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,
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Opportunities for Integrating Specialty Care Within Population-Based Payment Models

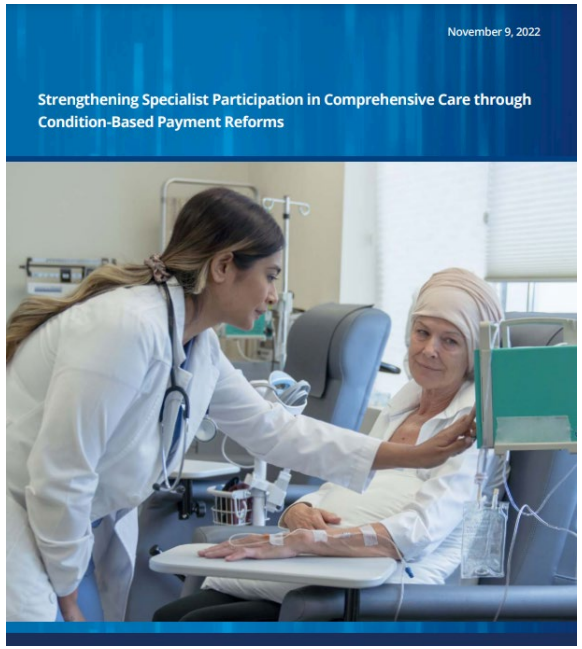
Mark McClellan, MD, PhD

Robert J. Margolis Professor of Business, Medicine, & Policy

Founding Director of the Duke-Margolis Center for Health Policy

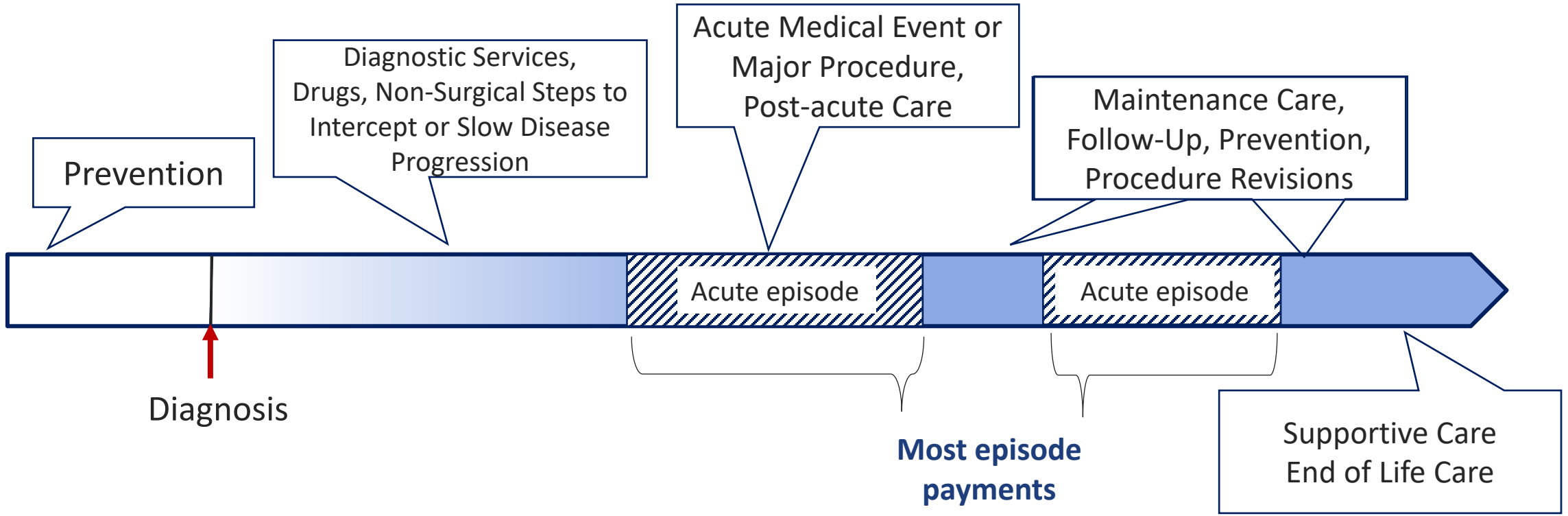
Current Duke-Margolis Specialty Care Initiatives

- 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



Components of care pathway generally influenced by specialty care

Source: Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms, https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

Major Types of Specialized Care

Specialized Care Episodes	• 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
Whole-Person Care	• 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
Longitudinal Coordinated Care	• 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

