

Preliminary Comments Development Team (PCDT) Presentation:

**Identifying Best Practices in Care Delivery for
Population-Based Total Cost of Care (PB-TCOC) Models**

Chinni Pulluru, MD (Lead)
Lauran Hardin, MSN, FAAN
Lawrence Kosinski, MD, MBA
Walter Lin, MD, MBA
Terry (Lee) Mills, Jr., MD, MMM

June 7, 2022

Objectives of This Theme-Based Meeting

Examine key issues related to the development and implementation of population-based total cost of care (TCOC) models (or PB-TCOC models)

- March public meeting focused on key definitions, issues, and opportunities
- June focuses on assessing best practices in care delivery

Explore options for integrating episode-based or condition-specific models within broader population-based accountable care models

- PTAC has deliberated on the extent to which 28 proposed physician-focused payment models (PFPMs) met the Secretary's 10 regulatory criteria (including Criterion 2, "Quality and Cost")
- Many included innovative care delivery approaches that could be relevant

Nearly all of the 35 proposals that have been submitted to PTAC addressed the potential impact on costs, to some degree – including at least 10 proposals that discussed the use of total cost of care (TCOC) measures in their payment methodology and performance reporting. Please see the Appendix for additional information.

Definition of Population-Based TCOC Models

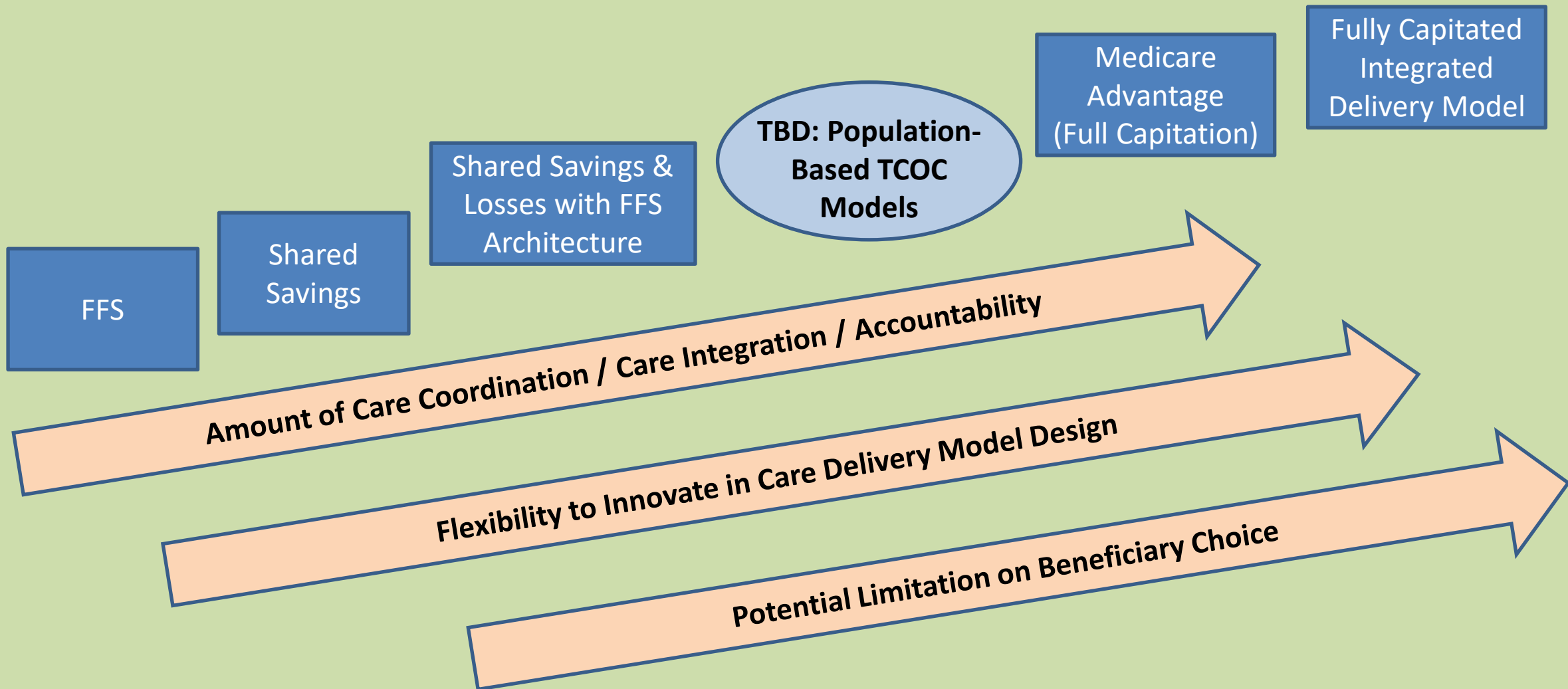
- PTAC's working definition of population-based TCOC models:
 - *Population-based APM in which participating entities assume **accountability for quality and TCOC** and receive payments for **all covered health care costs** for a broadly defined population with varying health care needs during the course of a year (365 days).*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

