Committee Members

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October 20, 2018

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions*, submitted by the American College of Emergency Physicians (ACEP). These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to 1) review PFPM models submitted to PTAC by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed ACEP's proposed model (resubmitted to PTAC on June 12, 2018); additional information on the model provided by the submitter in response to questions from a PTAC Preliminary Review Team and PTAC as a whole; and public comments on the proposal. At a public meeting of PTAC held on September 6, 2018, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended.

PTAC recommends the ACEP proposal to the Secretary for implementation. The Committee finds that the proposal meets all 10 of the Secretary's criteria. Members believe that patients who visit the emergency department (ED) and are discharged home could benefit from the model, which encourages better care for these patients by incentivizing improved

quality and decreased cost associated with the discharge disposition decisions made by ED physicians. Areas for potential Medicare spending reductions and improved quality of care focus on reducing avoidable hospital inpatient admissions and observation stays, providing the ability for ED physicians to coordinate and manage post-discharge home services, avoiding return ED visits, and other patient safety events. In addition, there are currently no alternative payment models focused on ED physicians. PTAC identified several issues at the September 6, 2018, meeting that the submitter willingly agreed to revise and/or consider to modify, such as ACEP's distinction between observation stays provided in the ED as compared to other hospital locations in the proposed model, alternatives to transition from the current facility-specific episode target price approach, potential expandability of the model by identifying additional conditions as part of the implementation process, and further examination of care coordination and communication in the 30-day episode period used to monitor costs and quality after discharge home from an ED visit.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

Jeffrey Bailet, MD
Chair

Attachments

Physician-Focused Payment Model
Technical Advisory Committee

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions
American College of Emergency Physicians

October 20, 2018

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

This report contains PTAC's comments and recommendation on a PFPM proposal, *Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions*, submitted by the American College of Emergency Physicians (ACEP). This report also includes 1) a summary of PTAC's review of the proposal, 2) a summary of the proposed model, 3) PTAC's comments on the proposed model and its recommendation to the Secretary, and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by ACEP, and additional information on the proposal submitted by ACEP subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC recommends ACEP's *AUCM* proposal to the Secretary for implementation. The Committee finds that the proposal meets all 10 of the Secretary's criteria and that the proposal deserves priority consideration based on the scope criterion. The proposed model centers on incentivizing improved quality and decreased cost associated with the discharge disposition decisions made by emergency department (ED) physicians. Areas for potential Medicare spending reductions and improved quality care focus on reducing avoidable hospital inpatient admissions and observation stays, providing the ability for ED physicians to coordinate and manage post-discharge home services, avoiding return ED visits, and other patient safety events for defined episodes of care. Members believe that patients who visit the ED could greatly benefit from the model, which encourages better care for these patients and follow-up care post-discharge home. In addition, there are currently no alternative payment models (APMs) focused on the discharge disposition decisions of ED physicians. At the September 6, 2018, PTAC meeting, the submitter agreed to revise aspects of the model and consider modifications based on challenges identified by the PTAC, such as ACEP's distinction between observation stays provided in the ED as compared to other hospital locations in the proposed model, alternatives to transition from the current facility-specific episode target price approach, potential expandability of the model by identifying additional conditions as part of the implementation process,[1] and further examination of care coordination and communication in the 30-day episode period used to monitor costs and quality after discharge home from an ED visit.

PTAC REVIEW OF THE PROPOSAL

The initial ACEP proposal was received by PTAC on October 25, 2017. The ACEP proposal resubmission was received by PTAC on June 12, 2018. The initial proposal and resubmission were first reviewed by a PTAC Preliminary Review Team (PRT) comprised of three PTAC members (Tim Ferris, Jeffrey Bailet, and Len Nichols), two of whom are physicians. These members requested additional data and information to assist in their review. The initial proposal and resubmission were also posted for public comment. The PRT's findings were documented in the *Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)* dated August 6, 2018. At a public meeting held on September 6, 2018, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended to the Secretary for implementation.[2] The submitter and members of the public

[1]The initial performance years of the proposed model focus on four high-volume ED conditions (abdominal pain, chest pain, altered mental status, and syncope). Additional conditions would be added in subsequent performance years if fewer than 90% of patients with those conditions are being admitted to the hospital.

