American Academy of Sleep Medicine

Innovation Care Delivery and Management Program for Patients with OSA

Introduction

Obstructive sleep apnea (OSA) is a disorder with significant prevalence in the Medicare community. OSA is linked to several co-morbidities, including myocardial infarction, stroke, hypertension and type-2 diabetes, which add significant burden to the health care system.

The diagnostic algorithm and treatment model for OSA is fragmented and flawed in its present state. Currently, physicians untrained in sleep medicine infer a diagnosis of OSA based on a computer-generated simplistic report provided by a commercial home sleep testing company. Further, treatment is not provided or managed by a physician but rather a DME company that emphasizes equipment sales. This model is the present standard because Stark law prevents the board certified sleep medicine physician that diagnoses OSA from providing treatment to patients.

These realities prompted the development of the Innovation Care Delivery and Management Program for Patients with OSA (ICDMPPO). This program creates a new model of patient management with an emphasis on the following goals: Improved care coordination; increased adherence to PAP therapy; reduced co-morbidities; strengthened patient satisfaction; and realized, significant cost savings for CMS.

There are two fundamental concepts that formulate the ICDMPPO: More patients will undergo Out of Center Sleep Testing (OCST) and treatment adherence will increase by 20 percent. A minimum of 50 and a maximum of 75 sleep centers will be recruited for the program. Each participating site will be required to annually enroll a total of 100 Medicare beneficiaries for a total participant base of 22,500. The program will change the current standard of all patients tested in-center to a testing algorithm of 20 percent in-center, 20 percent split-night in-center, 40 percent OCST and 20 percent OCST and in-center retest. Improved adherence will be realized on account of all care coordinated by the board certified sleep medicine physician, and greater patient education and support provided by the sleep center facilitator.

To achieve the program's objectives, there is a need for a waiver of Stark Law, allowing the board certified sleep medicine physician to diagnose and treat patient with OSA by providing PAP therapy and monitor the patient's progress during the demonstration project and long-term.

The proposed budget of the ICDMPPO is $8,733,481.52. Funds will be used to support the creation and implementation of the new care model and will be spent on activities including but not limited to accreditation, education, training and a database that tracks outcome measures. According to the CPT Claims Database, more than 360,000 in-center tests (CPT Code 95810) were performed in 2010. With the proposed change to 40 percent of patients undergoing OCST (CPT Code 95806), an estimated $177.00 will be saved per beneficiary. It is estimated this program will realize hard savings of $12.8M over the three-year program by changing the traditional diagnostic and treatment algorithm. In addition, soft savings of more than $88.8M over 10 years will be realized by decreasing overall cost of chronic health conditions. Factoring in the proposed budget and estimated net savings of approximately $92M, the ICDMPPO has a significant return on investment for CMS.

The changes outlined in the ICDMPPO will result in better care and improved health, significant cost savings, and a transformed model of care.

Section One: Design

Program Goals and Targeting: The goal of the American Academy of Sleep Medicine's (AASM) Innovation Care Delivery and Management Program for Patients with OSA (ICDMPPO) is to provide increased access to high-quality, coordinated and cost-effective diagnostic and treatment services for obstructive sleep apnea (OSA). In addition, through the ICDMPPO, CPAP treatment compliance will be improved by 20 percent over current levels by the board certified sleep medicine physician (BCSMP) managing and educating patients with OSA and related co-morbidities, and tracking outcomes data.

The current practice model of care for OSA is fragmented in its present state. Oftentimes, physicians untrained in sleep medicine infer a diagnosis of OSA based on a computer-generated, simplistic report provided by a commercial home sleep testing company and subsequently write a prescription for auto-titrating positive airway pressure (APAP). The treatment of the patient is then passed to a DME company without the involvement of a qualified physician. This fragmentation in care occurs because current Medicare policy and Stark law prevent the diagnosing physician from providing both the diagnostic procedure and the treatment. The subsequent follow-up visit with a physician within a 90 day period is often difficult to coordinate and often the required information from the DME company is not available or complete. It is our contention this model must change for sleep medicine care to improve for patients.

Another potential scenario under the current model, a BCSMP diagnoses a patient with OSA based on an in-center polysomnography (PSG) and CPAP titration then writes a prescription for a PAP device which includes the appropriate mask based on the titration and fitting conducted at the sleep center. Oftentimes, that prescription is not filled properly by the DME company. It is our contention that DME companies may provide inadequate educational training to patients and conduct minimal patient follow-up, which results in adherence challenges, redundancy of services and poor information flow among health care providers. If the fragmentation in the current practice model for sleep medicine is to be addressed properly, the BCSMP must have the ability to not only diagnose the patient but also provide the treatment therapy and monitor the progress of the patient long-term.

As a change from this traditional model, the ICDMPPO requires coordinated patient care led by the BCSMP and sleep center facilitators. It is estimated that the ICDMPPO will realize hard savings of more than $12.8M over the three-year program duration by changing the traditional diagnostic testing algorithm for OSA and administration of therapeutic equipment. In addition, potential soft savings of more than $88.8M may be realized by decreasing the frequency of acute health events such as stroke and myocardial infarction and decreasing overall cost of chronic conditions such as hypertension and type 2 diabetes. With project expenses totaling approximately $8.7M and the estimated net savings of the program approximately $92M, the ICDMPPO has a significant return on investment for CMS.

The specific goals of the ICDMPPO with OSA are:

- To identify the appropriate type of diagnostic testing for each patient presenting with symptoms of OSA using a standard patient assessment tool and to test patients with out of center sleep testing (OCST) when appropriate
- To provide integrated care including testing and treatment to patients diagnosed with OSA by imposing a model of care that includes an individualized care plan created through partnership with the patient, the primary care physician (PCP) and other specialists (e.g., dentists, surgeons, cardiologists), as required
- To manage and monitor the care provided to the patient with OSA while measuring the clinical outcomes of the various treatment avenues such as PAP therapy, oral appliance therapy (OAT) or upper airway surgery, and intervening, as necessary, to ensure optimal care at lower cost
- To demonstrate how this integrated model of care enhances patient satisfaction, provides cost-effective

care with desired clinical outcomes and can be continued over the time the patient is enrolled in the ICDMPPO and is sustainable thereafter

The services to be delivered in this program by the BCSMP and his/her staff include:

- Performing evaluation and management services
- Performing and supervising diagnostic testing procedures
- Prescribing and dispensing DME, such as CPAP or APAP and related equipment, from the sleep center
- Managing the individualized care of each patient with the diagnosis of OSA to achieve desired patient healthcare outcomes and collecting data via a registry
- Referring patients to other specialists as necessary and informing the PCP of changes to the care plan

All of the above services incorporate evidence-based sleep medicine practices derived from the AASM practice parameters and guidelines papers (See supplement for references).

The targeted populations for the ICDMPPO include Medicare and Medicaid patients. Participant sites will be selected from the following categories: rural, urban, suburban, hospital-based and university-affiliated centers. The definitive criteria for selection into the program are described in detail in the supplement.