Definition of an Accountable Care Relationship

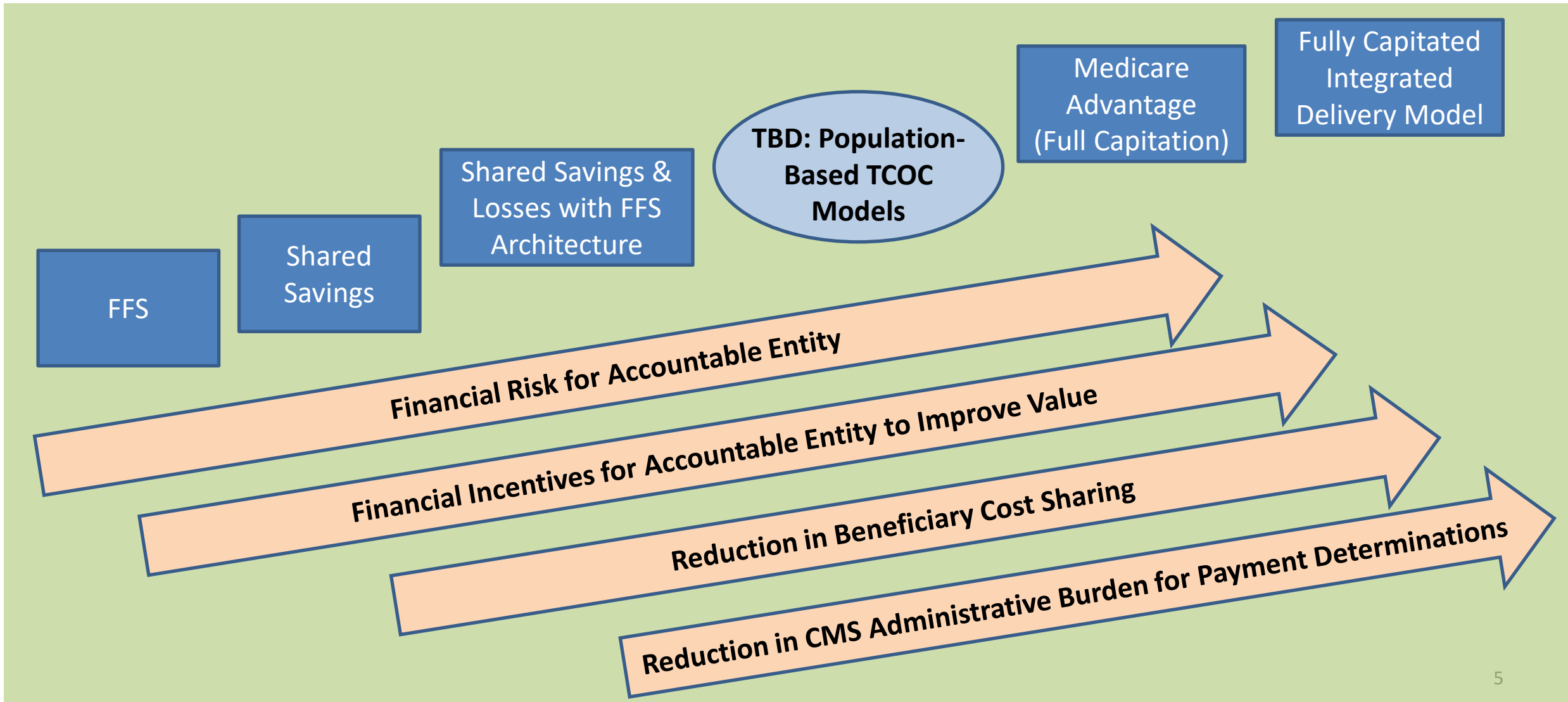
- The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having every Medicare fee-for-service (FFS) beneficiary with Parts A and B in a **care relationship with accountability for quality and TCOC** by 2030.¹
- PTAC is using the following working definition of an “accountable care relationship”:
 - *A relationship with a health care provider that focuses on accountability for quality of care and cost of care for an individual patient or group of patients for a defined period-of-time (e.g., 365 days).*
 - *Would typically include accountability for quality and cost for all of a patient’s covered health care services.*
 - *In some cases, a provider could potentially be accountable for the quality and cost of a subset of a patient’s health care services for an episode of care (which could be procedure-specific, condition-specific, disease-specific, or related to a medical event).*

