Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care Models

Presenters:

Subject Matter Experts

- **Mark McClellan, MD, PhD**, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University
- **François de Brantes, MBA, MS**, Senior Partner, High Value Care Incentives Advisory Group
- **Rozalina G. McCoy, MD, MS**, Associate Professor of Medicine, Mayo Clinic
- **Lili Brillstein, MPH**, Chief Executive Officer, BCollaborative
Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care Models

Mark McClellan, MD, PhD
Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University
Opportunities for Integrating Specialty Care Within Population-Based Payment Models

Mark McClellan, MD, PhD
Robert J. Margolis Professor of Business, Medicine, & Policy
Founding Director of the Duke-Margolis Center for Health Policy
Current Duke-Margolis Specialty Care Initiatives

- **Report** laying out vision for Specialty Condition Models released in November
- Two 2022 convenings on developing specialty condition models and improving specialist engagement
- Playbook for MSK engagement
- Ongoing collaborations with **specialty societies** public and private payers, primary care organizations, concurrent efforts to reform key model components such as **risk adjustment**
Health care from *person* perspective

**Care Pathway or Care Journey with Primary, Specialty, and Primary-Specialty Care**

- **Prevention**
  - Diagnostic Services, Drugs, Non-Surgical Steps to Intercept or Slow Disease Progression

- **Acute episode**
  - Acute Medical Event or Major Procedure, Post-acute Care
  - Maintenance Care, Follow-Up, Prevention, Procedure Revisions

- **Supportive Care**
- **End of Life Care**

Components of care pathway generally influenced by specialty care

## Major Types of Specialized Care

<table>
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<th>Most general surgery procedures, specialized elective services, major acute events. Policies should support excellence in delivery during the episode, coordinate with longitudinal care providers before and after, and promote shared decision-making throughout.</th>
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<td>Whole-Person Care</td>
<td>Care for advanced chronic kidney disease, complex geriatric conditions, cancer. Policies should support delivery of whole-person coordinated care by specialized providers, who can be accountable for key longitudinal outcomes and most or all costs of care.</td>
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<td>Longitudinal Coordinated Care</td>
<td>Care for chronic conditions involving specialized management in collaboration with primary care. Includes major chronic disease areas such as CV, MSK, diabetes, dementia, chronic lung diseases, IBD, and serious mental illnesses. Policies should support coordinated, integrated longitudinal condition management with shared primary-specialty goal of improving outcomes and avoiding costly complications and procedures.</td>
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## Focus For Today

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Relatively small set of specialty conditions drive significant share of Medicare beneficiary disease burden and spending

### Important Considerations

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<th>Specialty Condition</th>
<th>Consideration</th>
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<tr>
<td>Cardiology and Musculoskeletal</td>
<td>Many procedures of low/no value – better longitudinal patient management and accountability can encourage appropriateness</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Many acute hospitalizations could be avoided with better patient management</td>
</tr>
<tr>
<td>Cancer</td>
<td>Chemotherapy could be prescribed and administered more efficiently</td>
</tr>
<tr>
<td>Dementia and other mental health conditions</td>
<td>Worsens with age, often poorly managed today</td>
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Significant Portion of Spending Occurs Outside of Procedure/Acute Admission Episodes

Condition management is a substantial component of specialty care, and potential driver of reducing acute events and major procedures – but is mostly left out of current payment reforms for specialty care.

Optimizing support for condition management enables opportunities to improve patient outcomes and care journey.

Specialty Condition Models (SCMs) to Improve Longitudinal Care for Specialized Conditions

• CMS has suggested a transition to mandatory acute episode bundles for major procedures and acute medical admissions (i.e., acute admission/major procedure hospitalization + 30 days, based on BPCI-A and DRGs)
  • Supports care optimization within the acute episode
  • Complements goal of 100% of Medicare beneficiaries in coordinated, longitudinal care models by 2030

• CMS has also proposed “long-term” goal of longitudinal, condition-based payment for some specialty care – but details not yet developed

• SCMs are condition-based, person-level payments for common conditions nested between whole-person/total cost of care accountability models and acute episodes
  • Alternative to procedure-based specialty payments for common chronic conditions
  • Provides support for coordination and alternative care models to support maximizing patient outcomes and “upstream” activities to avoid costly complications and procedures
Nested Structure of Whole-Person Accountability Models

