



C-TAC *Innovations*

*ADVANCED CARE MODEL,
CARE DELIVERY
& ADVANCED APM*

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Guiding Principles

Support timely, nimble, and flexible implementation of the Advanced Care Model

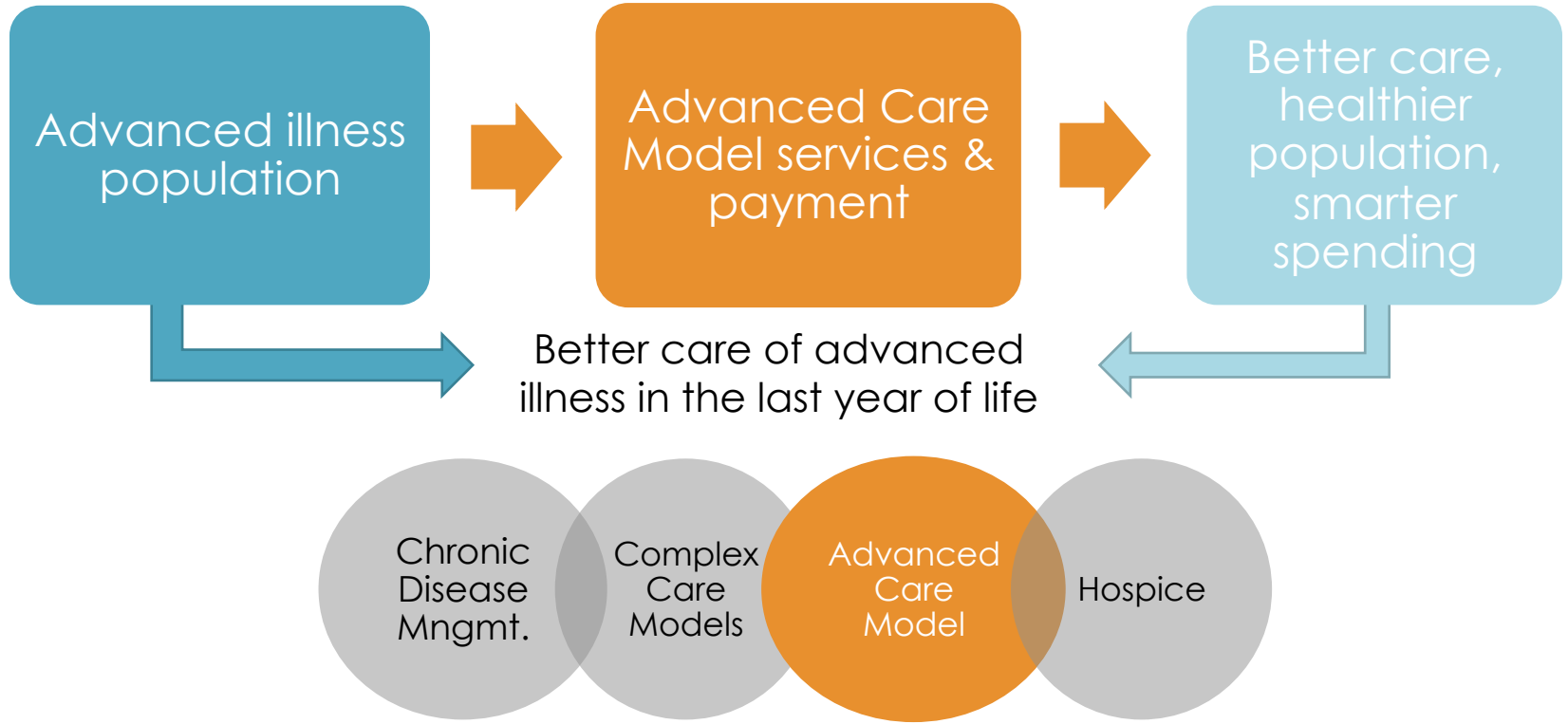
Integrate and strengthen other value-based CMS models