[2]PTAC member Elizabeth Mitchell was not in attendance. PTAC member Harold Miller recused himself from deliberation and voting on this proposal.

were given an opportunity to make statements to the Committee at the public meeting. Below are a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposed model centers on incentivizing the discharge disposition decisions made by ED physicians for defined episodes of care. The ACEP proposal uses an episode framework or bundled payment methodology with retrospective reconciliation, a target price based on historical controls, and a quality reporting or performance component for eligible participants. The model includes three options for participants to choose different tracks of quality reporting versus performance, which correspond to different options for risk-sharing, limits to gains or losses, applicable conditions for qualifying episodes, and the inclusion of Medicare fee-for-service (FFS) beneficiaries and dual eligible beneficiaries in a given performance year. The risk-bearing entity is the physician group, the faculty practice plan in academic settings, or the hospital in the case of employed physicians. The proposed model includes five performance years.

The model episode starts with a qualifying ED visit. All Medicare services that occur in the 30 days post-ED visit are included in the episode. The submitter proposes to use the same Medicare service inclusion and exclusion criterion for its model's episode definition as is used in the Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) Advanced model. The initial performance years of the proposed model focuses on four high-volume ED conditions (abdominal pain, chest pain, altered mental status, and syncope), with additional conditions to be added that do not result in greater than 90% of inpatient admissions in subsequent performance years. The episode ends at the beneficiary's death or 30 days after the qualifying ED event.

Savings in the model would be generated when the actual Medicare episode spending for selected conditions is below a facility-specific, historical cost for the episode. Areas for potential Medicare spending reductions and improved quality of care will focus on reducing avoidable hospital inpatient admissions and observation stays, financial incentives for ED physicians to coordinate and manage post-discharge services, avoiding return ED visits, and other patient safety events. The post-discharge events of interest in the 30 days following discharge home are return ED visits, non-ED observation stays, inpatient admissions, and deaths. Specific patient safety areas include repeat ED visits, inpatient or observation stay for injuries, adverse drug reaction, post-ED procedure complications, and unexpected post-ED deaths.

The submitter defines a qualifying ED case/anchor event as an ED visit that results in 1) discharge home to the community, 2) ED observation stay followed by discharge home to the community, 3) non-ED observation followed by discharge (any location), or 4) inpatient admission followed by discharge, including stays where patients admitted to non-ED observation are ultimately discharged from inpatient status. The proposal makes a distinction between observation stays that are under the care of an ED physician in the location of the ED (i.e., ED observation) as compared to observation stays that take place in hospital locations other than the ED under the care of non-ED physicians (i.e., non-ED observation). The parameters of the model define non-ED observation stays that take place in hospital locations other than the ED as equivalent to inpatient admissions in the calculation of the target price for the episode.

The model intervention is focused on the discharge disposition decisions made by ED physicians for patients who receive ED services or observation stays in the location of the ED and are discharged home to the community. A qualified ED case does not include a patient who presents at the ED from hospice or an end-stage renal disease (ESRD), had a prior hospitalization 1–90 days prior to the index ED visit, or who died in ED.

A facility-specific target price for each qualifying condition would be calculated by CMS based on three years of historical claims data for the initial ED visit plus all costs incurred for 30 days post discharge, including new services associated with proposed waivers in the model. To ensure cost savings, the model proposes that the cost target for each condition be reduced by 1.5% to 3%. The participant's performance on quality determines the target cost reduction. The model includes different options for eligibility for a reconciliation payment based on categories of performance and corresponding discount rates. Participants whose performance falls within higher quality-performance categories such as excellent (e.g., meeting the minimum threshold in all three measure categories and having a combined rate of clean cases of at least 90% or meeting or surpassing a threshold rate of clean cases that is calibrated to each facility's historical performance) have a lower discount to the episode target price or the potential to receive higher reconciliation payments. A clean case is defined as no post-discharge events of interest occurring within 30 days of discharge during a clinical episode. Lower quality performing participants such as acceptable (e.g., meeting the minimum threshold in all three measure categories) have a higher discount or the potential to receive lower reconciliation payments. If participants have an unacceptable quality score, they are not eligible for any reconciliation payment.