Whole-Person Accountability Model (e.g., ACOs and advanced primary care models)

TCOC Benchmark
Accountable for benchmark-based condition and acute episode spending plus additional spending outside of specialty condition and episode models

Specialty Condition Model

Condition Spending Benchmark
SCM: Voluntary with negotiated sharing of gains/losses for physician group ACOs; transition to mandatory for hospital ACOs

Acute Episode Bundles
Per-Episode Benchmark
Accountable for acute episode actual spending

Nested Specialized Care Condition Models to Support Longitudinal Coordinated Care

Promising Areas for Specialty Condition Models

• Musculoskeletal Condition Management Integrated with Specialist Care
  • Degenerative Joint Disease and Lower Back Pain

• Longitudinal Cardiology Team Care with Specialist Co-Management
  • Congestive Heart Failure (including nested bundles for major procedures and admissions for CHF complications)
  • Ischemic Heart Disease (including nested bundles for major cardiac procedures)
  • Conduction Disorders (Atrial Fibrillation; arrhythmias; heart blockages)

• Dementia/Alzheimer’s Disease Longitudinal Coordinated Care Models

• Crohn’s Disease and Ulcerative Colitis Longitudinal Care Models
## Key Elements of Duke-Margolis Specialty Payment Reform Strategy for Specialty Condition Models

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<th>Key Steps</th>
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<td>Implementation Pathway for Condition Payments</td>
<td>• Establish guidance and transition timelines that meet providers where they are, expanding opportunities for providers in FFS, MSSP ACOs, and advanced ACO Models (e.g., ranging from small PMPM payments with shared savings/risk to subcapitated payments for specialty coordination)</td>
</tr>
<tr>
<td>Complementary/Nested Acute Episode Payments</td>
<td>• Transition from DRGs and readmission penalties to DRG plus 30-day bundled episode payments for major procedures and acute medical admissions, nested within condition-based payments, with risk adjustments for social risk factors</td>
</tr>
</tbody>
</table>
| Performance Measures and Supporting Data | • Release condition-level measures of quality and spending, shift to measures that better capture meaningful condition-level outcomes including PRO-PMs  
• Enhance longitudinal quality measures in MIPS  
• Reduce reporting requirements or increase data/feedback to increase engagement |
| Systemwide Alignment | • Share specialty data across payers and providers, support alignment when possible for efforts driven by states, purchasers, and MA |

## Proposed Transition Based on ACO Attribution

<table>
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<tr>
<th>Beneficiaries Not in ACO Today</th>
<th>Beneficiaries Attributed to MSSP ACOs</th>
<th>Beneficiaries in Advanced APMs</th>
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</table>
| - Fee-for-service modifications to support transition to longitudinal specialty care and payment models (e.g. differential lower MIPS update, FFS adjustment in MIPS linked to performance on measures similar to those used in APMs, longitudinal care coordination payment), further alignment of MIPS Value Pathways to support transition | - Mandatory transition to SCMs for hospital-led/integrated ACOs, required adoption of condition-level quality and equity measures  
  - SCM templates/model contracts for physician-led ACOs, supported by sharing data on specialty practice performance  
  - Required adoption of condition-level quality and equity measures | - Flexibility to adopt own reimbursement arrangements within global payment as long as performance standards met  
  - Required adoption of condition-level quality and equity measures  
  - Implement complementary condition-based performance measures in MA STARS |

Short-Term Steps Toward Condition-Based Models

• Implement “Shadow Bundle” Reporting and Data Sharing for Lead Specialty Conditions
  o Suitable condition episode bundles exist, with many in use outside of Medicare – alternatives can be piloted in Medicare and in collaboration with other purchasers and payers
  o Complements potential BPCI-A based acute episode bundles to help accountable primary care groups identify promising specialty care partners, and work with specialists to improve longitudinal care
  o Provides clearer basis for developing and piloting condition-based payment reforms