Number of Participant Sites: A minimum of 50 sites and a maximum of 75 sites, based on facility-type and geographic location. Each participating center will enroll 100 Medicare patients each year for three years for a total of 300 patients participating in the program. A maximum of 22,500 patients will be enrolled in the entire program.

Proposed Partners: The AASM is the program awardee-convener. There is no other formal partnership with the AASM except CMS. However, each of the participating sites is considered by the AASM to be informal partners in this proposal and must commit, via a contract, to all the inclusion criteria in this proposal.

Geographic Location: Selection of centers to be part of the program is based on the definitive criteria listed in the supplement and there being room in the program. As much as is possible, participant sites will be selected from all geographic sections of the country that meet the above requirements. Of the 75 proposed sites, 75 percent will be hospital-based and 25 percent will be non-hospital based. Of the 75 percent of hospital-based participants and 25 percent of non-hospital-based participants, selected sites will be targeted to ideally achieve the following breakdown: 70 percent urban, 20 percent suburban and 10 percent rural. Since participant sites will vary geographically and include hospital and non-hospital sleep centers, this model is replicable nationwide.

Rationale for Goals, Population and Geographic Location of the Program: The goals identified reflect the commitment of BCSMP to provide patient care based on evidence-based medicine beginning with their initial patient assessment and diagnosis of OSA and initiation of an individualized plan of care for each patient. The services provided to the defined population will be tracked, monitored and managed within the sleep medicine program as well as with the patient's PCP/other specialists involved in the patient's care. This project is a strategic match with the AASM's overall mission of setting standards for clinical practice, advocating for the delivery of optimal care to patients with sleep disorders, fostering the investigation and application of scientific knowledge and ensuring access to quality care for patients. The project also addresses concerns about non-specialist physicians testing and diagnosing OSA through the use of OCST/portable monitoring. Further, it also addresses concerns regarding the efficacy, effectiveness and safety of non-specialist physicians providing CPAP treatment. In addition, the ICDMPPO assures that the BCSMP directs the diagnostic evaluation and testing, the patient is compliant with the prescribed treatment, and the BCSMP coordinates the treatment and management of the patient with OSA among all caregivers. The BCSMP also reviews outcomes data to evaluate whether the patient is compliant with the type of treatment ordered and that the type of treatment is effective for the individual patient.

Comprehensive Description of the Model and Supporting Evidence Base: The BCSMP conducts an

initial encounter with each participant, which includes a comprehensive history and evaluation to determine the correct testing pathway. Testing will typically be performed using one of two pathways: OCST and the use of APAP to determine settings for CPAP therapy and in-center PSG with in-center CPAP titration. Some patients may require retesting but it is hoped that since the BCSMP is guiding the algorithm, that the number of retests is minimized.

Determination of Type of Testing: The BCSMP will use the information from the initial history and physical examination to determine the type of test for the patient. A standardized assessment tool will be developed that will help guide the BCSMP to determine the patient's pre-test probability of OSA, presence of co-morbidities, and potential co-existing sleep disorders which the BCSMP will use to determine the appropriate test pathway for the patient.

In-Center Testing: Based on the BCSMP's clinical judgment and the combination of symptoms and findings from the referral or an exam, the BCSMP may order an in-center PSG. Evidence-based sleep medicine guidelines indicate that patients with significant co-morbidities or the presence of other sleep disorders should be tested in-center.

Out of Center Sleep Testing: Appropriateness of OCST is determined by the BCSMP using the intake history and physical exam and the completion of the standardized assessment tool to determine pretest probability. According to AASM clinical guidelines, OCST may be used as an alternative to PSG for the diagnosis of OSA in patients with a high pretest probability of moderate to severe OSA. OCST is not appropriate for the diagnosis of OSA in patients with significant co-morbid medical conditions, patients with co-morbid sleep disorders and asymptomatic populations. Additionally, OCST may be indicated for the diagnosis of OSA patients for whom PSG is not possible by virtue of immobility, safety or critical illness.

Determination of Individualized Treatment: Every patient in the program evaluated by a BCSMP will have his/her testing and subsequent plan of care developed by a BCSMP. The plan of care is developed according to the findings of the diagnostic testing, appropriate evidence-based medicine guidelines and the initial evaluation performed by the BCSMP. The majority of patients are treated using CPAP therapy; however, patients may also be referred for oral appliance therapy (OAT) or upper airway surgery. Patients referred for OAT or upper airway surgery will be tracked in the database but not included in reports.

Individualized Care Plan: All care is patient-centered and takes into consideration the patient's ability to comply with the treatment jointly chosen by the physician and patient as well as the patient's unique needs, preferences and priorities. The evidence-based guidelines are explained to the patient in terms the patient can understand. The patient signs the care plan and is given a copy of the plan each time it is revised. Written standards are in place for beneficiary access and communication, and a process is in place for beneficiaries to access their medical records.

Revision of the Care Plan: Depending on the success of the initial chosen treatment in eliminating the patient's symptoms of OSA, different treatment options may be considered for an individual patient during the course of his/her disease.

Data Collection: The purpose of data collection is to determine if the patient care is producing the desired results – reduction of symptoms of OSA and reduction in symptoms of co-morbidities with better total outcomes at a reduced cost. For purposes of the ICDMPPO, data collection begins at the initial encounter with the BCSMP. Data collected include targeted, measurable clinical information from the BCSMP assessment, PQRS measures and clinical information from subsequent visits for each patient in the program. Education provided by the BCSMP and sleep center facilitator is tracked to see an overall portrait of each patient's care and response to every care segment/interaction. Each patient-initiated intervention as well as each staff intervention is tracked. Evidence can be collected as to the patient's involvement in his/her care as well as to the patient's lack of involvement. Data from all patients with similar testing and treatment can be aggregated to

compare effectiveness for one patient in one category against all patients in that category.

How This Program Changes the Current Model of Care: Currently, care for patients with sleep disorders is fragmented among referring physicians, sleep medicine physicians and DME suppliers. Under the program, management, including evaluation, testing and treatment for patients with OSA, is coordinated by the BCSMP. As a result, care is patient-centered and cost-effective because of determined medical necessity. Based on the clinical judgment of the BCSMP, testing may include in-center PSG or OCST and treatment can include PAP therapy, OAT or upper airway surgery. In the ICDMPPO, the DME supplier is no longer the middle man; all education, including continuing patient education and CPAP-related troubleshooting, is provided by the BCSMP and his/her staff. In addition, in the innovation patient care model, the BCSMP will manage the patient beyond the initial 90 days of CPAP therapy, with regular follow-up conducted at a minimum of every six months for the duration of the program.

It is estimated that this model will save more than $1.8M in equipment costs over the three-year period of the program. This care coordination ensures no information is lost in a handoff of care, since each intervention is tracked by the BCSMP and his/her staff. The BCSMP and his/her staff provide the necessary management to optimize usage which may include desensitization therapy. Adherence to CPAP is promoted by the involvement of one set of care providers compared to disjointed efforts by multiple caregivers at different sites.

