction/strategy to the problem of sustained historical growth in health care expenditures

- Pitfalls:
  - Time-consuming negotiations
  - Complicated legal arrangements
  - Costly administration
  - Difficulty in assessing success (outcomes)
  - Success depends on changing attitudes/culture (away from fee-for-service)
  - Difficulty distributing appropriate payments
ACOs

- Term first used by Elliott Fisher, a health economist, in 2006

- ACOs are one form of shared risk models
ACOs

- Embedded in the Affordable Care Act

- CMS programs: Medicare Shared Savings Program, Advance Payment ACO Model, Pioneer ACO Model
  - ~360 ACOs, covering ~5 million Medicare beneficiaries

- 23% percent of emergency physicians report already in an ACO; 5% plan on joining one this year
  - Medscape online survey of ~24,000 physicians over 6 weeks (December 2013 – January 2014)
**ACO**

- **What is an ACO?**
  - CMS: “ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”

<table>
<thead>
<tr>
<th>Table. Health Maintenance Organizations vs Accountable Care Organizations</th>
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</thead>
<tbody>
<tr>
<td><strong>HMO</strong></td>
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<tr>
<td>Patient enrollment</td>
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<tr>
<td>Patient choice</td>
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<tr>
<td>Accountability</td>
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<tr>
<td>PCP role</td>
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<tr>
<td>Payment incentives</td>
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</tbody>
</table>
Panel Discussion

**Moderator:**
- Karin Rhodes, MD MS, University of Pennsylvania

**Panelists:**
- Brent Asplin, MD MPH, Chief Clinical Officer for Catholic Health Partners
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ED Quality Measurement within Shared Risk Models

Arjun Venkatesh, MD MBA
Yale University
RWJ Clinical Scholar
Quality Measures for ACOs

- Quality measures are central to shared-risk payment models
  - Align incentives
  - Create accountability: providers and patients
  - Drive payment distributions
  - Protect against “rationing”
ACO Quality Measures of Today

- Emergency Care is largely absent
  - Measures are population and not setting focused
  - Based on billing claims and don’t fit emergency care

- Original 33 ACO quality measures used by CMS cover 4 domains of care:
  - Patient/Caregiver Experience
  - Care Coordination/Patient Safety
  - Preventive Health
  - High-risk populations: Diabetes, HTN, CHF, etc.
# CMS ACO quality measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Emergency Care measure</th>
<th>EM plays Indirect Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Patient Experience: CAHPS measures</td>
<td>☒</td>
<td>☒</td>
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<tr>
<td>Risk-standardized All Condition Readmission</td>
<td>☒</td>
<td>☑</td>
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<tr>
<td>COPD Prevention Quality Indicator (Admission)</td>
<td>☒</td>
<td>☑</td>
</tr>
<tr>
<td>CHF Prevention Quality Indicator (Admission)</td>
<td>☒</td>
<td>☑</td>
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<tr>
<td>PCPs participating in EHR Incentive Program</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>8 Preventive Health measures: vaccination, screening*</td>
<td>☐</td>
<td>☕ - smoking</td>
</tr>
<tr>
<td>6 Diabetes Control measures</td>
<td>☒</td>
<td>☒</td>
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<tr>
<td>Ambulatory Hypertension control measure</td>
<td>☒</td>
<td>☒</td>
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<tr>
<td>2 Ischemic vascular disease measures: Lipids and ASA</td>
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<tr>
<td>Beta-blocker therapy for CHF patients</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>2 CAD measures: Lipids and ACE/ARB</td>
<td>☒</td>
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</tbody>
</table>
Commercial ACO Quality Measures

- Utilize same NQF endorsed measures but often provider selected

- BCBS Alternative Quality Contract
  - Unnecessary use of antibiotics for bronchitis
  - ASA on arrival for AMI
  - CT use in low probability PE patients
  - Nuclear imaging for chest pain

- Many others!
ACO quality measures and Emergency Care Access

- Risk that measures can reduce ED access
  - UTAH Medicaid ACO measures include:
    - ED utilization for low acuity CPT codes
    - Report of actions to expand primary care, urgent care or other innovation for “emergency room diversion.”

- Colorado Accountable Care Collaborative
  - Raw utilization: 30 day readmissions, well child visits, Emergency Room visits, High-Cost Imaging Services
Emerging ACO Quality Measures

- Transition to eMeasures that utilize EHR data instead of billing claims
- Development of patient-reported outcome measures beyond CAHPS
- CMS and ONC are promoting measurement in key populations:
  - Multiple Chronic Conditions (w/ behavioral health)
  - Frail Elderly
- Is Emergency medicine ready? How to fit in?
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Cost Considerations and the Financing (and survival?) of EM

Peter B. Smulowitz, MD, MPH, FACEP
Assistant Professor
Dept. of EM, Beth Israel Deaconess Medical Center
Harvard Medical School
Major Points for Discussion

1. EM’s place in and contribution to cost reduction within an ACO held to a global payment, i.e. the value of EM

2. Strategies for the financing of EM within an ACO framework
ACOs and Alternative Payment Models

Accountable Care Organizations

- Fee-for-service
- Bundled payments
- Episodes of Care
- Global payments
  “Risk contracts”
# Key Global Payment Contracts

<table>
<thead>
<tr>
<th>Contract</th>
<th>One-sided or Two-sided Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS Alternative Quality Contract</td>
<td>Two-sided</td>
</tr>
<tr>
<td>CMS Shared Savings Program</td>
<td>One-sided, maintains FFS payments</td>
</tr>
<tr>
<td>CMS Pioneer ACO (were 32, now 23)</td>
<td>Starts one-sided with FFS, may become two-sided with partial population based payments after year 2</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare & Medicaid Services
The cost of ED care

Table 1. Medicare 2011 national unadjusted payment rates.