• Improve Data Sharing and Measures to Support Improvements in Specialty Conditions
  o Develop and implement patient-centered, clinically relevant, outcomes-based measures (e.g., longitudinal functional outcomes, avoiding complications that lead to hospitalizations, measures of independence for dementia)
  o Develop range of model contracts for ACOs and accountable health plans, from modest PMPM payment with shared savings and risk to PMPM subcontracts by conditions – note that contracts can be implemented by specialty groups, advanced primary care practices, or combinations based on capabilities

• FFS Changes
  o FFS coordination payments for specialists
  o Adjustments to MIPS with support for Value Pathways at condition level
Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care Models

François de Brantes, MBA, MS
Senior Partner
High Value Care Incentives Advisory Group
PTAC Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care (PB-TCOC) Models

François de Brantes, MS MBA
Senior Partner, HVC Incentives Advisory Group LLC
What Matters to Everyone:

1. **Relevance & Actionability** – for any payment effort to succeed, it must be relevant to and actionable for those who participate. Cardiologists focus on cardiology, not cancer. Oncologists focus on cancer care, not orthopedics.

2. **Meaningfulness, Representativeness & Impact** – the conditions, procedures and treatments that are in scope must represent a sufficient portion of revenue and patient.
Example – Cardiology: Focusing on One Slice or Even a Portion of a Slice is Insufficient

- Acute events are all inpatient stays or ED visits. Inpatient acute events include 30 days post-discharge.
- Major procedures are all DRG-based. Costs include 30 days post-discharge.
- Minor procedures are all those performed in an outpatient facility and costs include same day facility and professional services.
Nesting Ensures Accountability Across the System

**Total Costs of Care (5,000 beneficiaries)**

- **Specialty Bundles (2,000 beneficiaries)**
  - Benchmark: $12,000
  - Actual: $11,500

- **Procedure Bundles (375 bundles)**
  - Benchmark: $10,000
  - Actual: $11,000

- **Total Costs of Care**
  - Benchmark: $10,000
  - Actual: $11,000

**HVC Incentives Advisory Group LLC 2023**

4
Reconciling Models – No Double Counting & All Rowing in Same Direction

The episode initiators for the procedure bundles receive $375K in savings. The episode initiators for the specialty bundles owe $2MM. The procedure benchmark costs are attributed to the specialty bundles (or TCC), giving the accountable entity an incentive to reduce the incidence of those procedures. The ACO receives $2.5MM in savings. The specialty bundle benchmark costs are attributed to the ACO.
The Net Effect

- Proceduralists are encouraged to optimize procedures, including selecting the most efficient site of service.
- Those managing the conditions are imputed the price/benchmark of each procedure so they are highly motivated to perform procedures when they are appropriate – and only then.
- Those managing the conditions are also motivated to provide the right level of care to the patient because any acute exacerbation will count against the benchmark.
- Those accountable for the total costs of care of the plan member are motivated to appropriately refer to specialty care providers to whom risk has been delegated and to select the providers who have the most favorable benchmark, creating competition among specialty care providers.
Thank You
Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care Models

Rozalina G. McCoy, MD, MS
Associate Professor of Medicine
Mayo Clinic
Implementing Nesting in PB-TCOC Models

Patient Attribution

Rozalina G. McCoy, MD MS
Division of Community Internal Medicine, Geriatrics, and Palliative Care
Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery
Mayo Clinic, Rochester, MN
Who is Responsible for my Patient with Diabetes?

Patient & Family

PCP (MD)

PCP (NP/PA)

Care Team RN

Psychologist

Endocrinologist

CDCES

Pharmacist

Dietician

Community Paramedic
Challenges to Patient Attribution

- Lack of a designated primary care clinician
- Obtaining care from multiple physicians and advanced practice providers (APPs) in multiple networks that may use multiple electronic health records
- Variation in the quality of and access to the data sources that define the patients’ interaction with the healthcare system
- Desire to assess outcome measures rather than process or structure measures, which cannot be easily attributed to multiple accountable entities
- There is no gold standard for attribution
- Different attribution methods produce vastly different measurement results
- There are >170 different attribution models currently proposed or in use

Cantor MN. JGIM. 2020;35: 3691–3693
Current State of Attribution Methods

Type of Provider Attributed

- Other/Unknown
- Specialist
- Physician group
- PCP preferred
- PCP
- Facility
- Any physician
- ACO

