Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models

Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC has conducted a series of theme-based discussions that examined key definitions, issues and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models with accountability for quality and TCOC.[1] Subsequent theme-based discussions have addressed topics related to improving care delivery and integration of specialty care, improving management of care transitions, increasing participation of rural patients and providers, and performance measures for PB-TCOC models.

These theme-based discussions are designed to give Committee members additional information about current perspectives on key issues related to developing and operationalizing PB-TCOC models. This information will be useful to policy makers, payers, accountable care entities, and providers for optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. The theme-based discussions provide an opportunity for PTAC to hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC with relevant components.

PTAC's two-day June 2024 public meeting focused on addressing the needs of patients with complex chronic conditions or serious illnesses in PB-TCOC models. During the public meeting, Committee members heard from various subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included components related to chronic conditions and/or serious illnesses. Specific topics that were addressed included:

- Care delivery needs of patients with complex chronic conditions or serious illnesses who account for the top five percent of Medicare spending;
- Strategies for providing patient-centered care for this patient population;
- Opportunities for improving care delivery and health outcomes for this patient population;
- Optimizing the use of post-acute care, palliative care, and end-of-life care for this patient population in PB-TCOC models;

[1] Please see the Appendix for PTAC's definition of PB-TCOC models.

- Approaches for measuring performance and quality of care for patients with complex chronic conditions or serious illnesses in PB-TCOC models; and
- Best practices for incentivizing improved outcomes and delivery system transformation for this patient population in PB-TCOC Models.

Stakeholders also had an opportunity to provide public comments. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS).

Background:

The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having all Medicare fee-for-service (FFS) beneficiaries with Parts A and B coverage in a care relationship with accountability for quality and TCOC by 2030.[2] CMMI has also identified a strategic objective of supporting care innovations, which focuses on integrated, person-centered care that attempts to close care gaps and encourages progress in areas such as integrated care, behavioral health, and social determinants of health.[3] As many patients with complex chronic conditions or serious illnesses are also high-cost,[4] better coordinating and supporting their care so that they avoid unnecessary service utilization may also play an important role in healthcare cost containment.

Additionally, the Secretary of Health and Human Services (HHS) has established "Integration and Care Coordination" as one of the 10 criteria for proposed PFPMs that PTAC uses to evaluate submitted proposals. The goal of this criterion is to "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" (Criterion 7).

Within this context, PTAC has assessed previous submitters' use of model design components related to care delivery and care integration for patients with complex chronic conditions or serious illnesses. Among the 35 proposals that were submitted to PTAC between 2016 and

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[2] Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. https://innovation.cms.gov/strategic-direction-whitepaper

[3] Centers for Medicare & Medicaid Services. Strategic Direction; 2024. https://www.cms.gov/priorities/innovation/about/strategic-direction

[4] Joynt, Karen E., Jose F. Figueroa, Nancy Beaulieu, Robert C. Wild, E. John Orav, and Ashish K. Jha. 2017. "Segmenting High-Cost Medicare Patients into Potentially Actionable Cohorts." Healthcare 5 (1): 62–67. https://doi.org/10.1016/j.hjdsi.2016.11.002.

2020, thirteen proposals included components related to addressing the needs of patients with complex chronic conditions and/or serious illnesses. The Committee found that seven of these proposals met Criterion 7 (Integration and Care Coordination).

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members understand the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal. To assist PTAC in preparing for the June 2024 theme-based discussion, an environmental scan was developed with background information on topics related to caring for patients with complex chronic conditions or serious illnesses in the context of APMs and PFPMs.

PTAC is using the following working definitions for patients with complex chronic conditions or serious illnesses:

- *Patients with Complex Chronic Conditions are those with more than one morbidity, chronic condition and/or comorbidity (lasting 12 months or more) who usually require a high complexity of treatment involving multiple health care providers across different specialties and settings.*

- *Patients with Serious Illnesses are those with advanced illness and patients who are in their last years of life.*

These definitions may evolve as the Committee collects additional information from stakeholders.

PTAC Areas of Interest:

PTAC is particularly interested in innovative approaches for addressing the needs of patients with complex chronic conditions or serious illnesses and encouraging the participation of providers serving these patients within the context of value-based care. Particular topics of interest include characteristics of patients with complex chronic conditions or serious illnesses; identifying and addressing challenges that affect providers' ability to identify patients with complex chronic conditions or serious illnesses; effective care delivery interventions/models for meeting the needs of patients with complex chronic conditions or serious illnesses and encouraging value-based care; opportunities for improving care for patients with complex chronic conditions in ACOs and other types of APMs; and designing financial incentives to

encourage increased participation of providers serving patients with complex chronic conditions or serious illnesses in PB-TCOC models and other types of APMs.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. PTAC also seeks additional information on stakeholders' experiences related to improving management of care transitions in population-based models. Therefore, PTAC requests stakeholders' input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1) What are the characteristics of patients with complex chronic conditions or serious illnesses? What are the characteristics of the highest cost patients with complex chronic conditions or serious illnesses?

    a) How have the characteristics (e.g., demographics, medical conditions, health-related social needs, health care coverage) of high-cost patients and patients with complex chronic conditions or serious illnesses changed since the COVID-19 Public Health Emergency (PHE)?

    b) How do patients who account for the top 5 percent of Medicare spending differ from patients who account for the to 6 to 10 percent of Medicare spending?