¹ Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. <https://innovation.cms.gov/strategic-direction-whitepaper>

Care Delivery Factor Trade Offs



Payment Factor Trade Offs



General Consensus about Accountable Care Relationships



Maintain a patient-centered approach



Increase coordination between various types of providers



Improve health equity



Support efforts to address health-related social needs (HRSNs) and social determinants of health (SDOH)

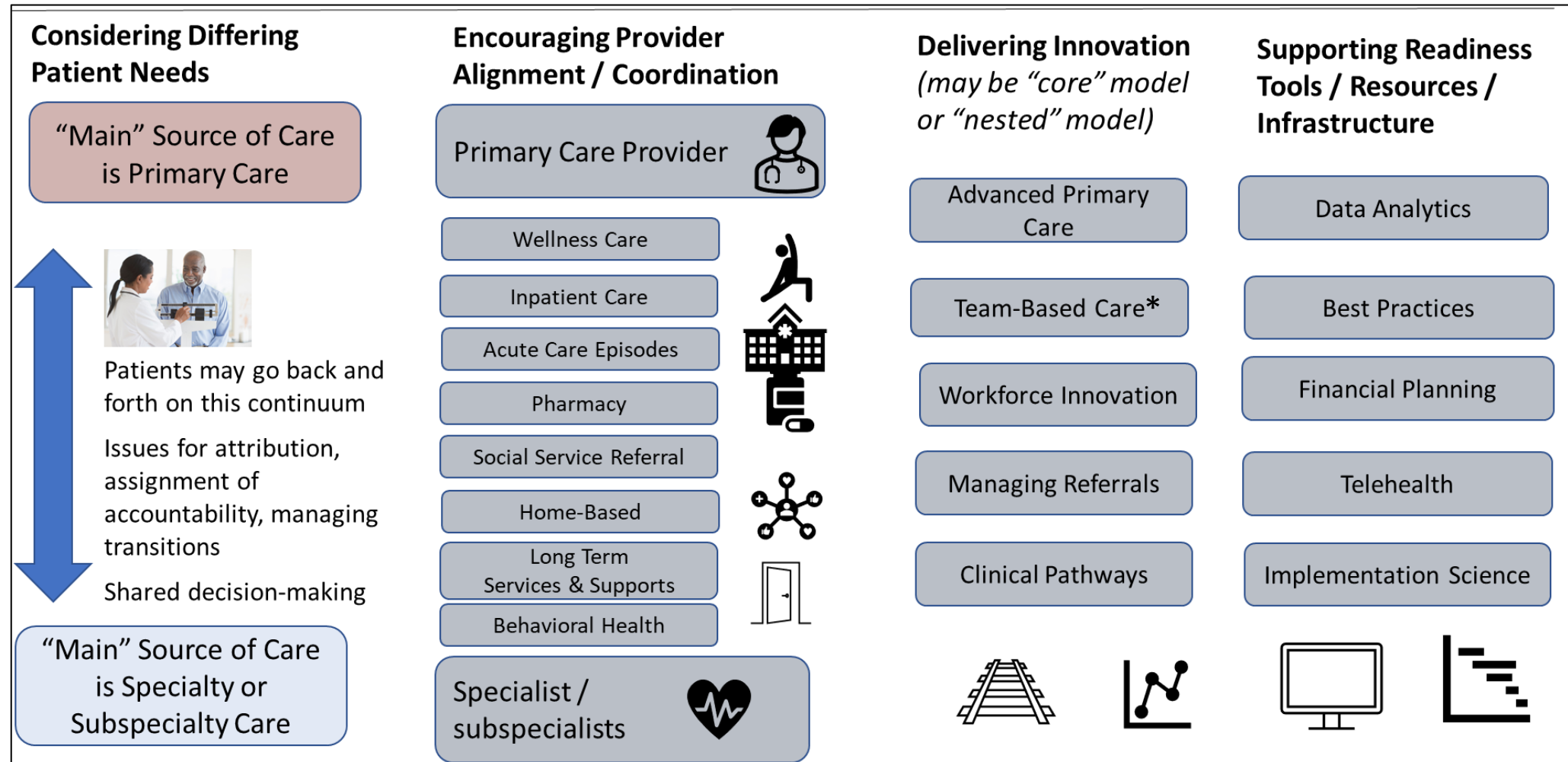
And more...