Thus, the AASM proposes a change in current reimbursement methodology for the duration of the cooperative agreement period. The 90-day period beginning with the diagnosis of OSA and the ordering of CPAP treatment by the BCSMP is considered the initial episode of care for the treatment of OSA with CPAP. Bundling the physician/facilitator services into one payment during this period lowers cost since all medically-necessary physician services provided are charged once using the episode of care code.

Following the diagnosis of OSA by the BCSMP and staff, services would be bundled under one payment for the initial 90-day period, billed at the 90-day visit with a G code created specifically for this program. These services include evaluation and management services, mask fittings, machine selection, and pressure settings as frequently as needed. Medically necessary equipment and supplies are billed separately during and after this 90-day global period, using existing HCPCS codes.

After this initial 90-day CPAP trial (discrete episode of care), BCSMP services provided to each patient can vary and are billed separately from the initial 90-day trial, using the CPT code that describes the physician's services documented in the patient's chart.

The retention rate for patients in this coordinated program led by the BCSMP will be higher because of the frequent interventions by the same physician and his/her staff during the critical initial 90-days of therapy, without any handoffs to DME personnel.

Risk factors are monitored and quality measures are reported, which correlate with the improvement in the patient's care.

Transformation of the Existing Workforce: The ICDMPPO will provide opportunities for education and training for the BCSMP, the sleep center facilitator (a role described below and in greater detail in section three) and sleep technologists. The AASM will offer the BCSMP training to aid in the successful implementation of the program requirements within the model. The program also creates the role of a sleep center facilitator. The AASM envisions this to be a voluntary position beginning in FY2 for the ICDMPPO and for the field once the integrated care model is adopted widely. The minimum requirements for the sleep center facilitator are an associate's degree in an allied health science field and experience as a sleep technologist, respiratory therapist or electroneurodiagnostic therapist. Responsibilities of the sleep center facilitator include providing patient education, assisting with treatment adherence, supporting the physician with patient monitoring and interface adjustment, importing data into the to the database

including the CPAP/APAP adherence information, scheduling sleep studies, refitting masks for PAP devices and aiding with interface adjustment. Learning tools used to provide additional training to the sleep center facilitator will be available and are described in section three of this proposal.

Anticipated Challenges to Successful Implementation of the Program:

- Start-up costs to integrate the dispensing of DME equipment into the BCSMP's practice are expected. The AASM plans to offset these costs by providing participant sites with start-up funds of $25,000 per center using funds from the Innovation Grant.
- Existing staff at participating sites will need to be trained to follow the ICDMPPO processes and additional staff, such as the sleep center facilitator, may need to be hired by the participating sites. The AASM will assist sites in educating the sleep center facilitator and sleep technologists via in-person courses and online learning.
- Participating sites may have difficulty modifying current sleep center processes to meet requirements of the program. The AASM has developed standardized forms and tools that can be used by participating sites to make their transition as seamless as possible.
- Participant sites may have difficulty collecting data per the program requirements. The AASM has developed an online database and will provide reliable tech support. In addition, participating sites can network with one another to discuss problem solving techniques for data collection issues.

Participant Recruitment and Enrollment: All Medicare patients will be eligible for participation in the ICDMPPO and recruitment for the patient population is not considered to be an issue. In regard to enrollment, participating sites are required to enroll 80 percent of patients throughout the protocol. Once a Medicare beneficiary is enrolled in the ICDMPPO, each intervention will be recorded. Each referring physician will receive an update on his/her patient each time they come in for follow-up. The retraining of the sleep center facilitator concerning care coordination and the education of patient participants about the therapy compliance goals of the program will also assist in retention of patients in the program. Patient support groups will be expected to be developed and utilized; the BCSMP and his/her staff will be present during the meetings to answer questions, present feedback on the success of the program to the patients and to provide group education on a predetermined topic. Handouts that provide information on each possible treatment pathway will be provided to all audiences. Periodic outreach programs will be expected to be given by each site included in the program to target prospective participants and update the community on the integrated program's attainment of goals.

Education and Outreach: The BCSMP will create physician networks with PCPs and other specialists (e.g., dentists, surgeons, cardiologists) by direct outreach and educational forums that provide details on the integrated program as well as discuss the specific roles of each provider in the patient's care. Similarly, the BCSMP will develop patient networks by creating mechanisms that educate patients on the coordination of care in the integrated program and discuss measurement of patient outcomes by all stakeholders – the patient, the sleep medicine physician, the referral physician network and the community at large.

Community Integration: The intent of an integrated care model is to increase the awareness of the prevalence of OSA and the need for proper diagnosis and treatment. The need for the involvement of the broader community, including all stakeholders, in the initial implementation of the program as well as throughout the program will be stressed. Information will be provided to educate the attendees on how this program will coordinate care for patients with OSA as well as work in collaboration with the other current community health care initiatives. For example, AASM's marketing staff will provide tool kits that include prepared materials for distribution at the initial open houses/meetings, at the periodic sleep medicine educational programs and through existing community health care programs/initiatives.

Section Two: Organizational Capacity

Established Leadership: With an established and experienced staff and many supporting resources, the AASM is well-positioned to manage the long-term success of the new integrated care delivery model beyond the three-year cooperative agreement period and to have an impact on CMS's goals of improved care for patients with OSA and significant cost savings. In the last decade, the AASM has led important initiatives, including the accreditation of fellowship training programs by the Accreditation Council for Graduate Medical Education and administration of the certification examination in sleep medicine by the American Board of Medical Specialties, which solidified the formal recognition of the sleep medicine field within the medical community. The AASM has also developed and introduced valuable services and resources for the sleep medicine field, including three accreditation models for the assurance of quality patient care, two respected peer-reviewed medical journals for cutting-edge clinical research, a standardized educational program for sleep technologists, training programs for specialized areas within sleep, and scoring proficiency products to test competence, among many other products and programs. Principles central to the AASM's success are innovation at all levels of leadership and staffing, organizational flexibility, and the execution of clear strategic goals. These principles are also central to the Health Care Innovation Challenge, and the AASM has the vision and capacity to successfully implement the ICDMPPO.

Organization and Administration: In addition to its demonstrated track record of programmatic success, the AASM has a wide-range of resources at its national office that will not only strengthen its relationship with the Medicare and Medicaid Center for Innovation and participating sites, but will also confirm the effectiveness of an integrated delivery model for the treatment of OSA. Founded in 1975, the AASM is a professional membership organization dedicated to the advancement of sleep medicine and related research. The AASM is governed by a twelve-member Board of Directors. Specialties represented on the BOD include Research Science, Internal Medicine, Neurology, Pediatrics, Pulmonology and Psychiatry. Additionally, an Executive Committee comprised of President, President-Elect, Immediate Past-President and Secretary/Treasurer and one at-large member meets monthly. Located in Darien, Illinois, the national office is a 30,000-square-foot facility owned by the AASM that supports the AASM's 55 full-time employees and 30 part-time employees. The AASM also manages nine other sleep-related organizations.