Focus For Today

Specialized Care Episodes	• 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
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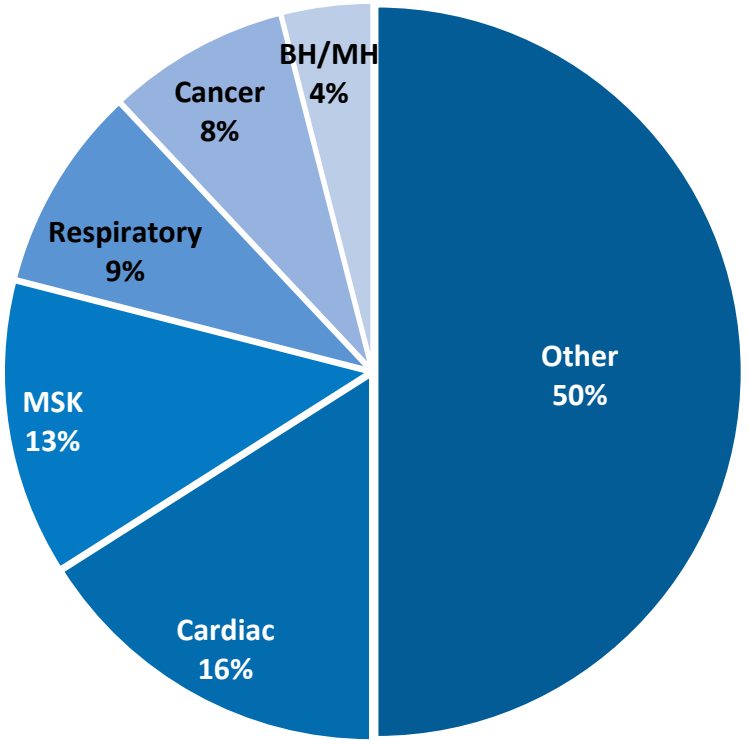
Relatively small set of specialty conditions drive significant share of Medicare beneficiary disease burden and spending



Important Considerations

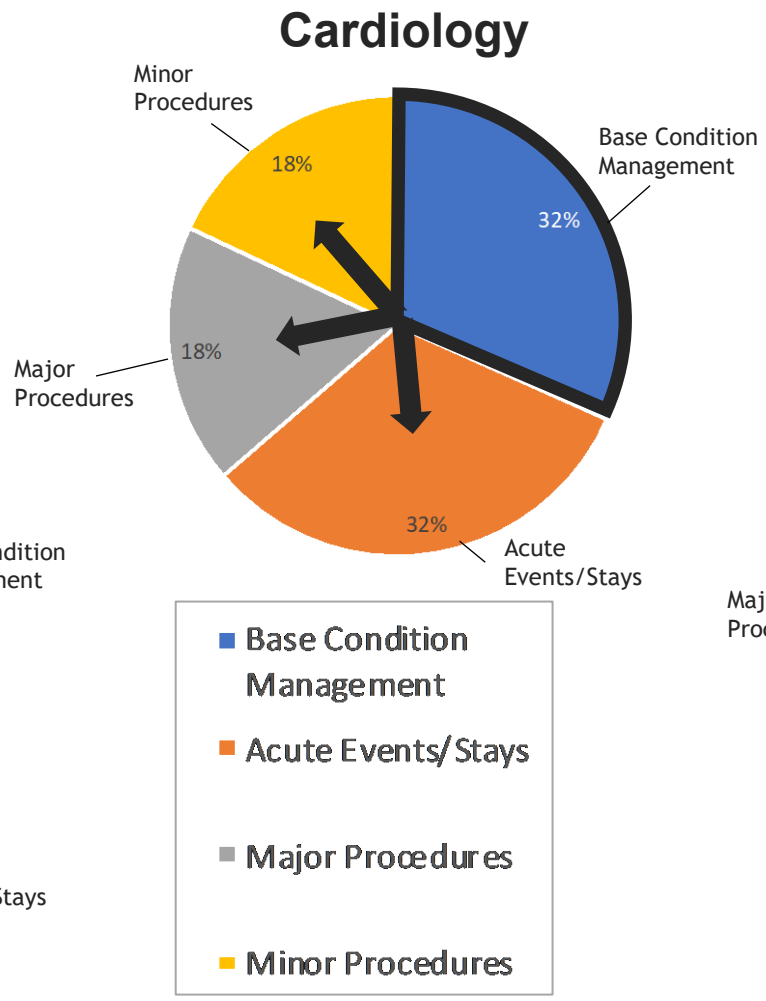
Cardiology and Musculoskeletal	Many procedures of low/no value – better longitudinal patient management and accountability can encourage appropriateness
Respiratory	Many acute hospitalizations could be avoided with better patient management
Cancer	Chemotherapy could be prescribed and administered more efficiently
Dementia and other mental health conditions	Worsens with age, often poorly managed today