2) How are high-cost patients with complex chronic conditions or serious illnesses prospectively identified by payers, ACOs, and providers?

    a) What are the most effective and most innovative risk stratification approaches for identifying high-cost patients with complex chronic conditions or serious illnesses?

    b) What kinds of health events might cause a patient to move from the top 6 to 10 percent of Medicare spending to the top 5 percent of spending? What prospective markers may indicate that patients in the top 6-10 percent are at risk of moving into the top 5 percent?

    c) How can artificial intelligence (AI) be used to identify patients with higher risk or patients with complex chronic conditions or serious illnesses?

3) What are the major challenges that affect patients with complex chronic conditions or serious illnesses? What are the major challenges that affect providers' ability to care for these patients?

    a) What is the desired relationship between management of complex chronic conditions or serious illnesses and primary care?

    b) What is the appropriate number and types of proactive "touches" for effectively managing the needs of high-cost patients with complex chronic conditions or serious illnesses? How does this compare with the appropriate number and types of "touches" for patients with one or more chronic conditions who are not at high risk of escalation?

    c) What are the most effective approaches for reducing potentially preventable events (e.g., complications, acute exacerbations) in patients with complex chronic conditions or serious illnesses?

    d) What high-value care delivery approaches can help to mitigate these challenges and improve health outcomes and TCOC for this population?

4) What are the major barriers associated with patients with complex chronic conditions or serious illnesses participating in APMs?

    a) How can attribution be improved to emphasize care coordination for patients with complex chronic conditions?

    b) What are best practices for attributing patients with complex chronic conditions or serious illnesses to providers in APMs?

    c) What are best practices determining when to include patients with complex chronic conditions or serious illnesses in PB-TCOC models versus specialized APMs?

5) What are the major barriers associated with participation and engagement in APMs from providers serving patients with complex chronic conditions or serious illnesses?

    a) How can financial incentives be used to encourage participation from providers serving patients with complex chronic conditions or serious illnesses? What are potential risks or unintended consequences associated with these approaches?

    b) Should models account for additional risk factors related to clinical characteristics, demographic characteristics, and/or social needs of patients with complex chronic conditions or serious illnesses?

6) What are examples of effective care models for patients with complex chronic conditions and/or serious illnesses? What specific issues have these models focused on (e.g., patient-

centered care, preventable events, management of care transitions, equity/health related social needs, specific conditions)?

a) How have these care models functioned from a care delivery, quality and cost perspective, specifically for this patient population?

b) What are specific elements of these models that have been successful in leading to improved outcomes for this patient population?

c) What are specific elements in these models that have consistently not been successful (e.g., not led to improved outcomes, improved quality, decreased TCOC) for this patient population?

7) Are additional or innovative efforts to improve care coordination needed for patients with complex chronic conditions or serious illnesses, compared to a more general patient population? If so, what efforts may be most effective at improving care coordination for patients with complex chronic conditions or serious illnesses?

a) What additional considerations may be warranted when managing care transitions and arranging follow-up care for patients with complex chronic conditions or serious illnesses?

b) How should behavioral health needs be identified and relevant behavioral health services be integrated into health care for patients with complex chronic conditions or serious illnesses?

c) How can payment models incentivize the adoption of care delivery and care coordination best practices for patients with complex chronic conditions or serious illnesses?

8) What are best practices in performance measurement for patients with complex chronic conditions or serious illnesses?

a) What measures or domains are most important to assess performance achievement and improvement for patients with complex chronic conditions or serious illnesses?

b) How might performance benchmarks (e.g., for spending or utilization) need to be modified to ensure that access to care is not limited for patients with complex chronic conditions or serious illnesses?

Where to Submit Comments/Input: Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of patients with complex chronic conditions or serious illnesses, APMs and PFPMs, and efforts by physicians and related providers caring for Medicare FFS beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models

PTAC is using the following working definition for population-based models.

> *Population-based models are models that include the entire patient population served by a given accountable entity or a broad subset of the patient population served by an accountable entity (e.g., Medicare-Medicaid enrollees).*

PTAC is using the following working definition for PB-TCOC models.

> *A population-based total cost of care (PB-TCOC) model is an Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).*
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> *Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model.*

Additionally, PTAC is using the following working definition of TCOC:

> *Total cost of care is a composite measure of the cost of all covered medical services delivered to an individual or group. In the context of Medicare Alternative Payment Models, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.*

Within this context, some examples of existing population-based models/programs that include components that are relevant for the development of PB-TCOC models include:

- *Advanced primary care models (APCMs)* that promote the use of Advanced Primary Care, an approach that enables primary care innovations to achieve higher quality care and allows providers more flexibility to offer a broader set of services and care coordination.

- *Accountable Care Organization (ACO) programs* where physicians or health systems assume responsibility for TCOC associated with a patient population.

While some existing APMs may include shared savings with upside risk only, PTAC anticipates that PB-TCOC models will include glide paths for allowing providers and organizations to gradually assume more downside financial risk over time.