<table>
<thead>
<tr>
<th>Visit Level</th>
<th>ED Physician Payment Rate, $</th>
<th>ED Facility Payment Rate, $</th>
<th>Office Visit Payment Rate, $*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21.02</td>
<td>51.77</td>
<td>41.11</td>
</tr>
<tr>
<td>2</td>
<td>41.30</td>
<td>87.25</td>
<td>71.02</td>
</tr>
<tr>
<td>3</td>
<td>62.68</td>
<td>139.14</td>
<td>102.95</td>
</tr>
<tr>
<td>4</td>
<td>118.73</td>
<td>222.58</td>
<td>126.41</td>
</tr>
<tr>
<td>5</td>
<td>174.77</td>
<td>329.54</td>
<td>162.42</td>
</tr>
</tbody>
</table>

*Except under rare exceptions, there is no separate facility component for office visits.

Prior to CMS Outpatient Prospective Payment System implementation
### The total cost of ED visits

Excludes retail sales of medical products, hospice, administrative costs of insurance, etc.

**Table 3. Summary of estimates for aggregate expenditures on emergency care.**

<table>
<thead>
<tr>
<th>Source</th>
<th>Methodology</th>
<th>Aggregate Expenses, $, Billions</th>
<th>Share of NHE, %</th>
<th>Share of Hospital and Professional Expenditures, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEPS unadjusted</td>
<td>Underestimates ED visits; counts discharged patients only</td>
<td>49</td>
<td>1.9</td>
<td>3.3</td>
</tr>
<tr>
<td>MEPS adjusted</td>
<td>Corrected for ED visits; adjustment for admitted patients</td>
<td>131–136</td>
<td>5.0–5.2</td>
<td>8.8–9.0</td>
</tr>
<tr>
<td>NEDS</td>
<td>Based on charges; no professional fees; adjust for admitted pts.</td>
<td>128–151</td>
<td>4.9–5.8</td>
<td>8.5–10.0</td>
</tr>
<tr>
<td>Private insurer</td>
<td>Medicare/Medicaid spending extrapolated from private plans</td>
<td>162–260</td>
<td>6.2–10.0</td>
<td>10.7–17.3</td>
</tr>
</tbody>
</table>

*MEPS, Medical Expenditure Panel Survey; NHE, National Health Expenditures; NEDS, National Emergency Department Sample.*
Where are the cost savings in the ED?

A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department

Table 3. Framework for categorizing ED visits.

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
<th>Components of Cost</th>
<th>% of Total Visits</th>
<th>Expected Potential Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergencies</td>
<td>Trauma, medical (eg, stroke), surgical (eg, acute abdominal pain)</td>
<td>Expense of ED visit</td>
<td>10%–16%</td>
<td>No available cost savings</td>
</tr>
</tbody>
</table>
| Intermediate/complex conditions | 1) Complex chronic disease: congestive heart failure, chronic obstructive pulmonary disease, diabetic complications  
2) Acute presentations of disease: urinary tract infection, pneumonia, abdominal pain, angina, atypical chest pain | Increased testing, increased likelihood of admission     | 31%–57%           | Reduction of 1.0%–2.5% of total health spending  |
| Minor injury/illness            | Sore throat, cough, sprains, rash                                        | Price of ED visit, possibly increased testing compared with primary care visit | 12% to 40%        | Reduction of 0.24% to 0.8% of total health spending |

Not necessarily true

Up to 2% if using 10% of FHE
Cutting costs in the ED

- Reduce admissions
- Reduce low acuity visits?
- Reduce/standardize testing
- Shift sites of care: urgent care, free standing ED?
- Continue to provide a valuable service
Long Term Survival

- Key issues for considering the financing of emergency care
Paying for the public good

- “Stand-by capacity”
What Payment Strategy Will Work?

- Fee-for-service vs. Global payments
- Hybrid model: case-mix payment + fixed grant approach
- EM having a stake in shared savings?
- Eliminate the facility fee?
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Impact of Shared Risk Models on the Practice of Emergency Medicine

Adam L. Sharp MD, MS
Kaiser Permanente Southern California
Where the rubber meets the road…
Prioritizing to Improve ED Value

- ED Hospital Admission Practices
- EM Provider CT ordering stewardship

ED Admission Practices

Less emphasis identifying "appropriate" ED use

ED Care 4%* of Healthcare Expenditures

Discharge Home

More emphasis on identifying "appropriate" admissions

Admit to Hospital

Inpatient Care 29%* of Healthcare Expenditures

Pneumonia

- #1 reason for ED admission\(^1\)
- Vast provider variability
  - IHC 38-79% admission rates between providers\(^2\)
  - No difference in patient outcomes
- 80% prefer outpatient pneumonia treatment\(^3\)

Pneumonia

- Reasons Providers Don’t Follow Severity Index
  - Comorbidities
  - Abnormal symptoms, vitals or labs
  - PCP/Specialist requested admission
  - Don’t trust the severity index
  - Problems with outpatient therapy
  - Patient/Family Request
  - Psychosocial
  - Required hospital services

Advanced Diagnostic Imaging

- Use Validated Decision Tools for Head CT
  - Canadian CT Head Rules for mild TBI
ED Admissions/HCT Utilization

- Create a Standard/Quality Metric
  - CURB-65/PSI/Other
  - Canadian HCT Rule
- Measure the Standard
- Report Provider Performance
  - Audit and feedback
  - Academic detailing
What are you measuring?
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