Source: https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

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



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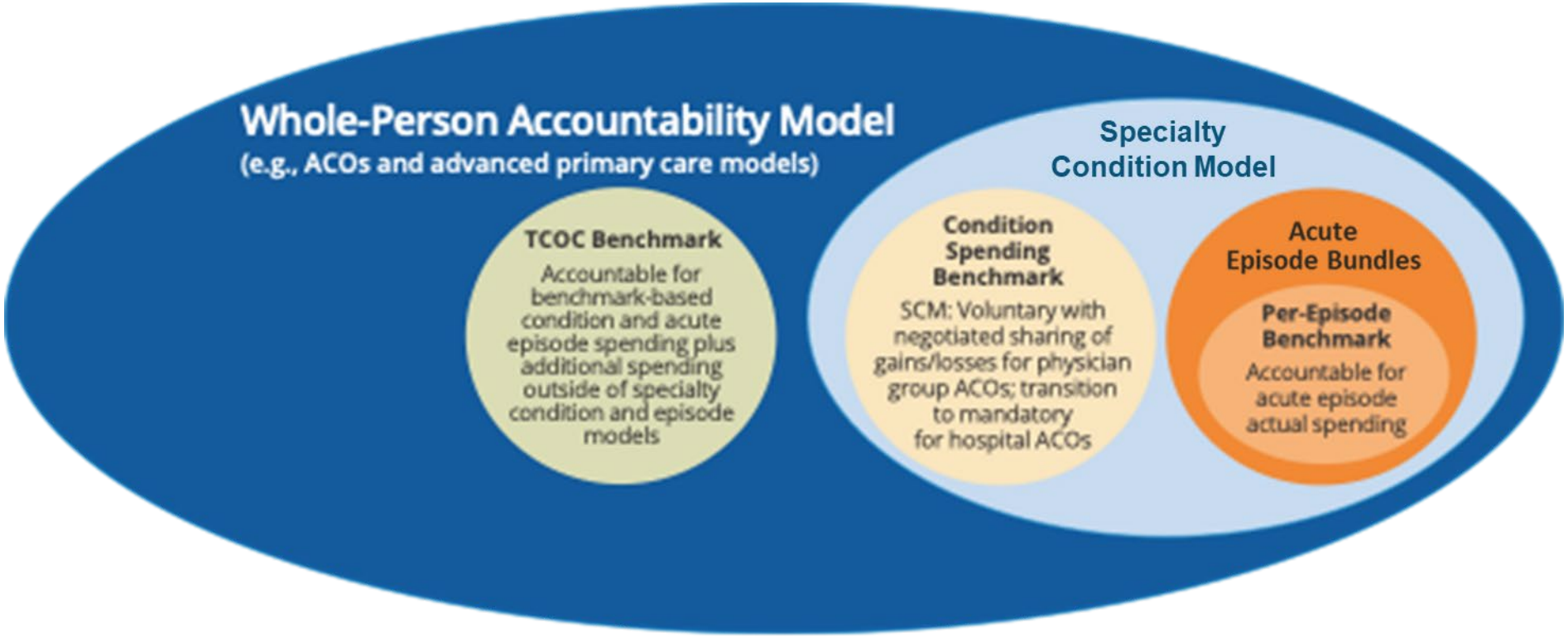
Specialty Condition Models (SCMs) to Improve Longitudinal Care for Specialized Conditions

- **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



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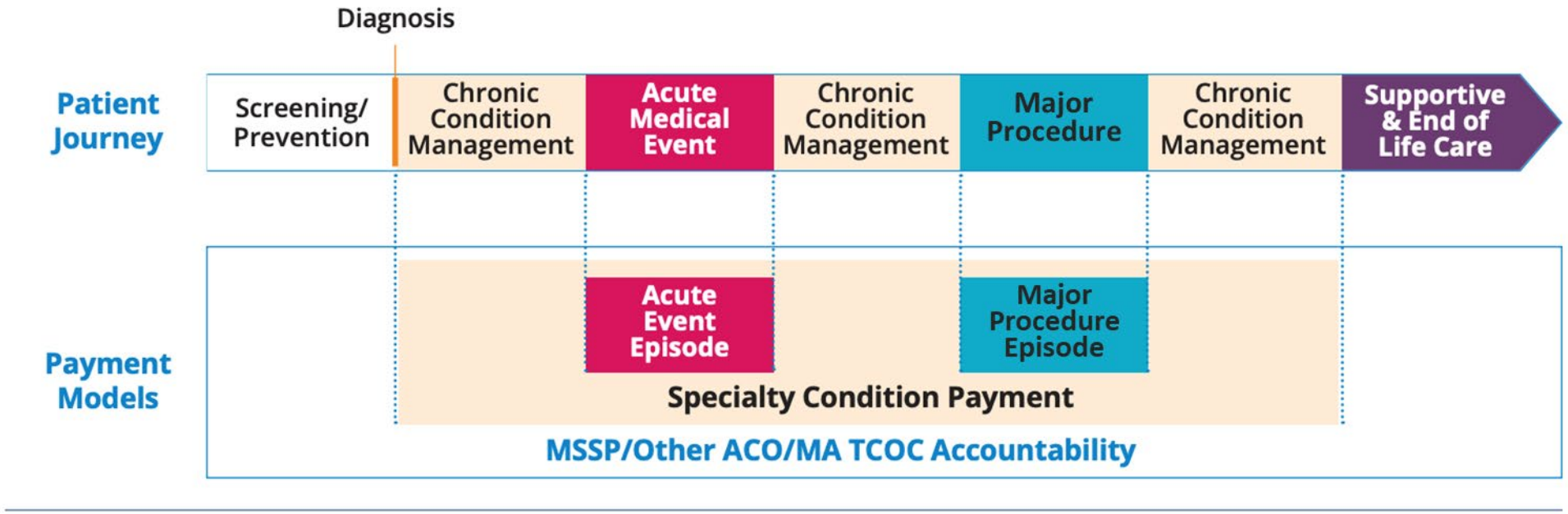
Nested Specialized Care Condition Models to Support Longitudinal Coordinated Care