Exclusivity of Attribution

- Multiple providers
- Single provider
- Unknown
Challenges to Patient Attribution in PB-TCOC Models: Moving beyond dyadic patient / primary care physician attribution

• Specialist involvement
  • Increasing patient multimorbidity and growing complexity of chronic disease management have resulted in greater specialist involvement and higher number of involved specialists

• Team-based care
  • Advanced Practice Providers (APPs): Nurse Practitioners (NPs), Physician Assistants (PAs), Clinical Nurse Specialists (CNSs)
  • Collaborative practice agreements with pharmacists
  • Clinical support staff: certified diabetes care and education specialists (CDCES), dieticians, podiatrists
  • Clinician extenders (potentially visible in claims): community paramedics, RNs, social workers and mental health specialists
  • Clinician extenders (not visible in claims): community health workers, health coaches

• Non-visit care
  • eVisits (patient-initiated and clinician-initiated)
  • Care coordination and case management
Specialist Integration within Primary Care

Each model results in different E&M claims patterns.

Model can change as the patient's complexity and needs change.

Different models can be employed for different specialists within the same patient and system.

Stand alone specialist:
- Integrated (closed) healthcare system
- Integrated (open) healthcare system
- Regional referral practice
- Destination referral practice

Co-located specialist:
- Consultative with visits
- Consultative without visits
- Co-management with visits
- Co-management without visits

Different models can be employed for different specialists within the same patient and system.
Each model results in different E&M claims patterns

Model can change as the patient's complexity and needs change

Different models can be employed for different specialists within the same patient and system
Specialist Engagement Level Is Not Static

- **Early (mild) disease**
  - Management by the primary care clinician and team

- **Serious disease requiring specialty guidance**
  - Specialist consultative model with one-time or episodic encounters

- **Advanced (dominant) disease**
  - Specialist co-management model, often with involvement of the specialist’s clinical team
  - Variable levels of communication, coordination, and integration with primary care

- **End-stage disease (palliative goals of treatment)**
  - Management by the primary care clinician and team, with engagement of specialist(s) as needed for palliative symptom management

Specialist Engagement Level Is Not Static
Different Attribution Models for Different Needs

Patient Population

Accountability Program

Measures

1. Outcome
2. Cost
3. Quality

Accountable Units

STEP 1: Identify the Accountable Unit(s)

1. Ask the patient!

2. Use claims data
   a. **Timing**: retrospective vs. prospective
   b. **Duration**: 1 vs. 2 vs. ??? years
   c. **Unit of comparison**: claims/visits vs. costs/spending
   d. **Eligible claims**: well-visit E&M, routine visits E&M, consultation E&M, non-E&M
   e. **Eligible clinicians**: primary care clinicians + ????
      a. How are NP/PAs categorized?
      b. How are trainees categorized?
      c. How to recognize team-based care?
   f. **Exclusivity**: single vs. multiple attribution (both: with or without a minimum threshold)
   g. **Assignment threshold**: plurality (with or without a minimum threshold) vs. majority
STEP 2: Assign Responsibility

**Single vs. Shared Accountability**

- Single accountable clinician
- Shared accountability among multiple clinicians

**Identify accountable clinician (for clinician metrics)**

- Using attribution rules, preference usually given to PCP (with or without minimum % of claims) → disease-concordant specialist → other specialist → no attribution
- Using attribution rules (one touch vs. multiple approach), assign shared responsibility to PCP and disease-concordant specialist(s) based on distribution of eligible claims

**Identify accountable team/system (for team or system metrics)**

- Single team or system is accountable, based on location of the PCP (if identified) or else another accountable clinician
- Multiple teams or systems are accountable, based on the locations of accountable PCP and disease-concordant specialist(s)
Weighted Multi-Attribution Models

Allow patients to be attributed to all clinicians involved in their care based on predetermined weights

Need a single, gold-standard, fair model

Examples from other industries

Player “win shares” calculated for the NBA
Multi-touch attribution algorithms used for internet marketing
Final Thoughts on Attribution

- Encourage patients to choose a primary care clinician (self-attestation) if possible
- Patients should be attributed to entities who can influence care and outcomes
- Attribution methods should be reliable and valid
- Attribution methods should be fair and equitable to both patients and providers
- Test, verify, and review attribution models
- Provide transparent, timely, and actionable information to patients and clinicians about their attribution
- Align attribution methods across different health plans and populations, and for performance measurement and financial accountability
- Prioritize quality measures ascertained at the care team or health system level, rather than individual clinician level to recognize and acknowledge team-based care
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Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care Models