- Emphasis on outcome metrics, adoption of improved care delivery processes, patient engagement, assumption of risk, incentives for population health and wellness
- Focus on evidence-based high value care, reduction of waste, and gains in efficiency, and maintaining budget neutrality
- Seeking to reduce unnecessary complexity

Areas Where Additional Discussion is Needed

- Focus on the high-cost patients with multiple chronic conditions (and related episodes of care), or on a more broadly defined population
- Strategies to support providers that are in accountable care relationships, particularly in cases where attribution occurs retroactively
- Accountability for individual providers versus a higher-level accountable entity
- Operational strategies for accountability shared among more than one provider
- Integrating screening and referrals for HRSNs and SDOH
- Types of providers and organizations that can serve as accountable entities (e.g., physician group practices, hospitals, and other health care providers; Medicare Advantage (MA) plans, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid managed care plans, etc.)
- Disseminating information about best practices and innovations to providers and organizations in accountable care relationships
- Flexibility accountable entities should have in determining how to manage care for the services they are responsible for (for example, through the use of provider networks)

Supporting Innovative Patient-Centered Care Delivery with Integration and Accountability for Different Kinds of Patients



*Including integration with community services for addressing social determinants of health (SDOH)

Considerations for Integrating Specialty Care

- Benefits of encouraging patients to receive care from an accountable provider or from providers whose care is being coordinated through a specific accountable entity
 - Potential for limiting patient choice
- Some providers are not comfortable assuming overall accountability for patient-centered, value-based care
 - Example: if they only provide a portion of the patient's overall care and do not have the analytic tools and prerogative necessary for effective coordination of care with other providers.
- Integrating specialty and PB-TCOC models will require addressing any unintended conflicting incentives built into benchmarks and TCOC calculations for shared savings and losses that can also affect care delivery.
 - Incentives may conflict across PB-TCOC models and episode-based models that are currently being implemented and tested separately.

Options for Integrating Specialty Care

- **Nested models:** hierarchical models with the ACO global budgets operating as an “umbrella” of accountability that encompass both population-wide management and value-based care for episode-based payments⁶
- **Carve-out models:** models with separate accountability for certain services outside of the ACO global budgets (determined based on ability to be managed by primary care providers, cost, etc.)
- **Mandating provider participation,** including specialist participation in PB-TCOC models
- **Structuring technical elements** of episode-based models so that they are better positioned for integration into PB TCOC models
- **Encouraging coordination** across accountable entities and population-based models to improve care for patients who see providers that participate in multiple models

⁷ Navathe AS, Song Z, Emanuel EJ. The Next Generation of Episode-Based Payments. JAMA. 2017;317(23):2371–2372. doi:10.1001/jama.2017.5902

Timely Data Sharing to Maximize Success

- Many commercial population-based models include the ability for providers to monitor real-time data on utilization, cost and other performance metrics.
- Challenges to effective and timely data sharing:
 - Lack of interoperability
 - Reliance on proprietary systems that are not integrated with other payers and providers
 - Lack of consistent funding for data collection and sharing
 - Lack of resources or in-house expertise to process and interpret data. *(Smaller physician practices, hospitals and federally qualified health centers (FQHCs) do not have the capacity to integrate claims, EHR, and quality data)*
- Lags in data on financial performance in PB-TCOC models:
 - Limits participants' ability to accurately forecast or benchmark expenditures
 - Tempers the incentives of shared savings