FIGURE 6 Nested Structure of Payment Models



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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

Specialty Payment Reform Element	Key Steps
Implementation Pathway for Condition Payments	• 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)
Complementary/Nested Acute Episode Payments	• 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
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

Source: https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

Proposed Transition Based on ACO Attribution

Beneficiaries Not in ACO Today	Beneficiaries Attributed to MSSP ACOs	Beneficiaries in Advanced APMs
- 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

Source: https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

Short-Term Steps Toward Condition-Based Models

- **Implement "Shadow Bundle" Reporting and Data Sharing for Lead Specialty Conditions**
  - 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
  - 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
  - Provides clearer basis for developing and piloting condition-based payment reforms
- **Improve Data Sharing and Measures to Support Improvements in Specialty Conditions**
  - 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)
  - 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**
  - FFS coordination payments for specialists
  - Adjustments to MIPS with support for Value Pathways at condition level

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

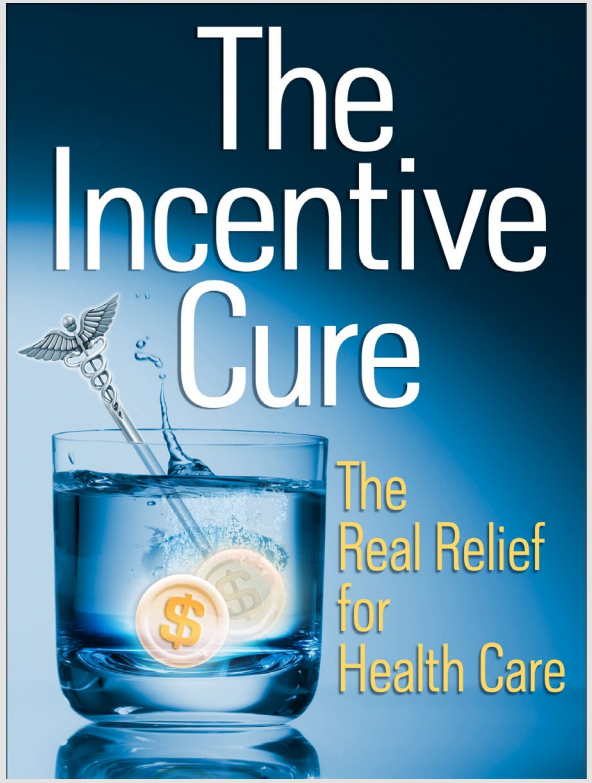
François de Brantes, MBA, MS

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

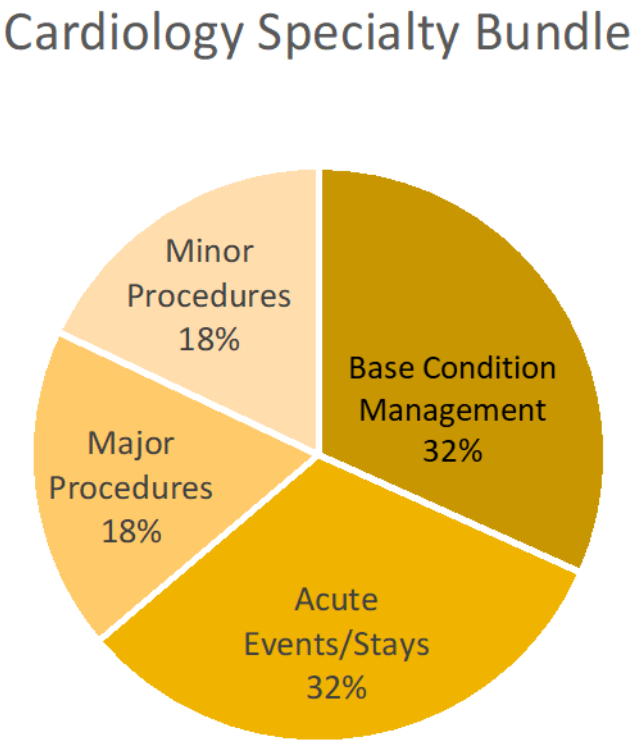


What Matters to Everyone:

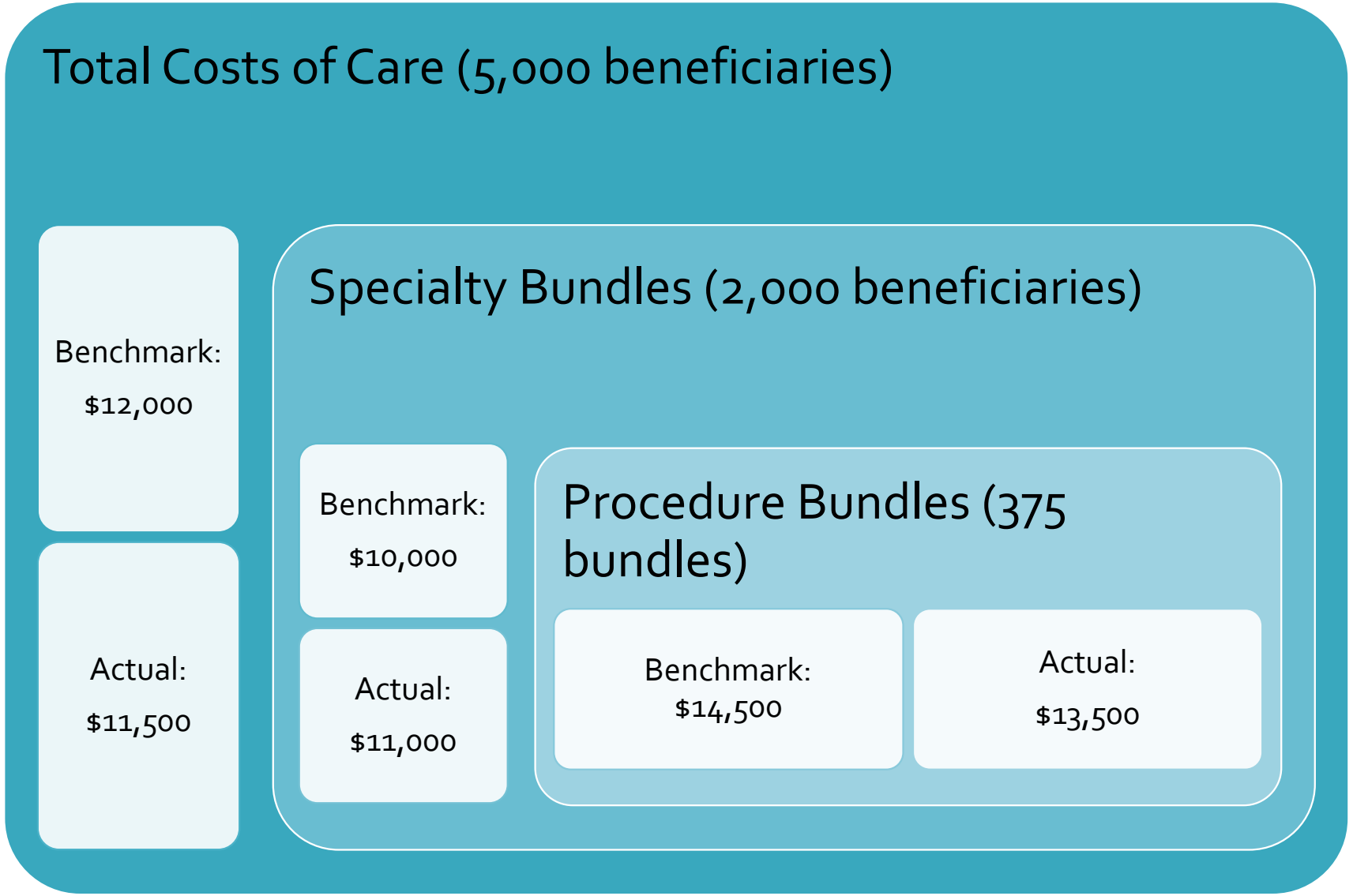
1. **Relevance & Actionability** – for any payment effort to succeed, it must be relevant to and actionable for those who participate. Cardiologists focus on cardiology, not cancer. Oncologists focus on cancer care, not orthopedics.
2. **Meaningfulness, Representativeness & Impact** – the conditions,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