The target prices would be updated by CMS annually and risk adjusted using the CMS-Hierarchical Condition Category (HCC) or other methodology determined by CMS. On an annual

performance year basis, CMS would determine whether the actual spending is below the target price (savings/gain) or above the target price (loss). If a participant's spending is below the episode target price and meets the specified quality thresholds, then it would be eligible for a reconciliation payment. If a participant's spending is above the target price, then it would be required to reimburse CMS as part of downside risk (option one does not start downside risk until performance year three; options two and three start downside risk in performance year one). The model also includes stop gain and stop loss thresholds that would vary with the quality reporting or performance option chosen by a participant.

There are three options for participants to choose different tracks of quality reporting versus performance, which correspond to different options for downside risk, stop gain/loss thresholds, applicable conditions, and the inclusion of Medicare FFS beneficiaries and additional dual eligible beneficiaries in a given performance year. The three options are: 1) pay for reporting transition to pay for performance, with downside risk starting in performance year three; 2) pay for performance with stop gain/loss of 10%, with downside risk starting in performance year one; and 3) pay for performance with a progressive stop gain/stop loss capped at 20%/20%, with downside risk starting in performance year one.

The proposal includes three performance measures with specified minimum thresholds in the domains of patient engagement/experience (% of eligible cases in which shared decision-making about discharge plan occurred is reported—minimum threshold 40%), process/care coordination (% of eligible cases in which a shared discharge assessment was completed and reviewed by physician is reported—minimum threshold 40%), and outcomes (% of eligible cases where an unscheduled ED revisit, hospitalization, or death did not occur within 30 days compared to the prior reference period (event-free post discharge period)—calculated at the facility level). The model defines observation stays that take place in hospital locations other than the ED to be considered equivalent to an inpatient admission for purposes of calculating the episode target price. However, those stays (i.e., inpatient admissions and observation stays that take place in locations other than the ED) do not appear to qualify for participation in the model intervention in terms of the cases or the physicians who would be accountable for those cases since the quality metrics that determine eligibility for reconciliation payments do not apply to them. However, at the September 6, 2018, PTAC meeting, the PRT raised concerns with this distinction between observation stays, and ACEP agreed with the PRT that this distinction should be eliminated and that all observation stays should be treated the same.

The ED physician is responsible for the final assessment of the patient for safe discharge home. ACEP included examples of safe discharge assessment (SDA) tools that could be used, such as Identification of Seniors at Risk (ISAR) tool or the Triage Risk Stratification Tool (TRST)

submitted via certified electronic health record technology (CEHRT). ACEP also proposes the possible use of ACEP's clinical emergency data registry (CEDR) or other registries to provide benchmarks and enable ED group participation in the model that could be submitted via CEHRT.

At the time of ED discharge, the model requires the ED physician to communicate with a follow-up care provider (primary care physician, specialist physician, or designee). The proposal suggests an ED-based care coordinator will assist scheduling follow-up care to facilitate the handoff of the patient at ED discharge.

The model also includes proposed Medicare program policy waivers: 1) authorize ED physicians to bill for transitional care management codes, 2) allow ED physicians to provide telehealth services, and 3) allow licensed clinical staff to provide home visits under the general supervision of an ED physician to eligible Medicare beneficiaries. Payments for ED acute care transition services, telehealth services, and post-discharge home visits would be included in the overall spending calculations. In other words, if these additional payments resulted in increased costs, the participant would need to pay CMS the difference between target cost and actual cost.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC finds that the proposal meets all 10 of the Secretary's criteria. The Committee recommends ACEP's *AUCM: Enhancing Appropriate Admissions* proposal to the Secretary for implementation. However, PTAC identifies issues to be resolved as part of the implementation process. At the PTAC meeting on September 6, 2018, the submitter agreed to revise aspects of the proposal in response to concerns raised at the meeting.