Align with MACRA Physician Quality Payment Program

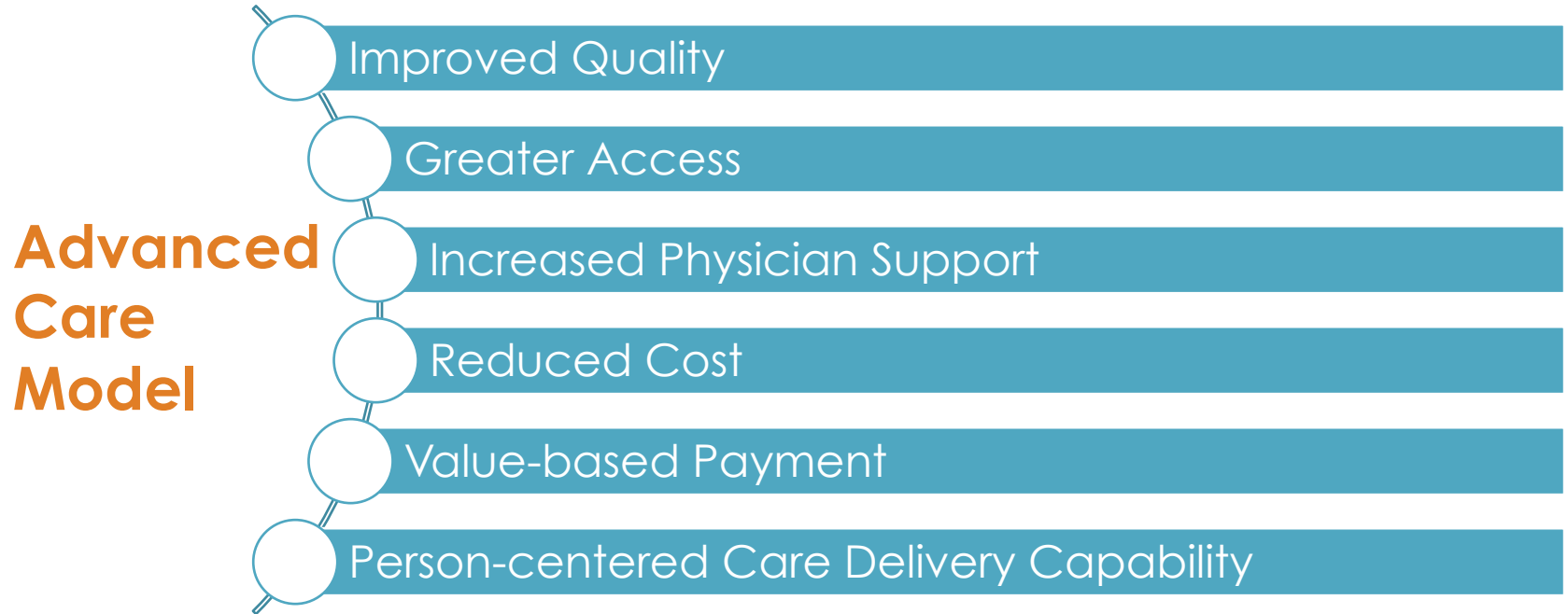
Coordinate existing provider capabilities or promote investment in new capacity

Create a path to scale advanced illness care nationally

Context for Demonstration Project



Improving Care for Advanced Illness



Advanced Illness Population

One or more chronic conditions

Recurrent or extensive disease: acute care utilization, functional decline and/or nutritional decline

High 1-year mortality risk

Identifying Target Population

1. Prospective selection

- Chronic conditions associated with early mortality

2. Eligibility screen: program level

- Active decline: clinical & utilization data

3. Retrospective evaluation

- 1-year mortality $80\pm 5\%$

Model Services

Comprehensive,
person-centered
care management

Interdisciplinary team
approach

Customized mix of
curative & palliative
care, coordinated
among inpatient,
ambulatory & home
settings

Systematic advance
care planning

Patient/family
engagement

24/7 availability of
contact with clinician

Metrics Tied to Payment

| Domain | Metric | Data Source |
|---------|--|-------------|
| Quality | 1. Level of symptom control | Survey |
| | 2. Level of decision support | Survey |
| | 3. Hospital admissions, last 12 months of life | Claims |
| | 4. ED visits, last 12 months of life | Claims |
| | 5. ICU days, last 12 months of life | Claims |
| | 6. Hospice LOS (average & median) | Claims |