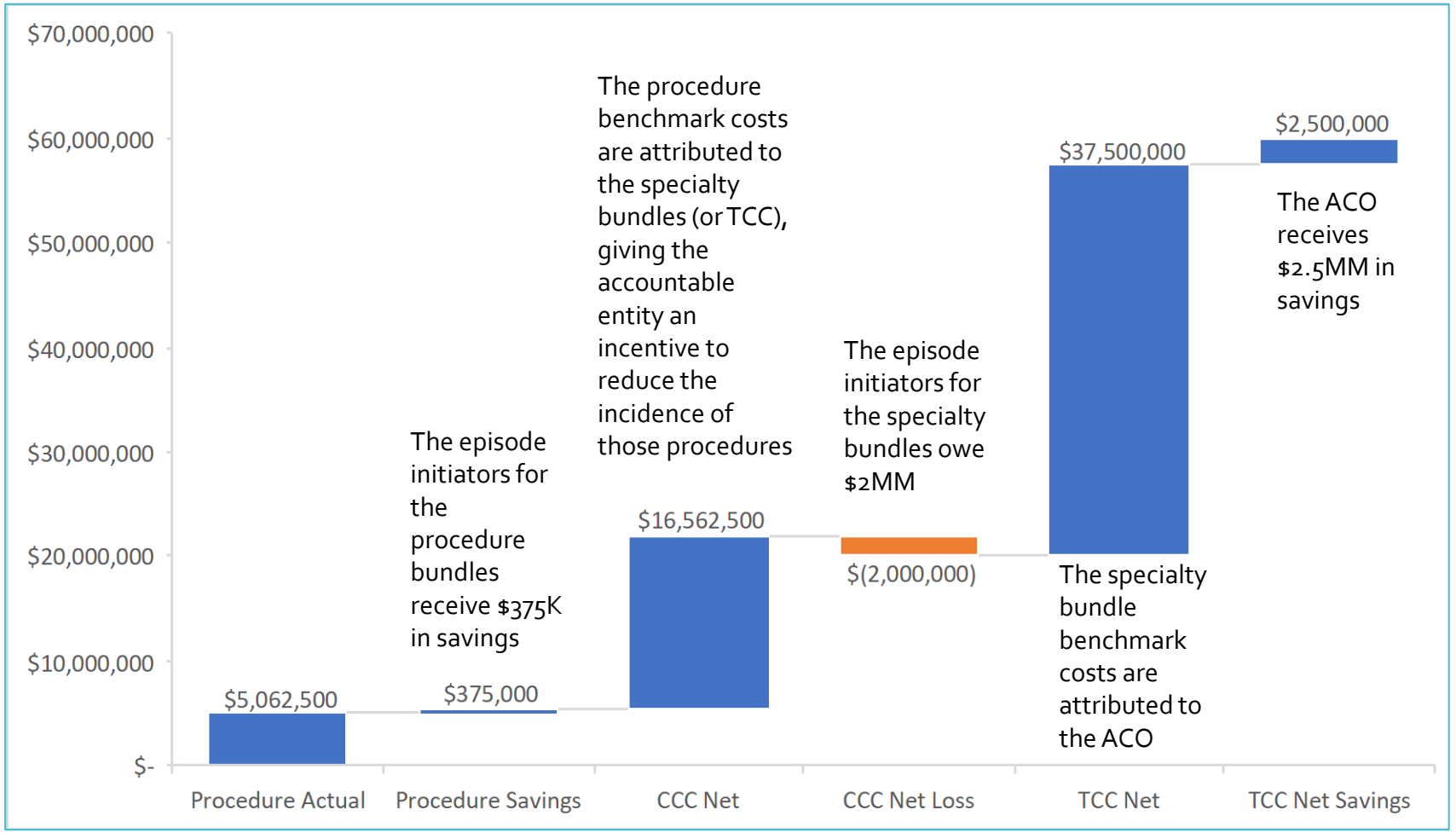
- Acute events are all inpatient stays or ED visits. Inpatient acute events include 30 days post-discharge
- Major procedures are all DRG-based. Costs include 30 days post-discharge
- Minor procedures are all those performed in an outpatient facility and costs include same day facility and professional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



Nesting Ensures Accountability Across the System



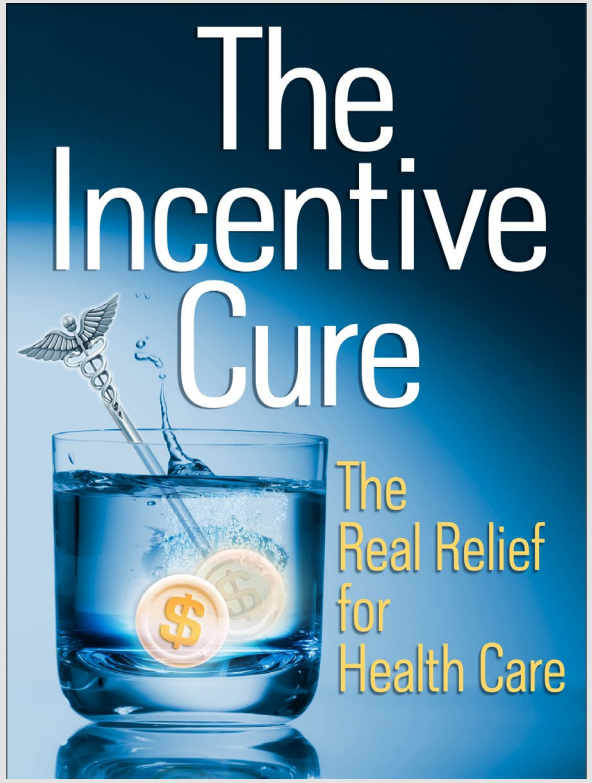
Reconciling Models – No Double Counting & All Rowing in Same Direction