Lili Brillstein, MPH
Chief Executive Officer
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PTAC Listening Session

Specialist Engagement
in Episodes & Other Models Nested within
Population Health-based Total Cost of Care Models

Lili Brillstein, MPH
CEO Bcollaborative

March 2, 2023
ACA Goal: Create Accountability Related to Care Quality, Patient Experience & Cost of Care. We are Not Quite There.

Where We Are:
Well Established Accountable Care Organizations (ACOs)
- Population Health
- Most principally focused on primary care
- Very small percentage of specialists engaged in specialty care VBC arrangements, in spite of their accounting for majority of complex care delivery and overall healthcare costs.

Moved from FFS unit silos to more “collaborative silos”
- PCMHs, ACOs and Episodes Of Care or Bundled Payments all developed independently.
- Moved from FFS units of cost/care to more collaboration and efficiencies, but care remains siloed (i.e., PCMH and ACOs focus primarily on primary care while EOCs and BPs focus primarily on specialty care)

Glide path to comprehensive collaborative, fully accountable care

Integration of Specialty with Primary care models required to create medical neighborhoods that can care for patients’ comprehensive needs while establishing larger scale efficiencies.
Perception is the Reality we must Address

Specialists are Fearful & Concerned

The Fears & Concerns

- Lack of Trust
- Loss of Ability to Make Clinical Decisions
- Fear of Risk
- Loss of Revenue
- Loss of Practice Control
- “Cookbook” Medicine
- Increased Administrative Burdens and Time Required
Perception is the Reality we must Address

The Language we use Affects Perceptions

• “WE” have built a model for You – implies control; reduces trust; creates discord
• Anything “Mandatory” implies power imbalance
• Bundled Payments – no reference to patient care, quality or experience; only money; supports perception that Payers are concerned only with money
• Value-based Care – perception of bargain shopping
Rather than inviting Specialists in to tell them what you’ve built, invite them to build it with you.

**Collaboration at every stage**
- Model design
- Data Review
- Metrics
- Program Refinements

**Recognize & Respect All Stakeholders**
- Leverage expertise of each stakeholder (Specialists & Others)

**Partnership**
- Nothing Designed by either partner without the other
- Model must be clinically meaningful and able to be administered

**Keep It Simple**
Considerations for Incentivizing Specialists

• Respect that each Specialty is Unique
  • Disease treatment pathways
  • Acute, Procedural, Chronic
  • One specialist does not represent all
  • Physicians managing the on-going care for those with chronic conditions have different time-frames than those who do not
    • These specialists act as the principal physician for these patients. Care is not episodic in nature, and outcomes are often on a longer time-frame. Consider financial arrangements similar to primary care, where some support and funds are provided up front.

• Invite Specialists to be represented in Leadership and on ACO Governance Boards & Committees
  • Specialists control the majority of care and spending – ensure that they are adequately represented
  • They do not want to be led/directed by Primary Care Physicians
Considerations for Incentivizing Specialists

• **Create financial models that do not immediately put specialists at a loss**
  - Like with primary care, be willing to provide financial and other support up front, rather than putting Specialists at an immediate loss
  - Keep focus on long term improvements in care and costs of care, rather than immediate ROI
  - Inquire about what they perceive they need
  - Establish no/low risk models to encourage engagement and collaborative learning on the path to more financial risk

• **Share longitudinal data to assess opportunities for engagement, collaboration, and improvement**
  - Specialists often have no information about what happens to the patient once they leave their office

• **Cultivate and Nurture Relationships**
  - Ongoing Communication
  - Regular cadence of Collaborative review of challenges, successes
  - Trusted Advisors
The Spirit of Collaboration will bring us closer to Comprehensive Accountability for Care Quality, Patient Experience & Cost of Care

- More comprehensive, well-informed, collaborative care
- More Consistent & Predictable Outcomes
- More Predictable Healthcare Cost/Spend
- Care rendered by well-informed, happily engaged physicians
Thank You

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