Membership: Physicians (MD and DO), PhD researchers, other doctoral degree and health care professionals as well as students comprise the AASM's membership. Current individual membership is at 10,000 members. Illustrating the value that the AASM provides to the sleep medicine field, 90 percent of members renew their membership annually. AASM members are actively engaged in their field, with volunteers participating on one of seven standing committees, including Academic Affairs, Accreditation, Education, Research, Sleep Technologist Issues, Standards of Practice, and Coding and Compliance, as well as various task forces and councils. AASM-Accredited sleep centers are also eligible to join as Center members of the AASM; currently more than 1,500 AASM-accredited centers are members of the AASM. The annual renewal rate for center members is greater than 90 percent. The organization provides unparalleled support to all of its members and center members to help advance the sleep medicine field, including the following core functions:

Accreditation: Since 1977 the AASM has provided sleep center accreditation. Today the AASM is the largest sleep center accrediting body with more than 2,300 accredited centers, providing voluntary accreditation for sleep centers, non-Medicare DME suppliers, and OCST entities. By achieving AASM accreditation, sleep centers demonstrate a commitment to the provision of quality diagnostic services and the longitudinal management of their patients with sleep disorders. The AASM's dedication to the continued quality of these requirements has made AASM center

accreditation the gold standard by which the medical community and the public evaluate sleep medicine facilities. The AASM Accreditation Committee writes and maintains the *Standards for Accreditation*, which receive final approval from the AASM Board of Directors. The *Standards for Accreditation* are updated regularly to remain consistent with changes in technology and clinical practice.

Science and Research: The Science and Research Department supports the activities of the Standards of Practice Committee (SPC), which is the medical practice evaluation committee of the AASM. The SPC evaluates medical procedures and practices, testing models and other technologies; makes recommendations on appropriate clinical application; and develops evidence-based standards for the practice of sleep medicine.

Educational Courses and Products: The AASM provides its members and staff at member centers with quality, ACCME-accredited educational programs and products that teach the fundamentals of sleep medicine, provide updates on new practice trends and introduce the application of emerging technology. Education is offered in multiple formats: in-person courses and workshops, on-demand videos and web-based examinations. The AASM's online store sells several resources, such as diagnostic and scoring manuals, for sleep physicians as well as patient education materials. The SLEEP annual meeting, a joint conference of the AASM and Sleep Research Society (SRS), celebrated its 25th Anniversary in June 2011.

Coding and Compliance: The Coding and Compliance department educates members on aspects of CPT and ICD-9-CM coding as well as all relevant Medicare National and Local Medical Policies through seminars and the informational AASM Coding Corner on the website.

Government Relations: AASM government relations staff are active at the state and national level by monitoring and influencing legislation and regulations.

In addition to these departments core to the ICDMPPO, nine other departments will provide support in areas such as information technology, communications, publications, graphic design and human resources.

Operational Plan: The AASM will recruit new staff to administer the program. Current AASM staff from the following departments developed the proposal and will lead training and management of the integrated program: Information Technology; Accreditation and Coding and Compliance. Core training for the new staff will begin immediately upon hire and will continue as needed throughout the six month start up and entire three-year program.

The AASM will request letters of intent for sleep centers as soon as the award is confirmed. This will be done by advertising on the AASM website and by direct mail. The new AASM staff members will attend the intense orientation program in April 2012 provided to the sites chosen to be in the program. The orientation curriculum includes: 1) an overview of the entire program; 2) an in-depth discussion of the program milestones and who is responsible for achieving them; 3) a site plan of the necessary steps to prepare for and achieve DME accreditation; 4) an in-depth presentation on how to create and update a mandatory compliance plan; 5) in-depth training on data collection; 7) instructions concerning the development of patient and physician outreach initiatives.

The database used to track all information will be developed by the AASM Information Technology staff, ensuring a smooth start up and collection of the appropriate outcomes data. The new staff will test the data collection system and work with individual sites to ensure the system captures the data from each program site. Testing of the actual database is expected to begin in March and will continue through the initial six month startup of the program.

The AASM staff will also provide education to the program site staff, via conference calls and webinars during April 2012, stressing their role as the local coordinator of the integrated program. Additional education will be provided to the site staff in April 2012 as to how the patient education component will

be delivered and tracked to patients in the integrated program. Sleep technologist training will be provided by a formal training curriculum offered with the AASM's A-STEP program.

Concurrent with the training of the program site staff mentioned above, AASM accreditation staff will begin the DME accreditation process for each of the sites chosen for the Integrated Program. Before May 31, 2012, all the modules related to the above initiatives will be in place and ready for immediate rollout Major milestones to track, include:

- Database completed and rigorously tested prior to March 30, 2012
- CMS awards the contract to AASM on March 30, 2012
- Letters of intent are requested from potential participating sleep centers
- AASM hires and trains the additional staff to supplement the current AASM integrated program staff
- Follow–up training is provided for site staff at annual meeting in June

Organization Structure and Staffing: If the project is approved, the AASM will immediately begin identifying and recruiting the direct and indirect staff to manage the cooperative agreement. In addition to senior leadership oversight, the AASM will recruit for the following additional positions. An organizational chart is provided at the end of this section for reference.

Director of Integrated Care: Responsible for oversight of entire program.

- Direct technical training for Program participants as needed.
- Monitor and manage CMS reporting requirements within established deadlines.
- Oversee data preparation for quarterly evaluation reports.
- Analyze data, develop findings and present to senior leadership for review and discussion before submitting final report to CMS.
- Monitor participant feedback.
- Directly supervise employees, providing ongoing guidance and strategic vision for the Program.
- Manage department and program budget, tracking cooperative agreement funding on an ongoing basis.

Integrated Care Coordinator: Assists with development and support of AASM Innovation Care Delivery Model:

- Communicate regularly with participants to address issues and concerns related to patient outcomes data collection
- Provide guidance with usage of online data collection tool
- Conduct periodic quality assurance checks. Verify consistent participant involvement
- Gather participant feedback and recommend adjustments as necessary
- Compile all required data in preparation for quarterly CMS evaluation report

Director of IT: Responsible for overseeing the development of the collection database (as described in section four) and providing technical support to center members in the cooperative agreement project.

Programmer: Initially dedicated to the design and development of the database (as described in section four). The programmer will provide initial training for sleep centers involved in project and provide ongoing support over the three-year program.

Graphic Designer: Responsible for developing graphic elements for the website that supports the ICD-MPPO database, providing web design for all online education and training modules created for the ICD-MPPO and designing all collateral education, training, informational and promotional collateral material for the program.

Marketing Manager: Responsible for providing assistance with communications for sleep centers in the program and assisting with messaging for centers to reach out to stakeholders, e.g., referral sources.