Overall, the PTAC believes this proposal fills an important gap in current APMs by providing a model option for ED physicians. The ACEP model provides an important platform to incentivize the possible placement decisions for beneficiaries who visit the ED for care and can be safely discharged home. Solving the issue of appropriate hospitalizations and decreasing ED use brings ED physicians into an APM in a meaningful way. The PTAC believes this model, if implemented in the right way for EDs in the United States, would directly align with the charge of the PTAC by bringing ED physicians into an impactful APM. The PTAC also believes the ACEP model would align with HHS/CMS priorities and nest within other population-based APMs. PTAC also noted that the implementation of this model would likely have a beneficial impact on ED workflows and decision-making beyond the specific included conditions. At the September 6, 2018, public meeting, the submitter responded with a commitment to address the PTAC's main concerns. The PTAC's main concerns centered on eliminating the current distinction in the model between observation stays that take place in the ED as compared to other hospital locations, a need to explore options other than a facility-specific episode-target pricing methodology, and

clarifying the integration and care coordination of the risk-bearing entity during the 30-day episode, which is used to monitor costs and quality after discharge home from the ED.

The PTAC raised additional concerns with a few aspects of the model that would likely require further refinement. These aspects include: the potential for expanding the model beyond the initial four conditions specified by the submitter; the resources needed to ensure care coordination in the 30-day post-discharge period by the risk-bearing entity; accountability for total cost of care in the 30-day post-discharge period (which could be mitigated by risk-bearing features of the model); and features of the model that could be refined to expand participation opportunities for small and rural ED departments.

EVALUATION OF PROPOSAL USING SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Rating
1. Scope (High Priority)[1]	Meets Criterion and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets Criterion
3. Payment Methodology (High Priority)	Meets Criterion
4. Value over Volume	Meets Criterion
5. Flexibility	Meets Criterion
6. Ability to Be Evaluated	Meets Criterion
7. Integration and Care Coordination	Meets Criterion
8. Patient Choice	Meets Criterion
9. Patient Safety	Meets Criterion
10. Health Information Technology	Meets Criterion

Criterion 1. Scope (High-Priority Criterion)

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets Criterion and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. The proposed model aims to provide a Medicare payment model whereby ED physicians currently not able to participate in APMs could do so through an episode framework

[1]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

in alignment with other APMs. PTAC believes the proposal reflects a strong commitment to improving health care and should be considered in line with models for better home-based care, better primary care, and ways to get beyond incremental to value.

Current variation in treatment of these types of patients supports the finding that this type of payment model is a potential candidate to advance the progression of best practices of care for patients who visit the ED and are discharged home. Many current APMs include the goal of reducing hospitalizations and ED services without bringing ED physicians into the conversation in a meaningful way through a specific APM targeted at an ED physician's discharge disposition decisions. PTAC members believe that ACEP's model has the capacity to provide a platform to look at best possible placement decisions for patients who visit the ED. The PTAC finds this model intervention fills a crucial gap in providing a means to incentivize improved quality and decreased costs associated with the discharge disposition decisions made by ED physicians for defined episodes of care. An additional strength of this model is it could be adopted by commercial payers and states, and even accountable care organizations (ACOs) could use a similar approach internal to their organization.

Criterion 2. Quality and Cost (High-Priority Criterion)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The episodic approach to care delivery shifts the focus from a volume of individual services to a more patient-centered approach focused on decision-making in the ED. The proposal is anticipated to improve quality by supporting appropriate discharge from the ED while ensuring beneficiaries are safe from harm by relying on both the professionalism of the care team and through monitoring of post-discharge events including hospital admission, death, and return to the ED within 30 days of discharge.

Areas for potential Medicare spending reductions and improved quality of care focus on reducing avoidable hospital inpatient admissions and observation stays, providing the ability for ED physicians to coordinate and manage post-discharge home services, avoiding return ED visits, and other patient safety events. The model includes three options for participants to choose different tracks of increasing risk/reward that moves through stages of quality reporting to performance-based that correspond to different options for risk-sharing, stop gain/loss thresholds, and other parameters.