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

MAYO CLINIC

Implementing Nesting in PB-TCOC Models

Patient Attribution

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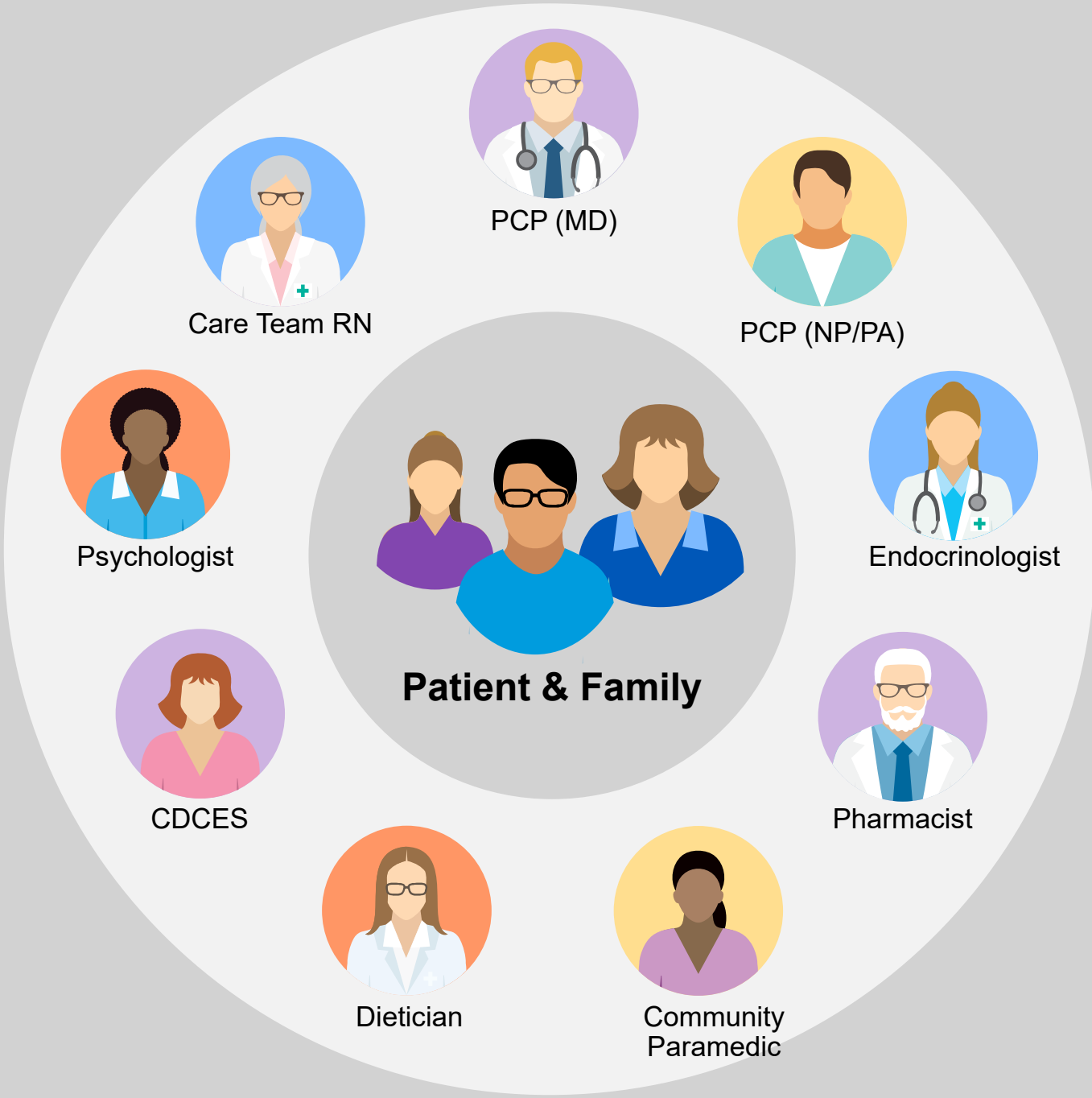
Division of Community Internal Medicine, Geriatrics, and Palliative Care
Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery
Mayo Clinic, Rochester, MN

Who is Responsible for my Patient with Diabetes?