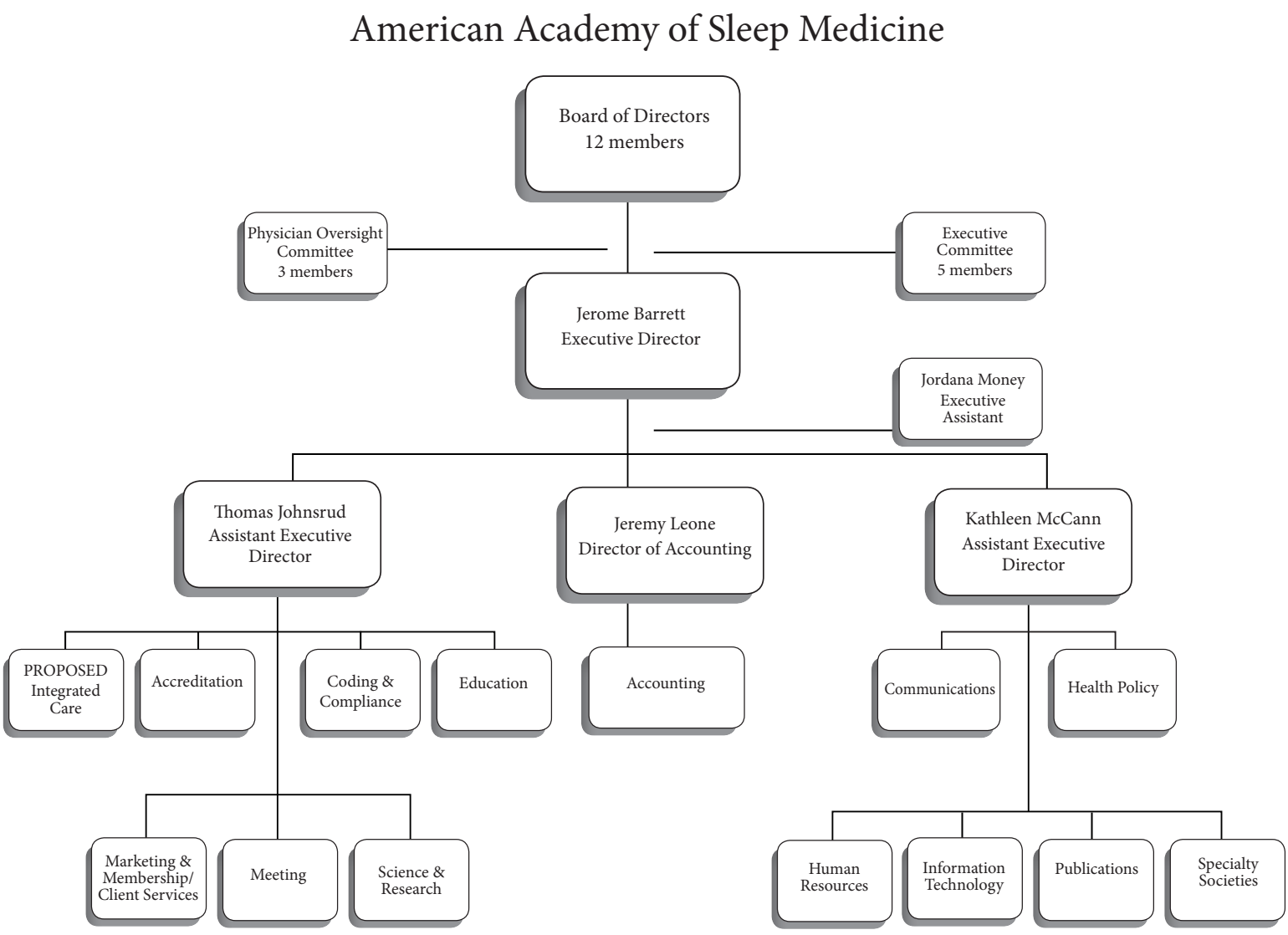
Director of Professional Education and Training: Responsible for developing initial training program for center staff. Will modify A-STEP program to incorporate modules relevant to an integrated care delivery model. See page 12 for description of A-STEP program.

Executive Leadership: Includes Executive Director, 2 Assistant Executive Directors and Director of Accounting.

General Support Staff: Includes various support from multiple departments, including human resources, communications, membership and accounting.

Physician Oversight Committee: A committee of three physicians with sleep medicine expertise will provide oversight of the program and assist with educational content and clinical oversight.

Organizational Chart: This chart reflects the organizational composition of the AASM and departments that will be involved with the ICDMPPO.



Section Three: Workforce Analysis

Transformed Workforce: The traditional sleep workforce includes physicians trained in the evaluation and diagnosis of sleep disorders through in-center PSG testing and in the provision of therapy using a DME provider. Sleep technologists are trained in the performance of sleep studies and the initial aspects of therapy including mask fitting and pressure titration. The proposal adds an additional element to the workforce – a sleep center facilitator – who will provide continuity of care and outcomes assessment for patients as they transition through the various elements of the integrated sleep center. Candidates for the sleep center facilitator position will be drawn from senior sleep technologists and other allied health professionals, with a minimum of an associate's degree. The AASM will develop an educational program for these professionals that will focus on these minimum requirements:

- Patient sleep disorders education elements and effective teaching skills
- Keys to improving PAP adherence, including mask fitting and adjustment, alternative PAP platforms and motivational interviewing
- Methods for entering data from clinical evaluations, diagnostic testing and treatment monitoring
- Health care utilization monitoring and management
- Coding and compliance methodologies
- Review of management programs for quality assurance
- Understanding of the center's compliance plan
- Understanding DME accreditation and OCST accreditation

Skill Enhancement of Existing Health Professionals: The educational program for the sleep center facilitator will employ a standardized methodology, similar to AASM's Accredited Sleep Technologist Education Program (A-STEP), which includes an introductory course followed by multi-media modules available online at the learner's convenience. Key thought leaders and content experts will be recruited for the introductory portion of the training. Modules will be produced using existing tools and strategies available at the AASM. Self-assessment tools will be a key part of every module.

Some centers will have current allied health staff that can, with additional training, fill the role of sleep center facilitator. Other centers will recruit new individuals to improve and enhance the integrated sleep program. The sleep center facilitator will encourage "team-based care" through monitoring of all patient contact with the sleep center as well as improving communication between clinical, diagnostic and therapeutic elements of the integrated sleep program. The sleep center facilitator will participate in the effort to help achieve better care, better health and cost savings. This will require systematic data collection, process improvement and reassessment. The sleep center facilitator will review and implement practice parameters and critical pathways for the center with a goal of helping to maximize care and minimize costs.

Workforce-Related Metrics: Workforce-related metrics will shift from the current emphasis on productivity to a new emphasis on patient outcomes. AASM expertise in this area stems from participation in the AMA Physician Consortium for Performance Improvement and the development of a measure set focused on OSA patients. These measures provide an excellent starting point that requires supplementation with quality of life measures that will be introduced over the course of the program. As a result of a "Future of Sleep Medicine" conference convened by the AASM, recommendations for other intermediary measures associated with OSA such as hemoglobin A1c, blood pressure and BMI were considered by a consensus of experts as suitable for inclusion in the data set. Longer range measures such as incidence of cardiovascular disease, development of diabetes and mortality will also be collected as part of this program.