The most important quality concern related to changing payment for ED services is the possibility that patients who should be admitted will not be. The proposed model addresses this concern in three ways. First, the payment model's inclusion criteria focus on diagnoses where evidence suggests there is considerable opportunity to reduce hospitalizations. Second, it uses historical controls, diminishing the incentive to change care patterns dramatically. Third, it proposes to measure post-discharge mortality and include performance on this metric in the assessment of the program. Fourth, it is important to consider the safety concerns raised from inappropriate admissions and the reduction in these safety concerns when an unnecessary admission is avoided. PTAC believes these mitigation strategies included in the proposal substantially reduce the risk of adverse effects of this proposed payment policy change.

PTAC believes other APMs have generated substantial savings from reduced hospitalizations and reduced ED utilization without bringing ED physicians into the conversation in a meaningful way through an APM. Bringing the ED physicians into an APM will further contribute to the value of improving health care quality and decrease cost for patients.

Criterion 3. Payment Methodology (High-Priority Criterion)

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. Similar to other episodic APMs, the ACEP model uses an episode framework with retrospective reconciliation, a target price, and a quality performance component for eligible participants. The ACEP model includes three options for participants to choose different tracks of quality reporting versus performance, which correspond to different options for downside risk, stop gain/loss thresholds, eligible conditions, and other parameters. The proposal meets the provider where they are in their readiness for risk tolerance and quality performance.

The PTAC raised concerns on the proposal's distinction between the definitions of observation stays that take place in the ED as compared to other hospital locations for purposes of the model. However, at the September 6, 2018, public meeting, the submitter proactively agreed that the distinction should be removed. The PTAC was also concerned with the submitter's reliance on a facility-specific episode-target pricing methodology. The submitter referenced an ED Benchmarking Alliance that ACEP participates in that is currently working on a methodology for determining peers for various methods that could inform a movement toward a regional or other blended approach. The PTAC acknowledged that starting with site-specific historical

controls has the advantage of mitigating the concern that excessive financial incentives could adversely impact appropriate decisions to admit a patient to the hospital. The PTAC encouraged the consideration of migrating over time to other benchmarking options as part of potential implementation.

The PTAC discussed the issue of holding the ED physician or risk-bearing entity accountable for total cost of care in a 30-day post-discharge period after discharge home from the ED. Related to this concern is the need to ensure resources for integration and care coordination by the risk-bearing entity during the 30-day post-discharge period that is used to monitor costs. PTAC members discussed design features of the model that could mitigate the amount of risk being taken. First, downside risk is limited in the model. A second design feature that could mitigate total cost of care is historical control. A third mitigating design feature is the structure of the ramp toward greater risk and multiple levels of risk.

The PTAC raised additional concerns with a few aspects of the model that would likely require further refinement, including the expandability potential of the model by identifying additional conditions beyond the initial four specified by the submitter and exploring features of the model that could be refined to expand participation opportunities for small and rural ED departments.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The focus of this model is to incorporate an episode of care triggered by an ED event. The current Medicare FFS structure focuses on individual service delivery. The PTAC Members find that the model would improve value over volume because it provides incentives to inform the ED physician's decision-making on the included populations. The design of the model focuses on diagnoses with high variability in admissions and returns to the ED. The shift toward incentivizing decisions in the ED focuses on opportunities to obtain value in the purchase and delivery of health care to patients.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The model is designed to include nearly all practice types found in the ED. The model does not specify how the target price will be achieved by participants and therefore provides adequate flexibility to providers to deliver

care they consider appropriate and innovative. The model provides a platform that could be extended to more diagnoses in the ED, which by definition provides flexibility. The model provides flexibility in options for quality performance strategies as well as paths toward two-sided risk based on the readiness of participants.

Criterion 6. Ability to Be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. PTAC believes that the model has evaluable goals for reducing avoidable ED visits and hospitalizations and lowering costs. The evaluation could be performed by comparing changes in spending and quality metrics under the model for participating versus nonparticipating practices. Patient, provider, and geographic characteristics of participants versus nonparticipants could be constructed using CMS administrative data sets.