Examples of Care Delivery Model Innovations

- **Program of All-Inclusive Care for the Elderly (PACE)**
 - A population-based Medicare and Medicaid program
 - PACE organizations receive fixed monthly payments to provide all Medicare and Medicaid-covered services and coverage for Part D prescription drugs, transportation, hospital visits, and nursing home stays when required.
- **Managed Care Plans and Integrated Delivery Systems**
- **Advanced Primary Care Models Targeting High Risk Patients**
 - Several organizations have developed care delivery models that target high-risk patients such as low-to-moderate income adults and patients with multiple chronic conditions.
- **Complex Chronic Care Management**
 - Some organizations have developed a care delivery model that supplements patients' regular primary care and specialty providers by using multidisciplinary teams to provide complex chronic care management via home health care and video telehealth services.

Examples of Specialty Care Model Innovations

- **Kidney Care Models**
 - CMMI's **Comprehensive ESRD Care Model** allowed for ESRD Seamless Care Organizations (ESCOs)
 - CMMI's **Kidney Care Choices Model** features ACO-based organizations
 - The Renal Physicians Association's **Incident Dialysis Model** is an episode-of-care payment model
- **Diabetes Care Models** – The Maryland Total Cost of Care Model provides a diabetes outcomes-based credit.
- **Serious Illness Models**
- Innovative Approaches in **PTAC Models**
 - Several previous PTAC proposals included innovative care delivery approaches with a potential to improve quality and reduce TCOC, such as primary care medical homes, specialty-based medical homes, and remote specialty care support of staff in skilled nursing facilities and nursing facilities.
 - *Please see the Appendix for additional information.*

Unaddressed Issues in Performance Measurement & Evaluation

- Identifying appropriate time periods
- Addressing Disparities
- Data Issues
 - Standardization of Data Elements
 - Selection
 - Refinement of Risk Stratification and Severity Adjustment
 - Delay in Realizing Return on Investment
 - Small Sample Sizes
- Addressing emerging health care issues

Questions for PTAC to Explore

- How to encourage integration and coordination between primary care and specialty providers
- Which care delivery innovations are most important for increasing provider accountability and improving quality and reductions in TCOC for broader populations and for patients with multiple chronic conditions (*including potentially covering additional services*)
- How to integrate episode-based or condition-specific models within population-based accountable care models
- How to most efficiently integrate screening and referral for HRSNs and SDOH into PB- TCOC models
- How to balance the trade-offs involved in designing PB-TCOC models to provide the best value for patients
- How to encourage and support more providers in participating in value-based care and transitioning to PB-TCOC models

Appendix on Innovative Care Delivery Approaches in Proposals Submitted to PTAC

Selected PTAC Proposals that Included TCOC-Related Components^{viii}

Nearly all of the proposals that have been submitted to PTAC addressed the potential impact on costs, to some degree – including at least 10 proposals that discussed the use of total cost of care (TCOC) measures in their payment methodology and performance reporting.

Advanced Primary Care Proposal:

- American Academy of Family Physicians (AAFP)

Population-Specific Proposals:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- Coalition to Transform Advanced Care (C-TAC)
- University of Chicago Medicine (UChicago)

Episode-Based Proposals:

- American College of Surgeons (ACS)
- American Society of Clinical Oncology (ASCO)
- Avera Health (Avera)
- Large Urology Group Practice Association (LUGPA)
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD)

^{viii} These proposals were identified using TCOC-based keyword searches of key documents related to the Committee's proposal review process, and were selected to include a diversity of provider types, care models and clinical settings, and payment approaches that are relevant for a discussion of the use of TCOC in multiple contexts.