Section Four: Evaluating And Reporting

Database Coordination: The AASM's Information Technology department, which includes a database administrator, programmer, web graphic designer and information architect/UX specialist, will develop a cloud-based, relational, SQL database system and a supporting front-end website for the ICDMPPO conditional on this application's acceptance by CMS. The database will support outcome data collected by the BCSMP at every episode of care for each participating patient. The database system will also support custom reporting, based on queries requested by CMS, of outcome metrics that demonstrate the effectiveness of the ICDMPPO on patients and overall cost benefit. In regard to security, the database system will be accessed via a secure website that requires a unique login and password, and participating sites will have protected access to their data only. All patient information will be encrypted via a unique identifier to comply with HIPPA standards and ensure anonymity of participants. Based on confirmation from a formal legal opinion, the AASM will require participating sites to obtain attestation from patients to ensure their consent with the collection and reporting of data. The website will have a standardized design and interface to facilitate ease of use in entering the data. The website will also use clear language to ensure the accuracy and integrity of data based on the information entered by staff at participating centers. Extensive user experience testing will be conducted on the database system and website to test functionality and navigation. The sleep center facilitator at each participating site will undergo online training on use of the database and ongoing support will be available to participating sites for troubleshooting of technical issues.

On a quarterly basis, each test location will be required to upload metric data in the areas of outcomes, claims, education and patient satisfaction to the database system via the ICDMPPO website. Outcomes that will be tracked by the test locations for each patient include:

- Co-morbid conditions such as stroke, myocardial infarction, hypertension and type 2 diabetes;
- Blood pressure and BMI;
- The 2012 Physician Quality Reporting System sleep apnea measures group, including measurement of sleepiness using the Epworth Sleepiness Scale, and PAP adherence; and
- Sleep quality measured by the Functional Outcomes of Sleep Quality (FOSQ)-10 and quality of life measured by the Short Form Health Survey (SF)-12.

In addition to outcome data, the test location will be required to upload claims data to the database system via the ICDMPPO website. Test locations will document each service by reporting the date of service, procedural code and diagnostic code. Claims data as well as outcomes data will be evaluated quarterly to determine the savings that result from the ICDMPPO.

To track the effectiveness of the educational component of the ICDMPPO, test locations will be required to report the types of education they provide to the patient at each episode of care. This information, in addition to any non-coded interactions with the patient such as telephone calls, will be documented and uploaded in the database system via the ICDMPPO website. The education received by each patient will be compared to the patient's PAP adherence to determine effectiveness of the education received and prompt additional patient education if necessary.

Patient satisfaction is also an important tool for measuring the success of the ICDMPPO. At the conclusion of each visit with the BCSMP, patients will be asked to complete a patient satisfaction survey.

Section Five: Funding And Sustainability

Project Budget, Financial Plan and Model Sustainability

Program Budget	Year 1 Cost	Year 2 Cost	Year 3 Cost	3 Year Total Cost
a. Personnel	$ 353,055.40	$ 300,658.40	$ 312,038.20	**$ 965,752.00**
b. Fringe Benefits	104,834.57	89,081.36	92,530.49	**286,446.43**
c. Travel	60,000.00	–	–	**60,000.00**
d. Equipment	10,000.00	–	–	**10,000.00**
e. Supplies	4,000.00	1,100.00	1,200.00	**6,300.00**
f. Sleep Center Compensation	2,435,625.00	1,978,125.00	2,383,125.00	**6,796,875.00**
g. Construction	–	–	–	–
h. Other	112,680.00	107,680.00	$107,680.00	**328,040.00**
i. Total Direct Charges	$ 3,080,194.97	$ 2,476,644.76	$ 2,896,573.69	**$ 8,453,413.43**
j. Indirect Charges	$102,386.07	87,190.94	90,491.08	**280,068.09**
k. Total Charges	**$ 3,182,581.04**	**$ 2,563,835.70**	**$ 2,987,064.77**	**$ 8,733,481.52**

Project Budget Narrative:

a. **Personnel (see section two for complete descriptions):** To effectively manage, administer and evaluate the program, the AASM will hire two full time employees and allocate a portion of time of several other current staff.

b. **Fringe Benefits:** The AASM provides various fringe benefits for their employees. These benefits are allocated based on compensation or by full-time equivalence. Compensation based benefits include Medicare, Social Security and SEP IRA contributions. Equivalent employee year compensation benefits include state and federal unemployment taxes, health insurance, HRA health, dental, life and disability insurance. The equivalent employee year compensation increases by 4 percent per year for inflation.

c. **Travel:** Travel costs associated with physician and tech training provided at the national office in Darien, IL. Projected to train of one representative from each participating site.

d. **Equipment:** A server that has cloud-based capabilities for data management, premier security protection and compatible software costing $10,000 is needed to store the database.

e. **Supplies:** Two new computers, with software, costing $1,500 each will be purchased for new employees hired for this project. The budgeted office supplies expense is $3,300 for the three years of the project.

f. **Sleep Center Compensation:** Each of the participating centers will receive start-up and data tracking and management costs annually. Each center will receive $25,000 in the first year when accepted into the program. Centers will each receive $15,000 in years two and three for outcome data collection and management for a total expense of $4.125M. This money is to assist with the start-up costs, which will include obtaining DME Accreditation, database set up, development of new accounting procedures, initiation of a comprehensive compliance plan, insurance and liability requirements and appropriate licensure requirements as dictated by respective states. To compensate the centers for their increased role in patient care and tracking, each participating site will be paid a $25 initial patient sign-up fee

based on 100 patients per year for the 75 sites. These costs will be $562,500 over the three years. In addition, a $5 monthly fee will be paid for each patient that stays in their care. Participating centers are expected to average 8.33 new patients a month with 80 percent of them being diagnosed and treated with CPAP. Therefore beginning in month two, year one, there would be 7.5 new patients diagnosed with OSA per facility. Each subsequent month an additional 7.5 patients would be added. In year one, patient care reimbursement would be $185,625; $590,625 in year two; and $995,625 in year three.

A physician oversight committee, comprised of three AASM members, all board-certified in sleep medicine, will provide general and clinical oversight for the duration of the project. The committee will oversee the collection and subsequent reporting of clinical data and outcomes compiled by participating centers. The oversight committee will liaise with the Board of Directors, providing regular updates of the project status. Committee members will each receive a stipend of $25,000 per year, for a total of $225,000. In addition, it is anticipated that data use agreements and/or institutional review board will be required for the centers therefore support is provided for this at $1,500 per participating center, or $112,500.

g. Construction: N/A

h. Other Costs: The majority of remaining costs are training for the physicians, sleep technologists and sleep center facilitators as described in section three. Training expense in year one for physicians is $45,000; for sleep center facilitators is $10,000; and for technologists is $30,000, for a total training expense of $85,000 in year one. In years two and three we anticipate training costs to be reduced for technologists and increased for sleep center facilitators. Total training expense over three years is $285,000.

