C-TAC
COALITION TO TRANSFORM ADVANCED CARE

ADVANCED CARE MODEL FOR PHYSICIAN-FOCUSED PAYMENT MODEL

As Baby Boomers age, a growing number will eventually experience *advanced illness*, when one or more chronic conditions become serious enough that general health and functioning begin to decline and chances of recovery diminish, a process that continues to the end of life.[1] Many of these individuals receive fragmented, costly care inconsistent with their wishes and values. As 25% of Medicare costs are spent for beneficiaries in their last year of life,[2] innovations that coordinate care and reduce unwanted treatment for advanced illness could benefit not just these individuals, but society as well. Building from successful, scalable advanced illness and community-based palliative care programs,[3] the Coalition to Transform Advanced Care (C-TAC) proposes an advanced illness care and alternative payment model, the Advanced Care Model (ACM), for a physician-focused payment model.

The Advanced Care Model provides a population health management approach for the advanced illness population in the last year of life. The ACM integrates with existing APMs and contributes to their success. By creating an integrative model that is focused on a high-cost and high-need population, the ACM provides a mechanism to risk-stratify a broader Medicare population, specifies effective care interventions and creates additional financial incentives for existing APMs. In addition, the ACM will offer multiple pathways for organizations to incrementally add risk as existing or new APM entities. Primary care providers and specialists can participate in the ACM APM for physician-focused payment under the Quality Payment Program. Furthermore, the ACM meets the requirements for an advanced APM, with the potential to qualify participating palliative care providers and specialists.

Expected Participants. The proposed ACM targets the advanced illness population, representing 25% of Medicare expenditures and about 3% of all Medicare beneficiaries (approximately 75% of the Medicare population in their last year of life). These individuals have an identifiable primary advanced chronic condition such as cancer, heart failure, or advanced dementia, often coupled with comorbidities, and meet quantifiable triggers of active irreversible decline.

Advanced illness beneficiaries utilize a wide range of health care services – these Medicare beneficiaries in their last six months of life averaged 8.4 days in the hospital, 9.4 days in a SNF, 10.5 different physicians, 8 home health visits and 23.3 days in hospice in 2014.[4] The ACM will coordinate care among all these providers: particularly hospitals, primary care providers, and specialists; and support a smooth transition to hospice.

Eligible ACM entities are organizations that can deliver the ACM core licensed clinical services, fulfill care model demonstration requirements, meet appropriate state licensure requirements, and enroll a sufficient number of eligible beneficiaries per year.

The advanced illness population is partially captured in existing APMs such as MSSP, IAH, Medicare Care Choices, Oncology Care Model, and Comprehensive ESRD Care Model. However, none of the existing APMs target or fully address the needs of this population, nor do they maximize the potential to improve quality and cost outcomes. Therefore, the ACM is proposed both as a standalone APM (for beneficiaries not currently enrolled in relevant existing APMs) as well as an integrated layered payment within a broader, existing APM. Providers and

APM entities have multiple pathways to participate: (1) by participating in a standalone ACM, (2) by accessing the ACM within existing APMs, or (3) by participating through a combination of standalone ACM and existing APMs.

ACM Goals. The ACM is a population health alternative payment model. The ACM goals are to improve quality, care experience, and cost outcomes for beneficiaries with advanced illness.

ACM Overview. The ACM delivers comprehensive, person-centered care management; multidisciplinary team-based care; concurrent curative and palliative treatment; care coordination across all care providers and settings; comprehensive advance care planning; shared decision making with patient, family, and providers; and 24/7 access to clinical support. ACM services end when the beneficiary enrolls in hospice or dies.

The ACM APM is designed to support provider investment in infrastructure, create an ROI opportunity, and help providers migrate from FFS to risk. The three core components of the payment model are 1) a PMPM for up to 12 months post enrollment; 2) a population and value-based payment through a phased-in two-sided risk arrangement; and 3) integration with existing value-based payments. The PMPM will cover care management and ambulatory palliative care provider E&M visits. The value-based payment will be adjusted based on meeting a minimum quality performance threshold. The proposed shared-risk model will encompass total cost of care in the last year of life (including PMPM fees) and include a 75-85% shared savings and shared loss rate, 30% total savings limit, 10% total loss limit, and 4% total risk and minimum loss rate.

The ACM provides a mechanism to risk-stratify a broader population, specifies effective advanced illness services, provides upfront payment to finance an interdisciplinary care team, incentivizes and supports coordination between primary care providers, specialists and hospitals, and promotes a successful path towards greater financial risks for provider organizations.

Implementation Strategy and Timeline. C-TAC is a coalition of over 130 national organizations, dedicated to the idea that all Americans with advanced illness receive comprehensive, high-quality, person-and family-centered care that is consistent with their goals and values and honors their dignity. During the ACM design phase, C-TAC consulted with leading experts in all health care sectors, including health care systems, home-based palliative care organizations, and regional and national health plans. Examples of leading health systems and other organizations who indicated commitment to implement the ACM include Sutter Health, Northwell, Priority Health, Aspire Health, and Aetna. C-TAC is coordinating with key professional organizations. We will submit a full list of collaborating professional organizations and committed ACM entities in the proposal in Q1 2017, with the expectation that Q3 2017 is the earliest date provider organizations could be ready to implement the ACM payment model.

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[1] Novelli B, Koutsoumpas S. A Roadmap for Success: Transforming Advanced Illness Care in America. https://www.amazon.com/Roadmap-Success-Transforming-Advanced-Illness-ebook/dp/B014WGLTUC (Accessed July 13, 2016)

[2] Gerald F. Riley and James D. Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," Health Serv Res 2010;45 (2): 565-76; Christopher Hogan et al., "Medicare Beneficiaries' Costs of Care In The Last Year of Life," Health Aff (Millwood) 2001;20(4):188-95.

[3] Health Care Innovation Awards e.g. Sutter Health's Advanced Illness Management; Medicare Advantage's Innovations e.g. Aetna's Compassionate Care and Aspire Health; Home-based Palliative Care Programs: e.g. AHA, CAPC, CHCF and C-TAC Reports/White Papers.

[4] The Dartmouth Atlas of Health Care. Key Issues: End of Life Care. http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944