Key Characteristics of Selected PTAC Proposals with TCOC-Related Components

Submitter Name	Proposal Type	Patient Population	Clinical Focus	Setting
1. AAFP	Advanced Primary Care	Medicare beneficiaries	Primary care	Primary care practices
2. AAHPM	Population-specific	Beneficiaries with serious/advanced illness	Palliative care	Inpatient, outpatient
3. ACS	Episode-based	Beneficiaries having at least one of over 100 conditions or procedures	Cross-clinical	Inpatient, outpatient, ambulatory
4. ASCO	Episode-based	Cancer patients	Cancer care	Inpatient, outpatient
5. Avera	Episode-based	Beneficiaries who reside in SNFs	Primary care in SNFs and Nursing Facilities (NFs)	SNFs, NFs
6. C-TAC	Population-specific	Beneficiaries with advanced illness, focusing on last 12 months of life	Palliative care	Patient home
7. NYC DOHMH	Episode-based	Beneficiaries with hepatitis C infection	Hepatitis C virus	Primary care and specialty practices
8. IGG/SonarMD	Episode-based	Beneficiaries with chronic illness (Crohn's Disease)	Chronic disease (Crohn's Disease)	Patient home
9. LUGPA	Episode-based	Beneficiaries who are newly diagnosed with prostate cancer	Urology/oncology	Urology and multispecialty practices
10. UChicago	Population-specific	Frail/complex beneficiaries with hospitalizations	Frequently hospitalized patients	Patient home and rehabilitation sites

Highlights of Care Delivery Innovations in Selected PTAC Proposals with TCOC-Related Components

Submitter Name	Type of Care Delivery Innovation	Care Delivery Innovation(s)
1. AAFP	Primary Care Medical Home	Requirement for APM entities to: <ul style="list-style-type: none"> • Attest to how they address or plan to address the five key areas (access and continuity, planned care and population health, care management, patient and caregiver engagement, and comprehensiveness) • Adopt the Joint Principles of the Patient-Centered Medical Home • Have at least 50% of their participating practices use Certified Electronic Health Record Technology (CEHRT)
2. AAHPM	Serious Illness Model with Team-Based Care	Core components include: <ul style="list-style-type: none"> • Targeting palliative care services to individuals with serious health conditions and distinguishing hospice from palliative care • Delivering palliative care through multidisciplinary palliative care teams (PCTs) that include a physician (adjusting the composition of the care team to meet the needs of the community) • Patient and caregiver education • Distress and safety assessments • Establishing goals of care plans with input from all providers • Home visits

Highlights of Care Delivery Innovations in Selected PTAC Proposals with TCOC-Related Components, continued

Submitter Name	Type of Care Delivery Innovation	Care Delivery Innovation(s)
3. ACS	Provide Episode-Specific Data on Quality and Cost to Physicians	<p>The proposed model would:</p> <ul style="list-style-type: none"> Identify more than one hundred potential procedure and condition episodes of care that would be defined by an episode grouper – including, but not limited to: upper respiratory infection; appendectomy; colonoscopy; cataract surgery; acute simple, benign fibrocystic / dysplastic breast disease; juvenile idiopathic arthritis; lung resection; coronary artery bypass grafting; open heart valve surgery; liver transplant; heart failure; and breast neoplasm (malignant) Identify Clinical Affinity Groups (teams of providers who regularly participate in a given type of episode of care) Allow organizational entities (which could consist of single-specialty practices, multispecialty practices or convenor groups of small provider practices with or without ties to particular facilities) to take on risk for an agreed-to set of procedure or condition episodes during an agreed-to performance period Provide information to providers on quality and total spending on episodes Encourage physicians in the CAGs to collaborate in addressing cost drivers in resource use and variation in care (potential approaches could include increasing integration across specialties through team-based care) Encourage reporting of quality measures (to be identified) that are relevant to the specific covered procedures and conditions <p>Participation in the proposed model’s procedural episodes and associated condition episodes would be voluntary for all members of the care team</p>
4. ASCO	Oncology Medical Home	<p>Requirements for participating practices:</p> <ul style="list-style-type: none"> Provide team-based care led by a hematologist/oncologist Meet 22 “PCOP care delivery requirements,” including having a medical oncologist direct the patient’s care team within the practice, direct care coordination with other pertinent physicians and services, and manage or co-manage inpatient care Prioritize team-based care with policies and practices that clearly delineate roles and responsibilities; implement and prioritize team huddles for communicating and promoting patient safety; and regularly assess how the practice team is functioning Additional requirements for Track 2 practices, including patient and family advisory councils, triage and urgent care, patient navigation, risk stratification, and advanced care planning <p>The proposed model would also encourage use of common clinical pathways and performance metrics for all participating payers</p>