To manage the increase internet traffic expected due to the data entry of the facilities, upgrading bandwidth is necessary. The monthly cost for this upgrade is $640 for a project total of $23,040.00. In addition, estimates legal fees are $20,000 for year one only.

i. Total Direct Charges: $8,453,413.43

j. Indirect: The indirect cost of the AASM is estimated to be 29 percent of salary, or $280,068.09 for the three years. Indirect costs include building and equipment depreciation, utilities, insurance, general office supplies, printing/copying, phone, internet, postage, accounting, payroll, equipment maintenance and recruitment.

k. Total Charges: $8,733,481.52

Summary of Savings:

If approved, the AASM estimates that the proposed model of care delivery for Medicare patients diagnosed with OSA could reduce sleep testing costs by nearly $11M. With effective care management and significant improvement of CPAP/APAP adherence, the AASM estimates saving an additional $100 per OSA patient, or $1.8M, by reducing unnecessary equipment costs due to improper fitting and increased patient education on use and operation of CPAP for a total testing and equipment savings of $12.8M over three years. We estimate an additional $88.8M savings over 10 years in overall health care costs in patients with the potential for strokes, myocardial infarctions, hypertension and type 2 diabetes.

Integrated Management Model Savings
Starting in 2012

Testing Savings	$ 10,961,775.00 +
Equipment Savings	$ 1,800,000.00
Total Test and Equipment Savings	$ 12,761,775.00 +
Health Savings over 10 yrs	$ 88,758,000.00
Gross Project Savings	$101,519,775.00 −
Project Budget	$ 8,733,481.52
Net Project Savings	**$ 92,786,293.48**

Current vs. Integrated Care Delivery Cost/Savings Comparison *Based on 22,500 Patients*

CURRENT TREATMENT MODEL			
Patient Care Full In-Center	**100% of Patients (22,500)**		**Total Patient Care Cost**
	20% Without OSA	**80% Diagnosis OSA**	
Office Visit (99203)	$ 97.00	$ 97.00	
Test (95810)	694.14	694.14	
Titration (95811)		749.18	
3 Months PAP		303.00	
3 Months Office Visits*	70.00	140.00	
Per Patient Cost	$ 861.14	$ 1,983.32	
Total Patients Over 3 Years	4,500.00	18,000.00	
Total Cost Patient Care In-Center	**$ 3,875,130.00**	**$35,699,760.00**	**$ 39,574,890.00**
Current Treatment Model Average Patient Cost			**$ 1,758.88**

**Consists of One Primary Care Visit and One Sleep Doctor Visit if Diagnosed with OSA*

INTEGRATED TREATMENT MODEL			
Patient Care Full In-Center	**20% of Patients (4,500)**		**Total Patient Care Cost**
	20% Without OSA	**80% Diagnosis OSA**	
Office Visit (99203)	$ 97.00	$ 97.00	
Test (95810)	694.14	694.14	
Titration (95811)		749.18	
3 Months PAP		303.00	
3 Months Office Visits	70.00	180.00	
Per Patient Cost	$ 861.14	$ 2,023.32	
Total Patients Over 3 Years	900.00	3,600.00	
Total Cost Patient Care In-Center	**$ 775,026.00**	**$ 7,283,952.00**	**$ 8,058,978.00**
Model Patient Care In-Center Average Cost			**$ 1,790.88**
Patient Care Split Night In-Center	**20% of Patients (4,500)**		**Total Patient Care Cost**
	20% Without OSA	**80% Diagnosis OSA**	
Office Visit (99203)	$ 97.00	$ 97.00	
Test (95810)	694.14		
Titration (95811)		749.18	
3 Months PAP		303.00	
3 Months Office Visits	70.00	180.00	
Per Patient Cost	$ 861.14	$ 1,329.18	
Total Patients Over 3 Years	900.00	3,600.00	
Total Cost Patient Care In-Center	**$ 775,026.00**	**$ 4,785,048.00**	**$ 5,560,074.00**
Model Patient Care In-Center Average Cost			**$ 1,235.57**

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INTEGRATED TREATMENT MODEL *(continued)*			
Patient Care Portable Out of Center	**40% of Patients (9,000)**		**Total Patient Care Cost**
	20% Without OSA	**80% Diagnosis OSA**	
Office Visit (99203)	$ 97.00	$ 97.00	
Test (95806)	182.11	182.11	
3 Months PAP		303.00	
3 Months Office Visits	70.00	180.00	
Per Patient Cost	$ 349.11	$ 762.11	
Total Patients Over 3 Years	1,800.00	7,200.00	
Total Cost Patient Care Out of Center	**$ 628,398.00**	**$ 5,487,192.00**	**$ 6,115,590.00**
Patient Care Out of Center Average Cost			**$ 679.51**
Patient Care Portable Out of Center and In-Center Retest	**20% of Patients (4,500)**		**Total Patient Care Cost**
	20% Without OSA	**80% Diagnosis OSA**	
Office Visit (99203)	$ 97.00	$ 97.00	
Test (95806)	182.11	182.11	
Test (95810)	694.14	694.14	
Titration (95811)		749.18	
3 Months PAP		303.00	
3 Months Office Visits	70.00	180.00	
Per Patient Cost	$ 1,043.25	$ 2,205.43	
Total Patients Over 3 Years	900.00	3,600.00	
Total Cost Patient Care Out of Center Needing In-Center Retest	**$ 938,925.00**	**$ 7,939,548.00**	**$ 8,878,473.00**
Patient Care Out of Center Needing In-Center Retest Average Cost			**$ 1,972.99**
Integrated Treatment Model Testing and Treatment over First Three Months of Care for the Three Year Trial Summary Cost			
Integrated Treatment Model Cost			**$ 28,613,115.00**
Integrated Treatment Model Average Patient Cost			**$ 1,271.69**

SLEEP MANAGEMENT CARE DELIVERY MODEL COST/SAVINGS COMPARISON			
Testing and Treatment Savings in Switching to Integrated Treatment Model Over the First Three Months of Care for the Three Year Trial			**$ 10,961,775.00**
Equipment Savings over three year trial			**$ 1,800,000.00**

Testing, Treatment and Equipment Savings: **$12,761,775.00**

Under the current model of reimbursement, we estimate that of the 22,500 Medicare patients with suspected OSA, 80 percent will be diagnosed with OSA and require CPAP titration in the sleep center for a total cost of $39.6M over three years.

Using the proposed model of care delivery, the AASM expects 60 percent of the patients with suspected OSA could qualify for OCST. One-third of those who receive an OCST will eventually require re-testing in the sleep center due to unanticipated issues such as false positives/false negatives and testing equipment complications. Of the remaining 40 percent of patients tested in the center, half will have a full in-center PSG and titration. The other half will have a split-night in-lab PSG, which is billed as a titration. Therefore we estimate that approximately 20 percent of patients will receive a full in-center PSG and titration, 20 percent of patients will receive a split-night titration study, 40 percent of patients will be tested with OCST and 20 percent of patients will be tested both at home and in-center. Under the proposed care delivery model, the AASM estimates that there will be an increase in the frequency of office visits during the first three months of treatment for centers participating in the innovation project because of the model's emphasis on patient care coordination, ongoing care management and education. An initial office visit will be required by the BCSMP prior to testing to determine the appropriate test.