Criterion 7. Integration and Care Coordination

Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The model incentivizes greater communication and coordination between the ED and all ambulatory physicians who are planning to follow-up with the patient. The submitter's willingness to remove the distinction between observation stays that occur in the ED versus other locations in the hospital mitigated potential internal hospital barriers to coordination. The PTAC believes the hand off after ED discharge becomes really important. The ED physician, at the time of care in the ED, has a unique opportunity to positively impact a patient's care, but the handoff needs to occur so that patients are not returning to the ED.

The PTAC believes the feedback loop of patient information that would be necessary during the 30 day post-discharge period and devoting resources to the integration and care coordination during the 30-day episode, which are used to monitor costs and quality after discharge home from the ED, are critical features of the model. Achieving the goal of getting people to the most appropriate care settings after they've been assessed and the care plan has been outlined for them is vitally important.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The payment incentives included in the model are unlikely to negatively impact patient choice. The checks and balances included in the proposed model were sufficient to prevent the pursuit of a course that was not in the best interest of the patient. Importantly, patients who would otherwise be admitted without benefit would have the opportunity to go home.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The model incentives will hold ED physicians accountable for post-discharge complications in the scoring of quality and costs in the post-discharge 30-day episode. The magnitude of the required discount appears appropriate so should not unduly incent injudicious decision-making. Combined with the quality metrics, the model builds in sufficient checks for patient safety. For a more detailed discussion of safety concerns, please see the discussion under Criterion 2.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets Criterion

PTAC concludes that the proposed model meets this criterion. The model does not place any restriction on the use of health information technology and may incentivize the use of technologies such as registries to provide information on model discharges and web-based applications to communicate with patients and other providers. The use of shared discharged assessments and shared decision-making measures could be facilitated through the use of CEHRT. The model also includes the possible use of ACEP's clinical emergency data registry (CEDR) or other registries to provide benchmarks and enable ED group participation in the model using CEHRT.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, *Chair*

Term Expires October 2018

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Elizabeth Mitchell
Blue Shield of California
San Francisco, CA

Robert Berenson, MD
Urban Institute
Washington, DC

Kavita Patel, MD, MSHS
Brookings Institution
Washington, DC

Term Expires October 2019

Paul N. Casale, MD, MPH
NewYork Quality Care
NewYork-Presbyterian, Columbia University College of Physicians and Surgeons, Weill Cornell Medicine
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians Organization
Boston, MA

Term Expires October 2020

Rhonda M. Medows, MD
Providence St. Joseph Health
Seattle, WA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY
1. **Scope.** Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
2. **Quality and Cost.** Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
3. **Payment Methodology.** Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.
4. **Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
5. **Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
6. **Ability to Be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
7. **Integration and Care Coordination.** Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.
8. **Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
9. **Patient Safety.** Aim to maintain or improve standards of patient safety.
10. **Health Information Technology.** Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA AND OVERALL RECOMMENDATION[1]

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority)[2]	-	-	-	3	1	3	2	Meets Criterion and Deserves Priority Consideration
2. Quality and Cost (High Priority)	-	-	1	5	2	1	-	Meets Criterion
3. Payment Methodology (High Priority)	-	-	3	4	1	1	-	Meets Criterion
4. Value over Volume	-	-	-	2	5	2	-	Meets Criterion
5. Flexibility	-	-	-	3	4	1	1	Meets Criterion
6. Ability to Be Evaluated	-	-	-	2	6	1	-	Meets Criterion
7. Integration and Care Coordination	-	-	2	5	1	1	-	Meets Criterion
8. Patient Choice	-	-	-	4	4	1	-	Meets Criterion
9. Patient Safety	-	-	1	3	4	1	-	Meets Criterion
10. Health Information Technology	-	-	-	6	3	-	-	Meets Criterion

Not Applicable	Do Not Recommend	Recommend for Limited-scale Testing	Recommend for Implementation	Recommend for Implementation as a High Priority	Recommendation
-	-	2	5	2	Recommend for Implementation

[1]PTAC member Elizabeth Mitchell was not in attendance. PTAC member Harold Miller recused himself from deliberation and voting on this proposal.
[2]Criteria designated as "high priority" are those PTAC believes are of greatest importance in the overall review of the payment model proposal.