Highlights of Care Delivery Innovations in Selected PTAC Proposals with TCOC-Related Components, continued

Submitter Name	Type of Care Delivery Innovation	Care Delivery Innovation(s)
5. <i>Avera</i>	Remote Geriatric Care Management in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)	<p>Key model features:</p> <ul style="list-style-type: none"> • Geriatrician-led care teams (GCTs) would supplement the SNFs/NFs' on-site staff via telehealth • Provision of geriatric care management activities such as monitoring beneficiaries' care, risk stratification of the patient population, development of care plans for high-risk patients, medication reconciliation and management, evidence-based disease management, behavioral health support, advance care planning, and transitional care support • Timely access to care such as 24/7 access via telehealth to a physician or advanced practice provider on the GCT and real-time response to a patient's change in health status • Provision of facility staff coaching and mentorship, and continuing education targeted at identifying knowledge and skill gaps • The GCT would be expected to have the capability to provide HIPAA-compliant, real-time, two-way audio/visual assessment of the patient, virtual access to health records at the facility, and risk stratification and population health tools • The GCT would work with the primary care physician (PCP), who would retain ultimate oversight and management of a patient's care
6. <i>C-TAC</i>	Serious Illness Model with Team-Based Care	<p>The proposed model features:</p> <ul style="list-style-type: none"> • Care delivery through an interdisciplinary palliative care team comprised of a nurse, social worker, and spiritual care worker • Targeting palliative care services to individuals with serious health conditions and additional prognostic criteria • Care coordination and case management of the beneficiary's total health care needs • Shared decision-making, addressing patients' curative along with palliative care needs, and 24/7 access to clinical support • Allowing participation of different types of entities, including physician practices, hospitals, Accountable Care Organizations (ACOs), health systems, hospices, and home health agencies • Use of 13 quality measures as performance metrics

Highlights of Care Delivery Innovations in Selected PTAC Proposals with TCOC-Related Components, continued

Submitter Name	Type of Care Delivery Innovation	Care Delivery Innovation(s)
7. NYC DOHMH	Integrated Cross-Sector Care Coordination	<p>Features of the proposed model:</p> <ul style="list-style-type: none"> • Coordination of patients with Chronic hepatitis C virus (HCV) to ready them to initiate and adhere to pharmacotherapy – with a particular focus on higher-need patients (i.e., dual-eligible patients, patients with behavioral health and substance abuse disorders, etc.) • A comprehensive psychosocial evaluation to identify barriers to care • A medical evaluation to determine the complexity of liver disease • Assisting patients in overcoming barriers through various means such as: referrals for psychosocial issues or other comorbid conditions; direct counseling services (except those separately billed for by the provider), including health promotion, alcohol counseling and treatment readiness assessment and counseling, or medication adherence measurement and counseling; helping patients navigate appointments; and assistance with prior authorization • Required participation of all employed physicians who treat HCV in hospital outpatient clinics within a given facility • Primary care physicians taking on a greater role in managing the patients with HCV, particularly those without advanced liver disease or other medical complexities • Training of primary care physicians by hepatologists or other gastroenterologists through tele-mentoring • Inclusion of nurse practitioners, and physician assistants across the specialties of infectious disease, hepatology and other gastroenterology, and mental health in the care team to varying degrees based on patient need • Use of non-clinician staff, especially care coordinators
8. IGG/SonarMD	Specialty-based Intensive Medical Home	<p>The proposed model includes:</p> <ul style="list-style-type: none"> • Beneficiary participation in an enrollment visit with a nurse care manager (NCM) • Contacting enrolled beneficiaries at least once per month via smartphone or other device of their choice to submit self-assessment data • Providing follow-up from the NCM if the beneficiary’s data indicates a potential health problem requiring intervention • If indicated, engagement of the specialist physician by the NCM • Use of a communications platform, clinical algorithms, clinical decision support tools, and predictive analytics to support these activities <p>The proposed model focuses on treatment of Crohn’s disease, but could also be used for other “high-beta” chronic diseases associated with high cost, high risk, and high variability in outcome and cost</p>

Highlights of Care Delivery Innovations in Selected PTAC Proposals with TCOC-Related Components, continued