All patients diagnosed with OSA will require two level-III office visits with the sleep physician as well as three level-I incident-to office visits provided by the sleep physician and sleep center facilitator, in the first three months following diagnosis. The total cost of these visits would be $197 under current Medicare reimbursement rates; however, we propose bundling these services for a single payment of $180, for which a G-code can be created specifically for this program. These services include evaluation and management services, mask fittings, machine selection, and pressure settings as frequently as needed.

Based on this change in care delivery and reimbursement, the average cost per patient will be $1,271.69 compared to the current $1,758.88. The three year savings will be $11M. With the additional $1.8M savings in equipment costs, the total savings for testing and treatment is $12.8M over three years.

Health Care Savings Analysis for Expanded Populations:

Patient Population	Current Treatment Model	Current Treatment Model	Additional Patient Adherence to CPAP Usage
100 patients a year at 125 centers over 3 Years	22,500	22,500	
Diagnosed Rate of Obstructive Sleep Apnea	80%	80%	
Number of Patient diagnosed with Obstructive Sleep Apena	18,000	18,000	
Improved Adherence of CPAP Usage from 50% to 70%	50%	70%	
Patient Adherence to CPAP Usage	9,000	12,600	3,600

As discussed in greater detail in section one, we estimate each program center will average 100 Medicare patients per year. Typically, 80 percent of Medicare patients treated by a BCSMP will be diagnosed with (OSA). Under the proposed model of care delivery, the AASM estimates that average CPAP/APAP adherence will increase from 50 to 70 percent over the three year period. Adherence will continue to be monitored and recorded on each patient for two years. An increase of 20 percent CPAP adherence will result in an additional 3,600 Medicare patients managed in this care delivery model.

Effect on Co-morbidities to OSA Over 10 Years
Based on 3,600 Patients with Improved Adherence

SAVINGS BY REDUCING OCCURRENCES

	Stroke	Myocardial Infarction
Additional Patient Adherence	3,600	3,600
Current Rate of Occurrences	3%	5%
Estimated Occurrences	108	180
Reduced Occurrences %	50%	50%
Reduced Occurrences	54	90
Estimate Cost Per Occurrences Per Patient	$ 103,000.00	$ 44,000.00
Estimated Cost Savings	$ 5,562,000.00	$ 3,960,000.00

SAVINGS BY REDUCING EXPENSE

	Hypertension	Type 2 Diabetes
Additional Patient Adherence	3,600	3,600
Current Rate of Occurrences	73%	50%
Estimated Occurrences	2,628	1,800
10 Year Estimate Cost Per Untreated Patient	$ 24,000.00	$ 53,000.00
Untreated Cost	$ 63,072,000	$ 95,400,000
% Savings due to Treatment	50%	50%
Estimated Cost Savings	$ 31,536,000.00	$ 47,700,000.00

Total Health Care Savings for all OSA Co-morbidities: $88,758,000.00

The AASM estimates that an increase of CPAP/APAP adherence in the population described will have an effect on the care, cost and savings for conditions co-morbid to OSA in Medicare patients, specifically stroke, myocardial infarction, hypertension and type 2 diabetes:

- A stroke is estimated to cost $103,000 per incident and we estimate that stroke occurs in three percent of Medicare patients with untreated OSA. The AASM estimates that for the patients treated sleep centers participating in our innovation care model, a likelihood of 54 fewer strokes will occur resulting in savings of $5.6M.
- A myocardial infarction is estimated to cost an average $44,000 per incident and we estimate that myocardial infarction occurs in five percent of Medicare patients with untreated OSA. The AASM estimates that for the patients treated in this program, 90 fewer myocardial infarctions will occur, resulting in savings of $4M over 10 years.
- Hypertension is estimated to cost $24,000 per patient over 10 years and occurs in 73 percent of Medicare patients with untreated OSA. The AASM estimates that for the additional patients treated in this model, a 50 percent reduction in health costs will occur over a 10-year period in OSA patients with hypertension, resulting in savings of $31.5M.
- Type 2 diabetes is estimated to cost $53,000 per patient over 10 years and occurs in 50 percent of Medicare patients with untreated OSA. The AASM estimates that for the additional patients treated by our program, a 50 percent reduction in health costs in OSA patients with type 2 diabetes resulting in a savings of $47.7M over 10 years.

Model Sustainability: The AASM plans to take significant steps to ensure that the innovation care model grows beyond the 75 participating test locations and the three year duration of the innovation project. It is the AASM's intent that a new accreditation model will be developed for the innovation care model. The new innovation patient care accreditation model will complement the current Center, OCST and DME accreditation models offered by the AASM. In order for the innovation patient care model to sustain beyond the three-year pilot, the AASM will request that reimbursement for CPT code 95806 be increased from its current rate of $183.80 to $365 to accommodate the increased expenses sleep centers will incur with the shift to OCST. Encouraging care coordination, improved patient education and community outreach across all AASM-accredited sleep centers will ensure the sustainability of the model and will address the three-part aim of better care, better health and reduced cost.

Better Care: Throughout the duration of the project, the AASM will transform test location sleep technologists into sleep center facilitators with expanded knowledge of care coordination and improved patient education techniques. Sleep physicians at project test locations will be trained to provide quality management of PAP therapy. They will also be educated to effectively incorporate OCST into their sleep programs. Education and training techniques for sleep technologist and physicians are further described in section three of this proposal. Beyond the parameters of the innovation project, the AASM plans to train sleep center facilitators and sleep physicians across the country to encourage the future sustainability of this patient care model.

Better Health: As described in detail in section one, participating centers will be required to establish education and outreach programs to target the undiagnosed OSA populations in their region. Particularly in the Medicare population, patients with undiagnosed OSA are at high risk for costly co-morbid conditions. With treatment, the severity of high risk patients' co-morbid conditions can decrease significantly. Throughout the duration of the project, the AASM will encourage education and outreach mechanisms similar to those required in the innovation project for all accredited sleep centers to address the needs of undiagnosed patients across the country.

Reduced Cost: As described in the financial plan above, health savings projections for the innovation project could exceed $88M for the Medicare patients tested at the 75 test locations. Modification of OSA testing mechanisms and equipment savings will lead to

an immediate reduction of $12.8M for the duration of the project. Additionally, significant overall health care costs savings will be experienced over the next 10 years. Savings projections outlined in this proposal are limited to Medicare patients. We anticipate that all payers will experience a decrease in both testing and health care costs for the patients participating in the program.

When this care model is widely implemented, the AASM expects test cost and health care cost savings for all patients and all payers. By committing to expand the principles of the ICDMPPO care model beyond the 75 test locations and three year duration of the project, the AASM will ensure the sustainability of the model and continued cost savings of both testing and treatment.