Metrics Tied to Payment cont.

| Domain | Metric | Data Source |
|--------|--|-------------|
| Access | 1. Visit within 48 hours of hospital discharge | EHR/Claims |
| | 2. Responsiveness to emergent medical issues | Survey |
| | 3. Evidence of advanced care planning within 14 days of enrollment | EHR/Claims |
| | 4. Advanced Directive completion rate | EHR/Claims |
| | 5. POLST completion rate (or equivalent, e.g. Code Status) | EHR/Claims |

Metrics Tied to Payment cont.

| Domain | Metric | Data Source |
|---------------------|---|-------------|
| Person-centeredness | 1. Person-centered goals documented in routine care notes | EHR/Claims |
| | 2. Care/treatment consistent with preferences | EHR/Claims |
| | 3. Level of confidence in managing illness | Survey |
| | 4. Composite patient satisfaction score | Survey |

Payment Model Structure

- Overall goals:
 - Support provider investment in infrastructure
 - Create ROI opportunity for providers, especially integrated systems
 - Help providers migrate from FFS to risk, population health
- New alternative payment model (APM), eligible for advanced APM
- Payment model components:
 - Care management fee: PMPM
 - Population-based payment: shared savings & shared risk
 - Integration with existing value-based payments
 - Support specialists and primary care provider participation for physician-focused payment

ACM Payment Components

PMPM* \$400
Wage-adjusted

*Per enrolled member per month

- Cover care management and ambulatory palliative care provider E&M visits
- Up to 12 months per enrollee
- Ends at death, hospice enrollment, healthy discharge, or disenrollment
- Included in the total cost of care calculations

Phase 1:

- Shared Savings

Phase 2:

- 2-sided Shared Risk

- Metric: Total cost of care in last 12 months of life
- Impact size must be statistically significant
- Compared to a matched cohort of patients in the region
- Minimum quality threshold requirement
- Underperforming programs will be required to drop out
- Small proportion of healthy discharges will not be counted in the shared risk payment, evaluation of this cohort to be conducted at the end of pilot

Shared Risk Model

| Model | ACO Tracks 2-3 | Next Gen ACO | ACM |
|---------------------|----------------|----------------|--------|
| Shared Savings Rate | 60-75% | 80-85% or 100% | 75-85% |
| Total Saving Limit | 15-20% | 15% | 30% |
| Shared Losses Rate | 60-75% | 80-85% or 100% | 75-85% |
| Total Loss Limit | 5-10% | 15% | 10% |

Other ACM ACP Components:

- \$400 PMPM up to 12 months
- Bear nominal total risk of 4%
- Phased-in timeline over 1 year

Program Level Patient & Spending Target Attribution

Options:

- By Defined PCPs
- By Defined Specialists
- By Defined PCPs & Specialists

| Integration Options | Applicable APMs/PFPMs | Impact |
|---|--|---|
| Migrate Over to ACM | <ul style="list-style-type: none"> Models with shorter duration: OCM, Bundles, Migrate over at the end of episode | <ul style="list-style-type: none"> Patients and shared savings attributed to ACM |
| | <ul style="list-style-type: none"> Models with lower payment or shared risk potential: IAH, future PFPMs, CPC+ Migrate at identification | |
| Subset/ Layered Payment within Other Models | <ul style="list-style-type: none"> Shared savings program | <ul style="list-style-type: none"> Two-sided risks determined at ACO level ACM maintain down-sided risk for Track 1 Patients & shared savings attributed to MSSP |

Advanced APM Eligible

| Advanced APM Requirements | Advanced Care Model Fit |
|---|-------------------------|
| Certified EHR Technology*: <ul style="list-style-type: none">• 50% use by eligible clinicians PY1• 75% use by eligible clinicians PY2 | ✓ |
| Payment-based quality measures comparable to MIPS Quality Performance Measures <ul style="list-style-type: none">• At least 1 outcome measure | ✓ |
| Bear more than nominal risk <ul style="list-style-type: none">• Total risk of at least 4%• Marginal risk of at least 30%• Minimum loss ratio of no more than 4% | ✓ |

**ACM programs may operate in a non-certified EHR, but electronically interact with providers' certified EHR*

Contact Information

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