Submitter Name	Type of Care Delivery Innovation	Care Delivery Innovation(s)
9. LUGPA	Coordination within Condition during Episode	<p>The proposed model's features include:</p> <ul style="list-style-type: none"> • Seeking to incentivize increased use of active surveillance (AS) for appropriate patients, as opposed to active intervention • Focusing on urologists as eligible professionals; however, PAs/NPs at participating practices as well as other medical specialists are not excluded from participating • Targeting Medicare patients who are diagnosed with localized prostate cancer after a biopsy as the population eligible for initial episodes and could continue subsequent 12-month episodes on AS • Providing enhanced services such as tracking AS beneficiaries to ensure compliance, tracking lab results longitudinally in a consistent format, educating beneficiaries about disease progression, social services, and reviewing the care plan • Measuring provider performance on quality measures and total cost of care during the AS episode
10. UChicago	Coordination during Transitions between Inpatient and Outpatient Settings	<p>Key features of the proposed model include:</p> <ul style="list-style-type: none"> • Having the same physician follow the patient between the inpatient and outpatient settings, and oversee the patient's care during the immediate period surrounding a transition between settings • Most participating physicians would be general internal medicine physicians, hospitalists, or family practitioners.; however, some medical subspecialists and physicians from other specialties that provide primary care might be appropriate in some instances (e.g., gynecology) • Capping of patient panels at 300 patients per physician, with a maximum of 10 participating physicians per participating institution or practice • Participating physicians would spend all or the majority of each weekday morning caring for their own patients in the hospital and spend weekday afternoons in clinic • Participating physicians would also be encouraged to see their patients in the home and rehabilitation settings when appropriate • Potential variation in the structure for off-hours coverage (e.g., participating physicians might rotate with other participating physicians serving as the "hospitalist" – covering the inpatient service in the weekday afternoons when their colleagues are in clinic and covering for their colleagues when they are off on the weekend. • Participating physicians interacting with specialists to reduce duplicative consultation and testing • A focus on high-risk patients

Objectives and Performance Measures in Selected PTAC Proposals with TCOC-Related Components

Submitter Name	TCOC-Related Objectives	TCOC-Related Performance Measures
1. AAFP	Reduce TCOC by increasing percentage of total spending allocated to primary care	Core Quality Measure Collaborative measures; hospital utilization; ED utilization
2. AAHPM	Reduce per capita end-of-life costs by providing coordinated palliative care and support services	Patient-reported outcomes for experience of care, completion of care processes, utilization of health care services
3. ACS	Reduce TCOC for a specific episode	Total savings (number of episodes x [expected cost – actual cost])
4. ASCO	Reduce TCOC by decreasing costs associated with drugs, monitoring activities, and emergency / acute / post-acute care	Unplanned hospital admissions, emergency and observation care visits, supportive and maintenance drug costs
5. Avera	Reduce TCOC through prevention of avoidable escalation of illness for residents living in SNFs	Monitoring 11 scored metrics for determining losses / savings, and 13 additional quality metrics
6. C-TAC	Reduce TCOC for enrollees in their last 12 months of life using palliative care teams (PCTs)	Measures for developing bonus payments and additional quality measures for monitoring program
7. NYC DOHMH	Lower costs by reducing expenses from preventable hospitalizations, ED visits, and complications associated with hepatitis C intervention	Risk-adjusted facility-based sustained virologic response (SVR) score, matched cohort study analyzing the impact of care coordination
8. IGG/SonarMD	Incentivize proactive care to improve patient quality of life and decrease total costs (by reducing avoidable complications, ED visits, and inpatient admissions)	TCOC (including costs related to outpatient visits, ED visits, and infusion / injection biological costs)
9. LUGPA	Defer active intervention (AI) and avoid overutilization of services while reducing morbidity and costs	Proportion of beneficiaries receiving AI after an initial episode, efficiency and cost reduction, care coordination, patient-reported outcomes, cost of care
10. UChicago	Reduce overall spending on high-cost patients (high-risk Medicare beneficiaries) by improving inpatient-outpatient care coordination	Financial and quality measures, patient and provider satisfaction, self-rated patient mental health, rehospitalization rates, TCOC (Medicare) reduction