Challenges to Patient Attribution

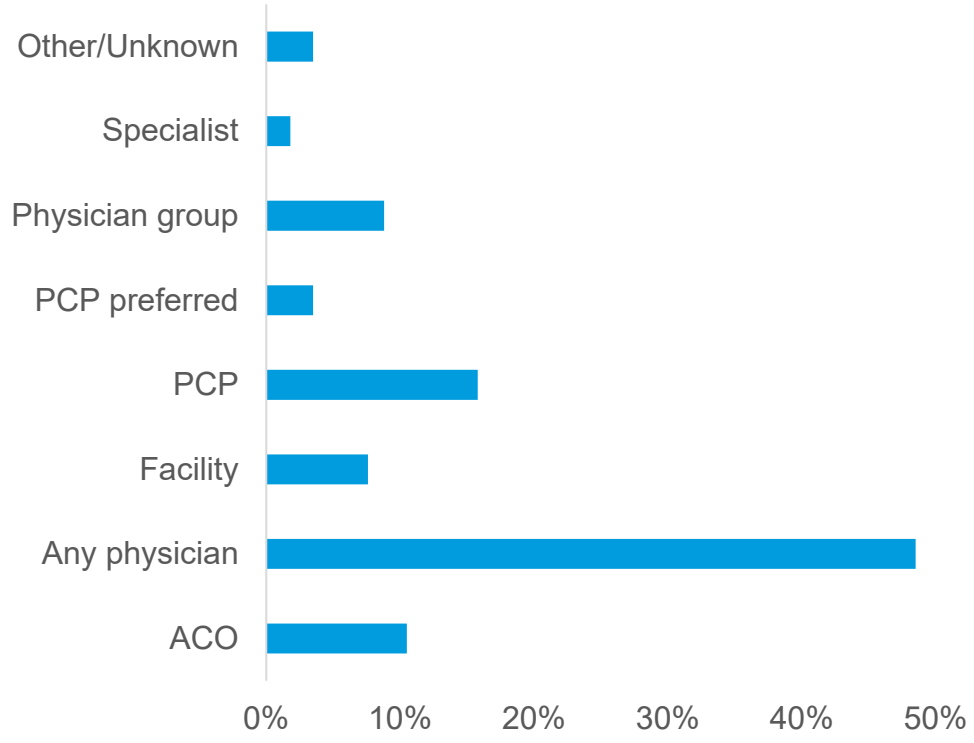
- Lack of a designated primary care clinician
- Obtaining care from multiple physicians and advanced practice providers (APPs) in multiple networks that may use multiple electronic health records
- Variation in the quality of and access to the data sources that define the patients' interaction with the 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

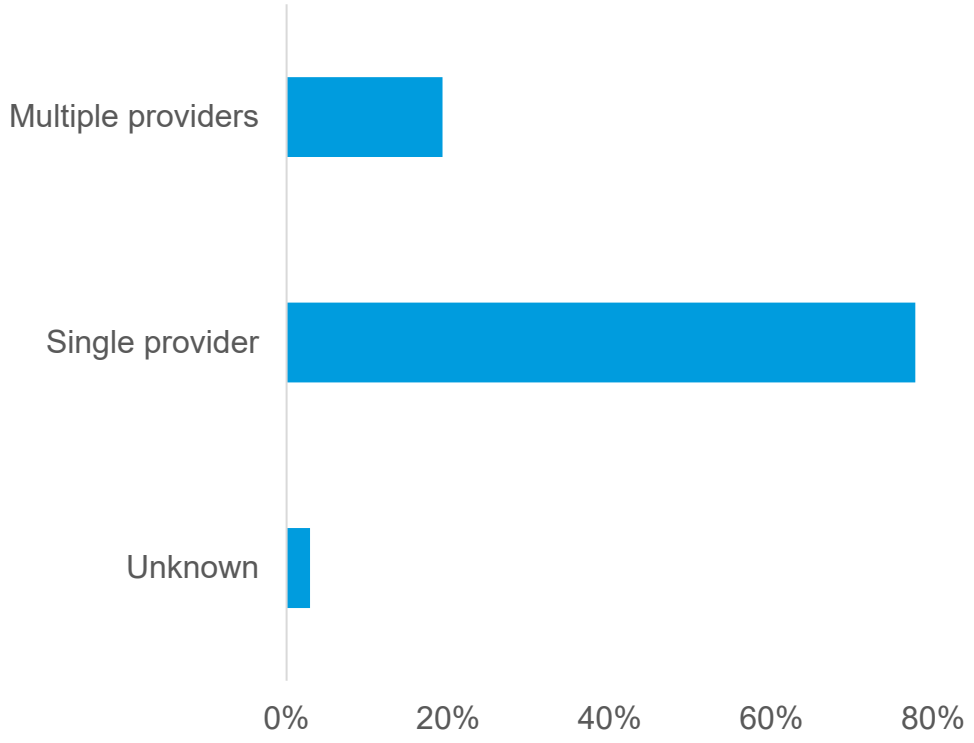
Cantor MN. JGIM. 2020;35: 3691–3693
Mehrotra A, et al. Ann Intern Med. 2017;167(6):434-5
Ryan A, et al. National Quality Forum 2016

Current State of Attribution Methods

Type of Provider Attributed



Exclusivity of Attribution



Ryan A, et al. National Quality Forum 2016

Challenges to Patient Attribution in PB-TCOC Models:
Moving beyond dyadic patient / primary care physician attribution

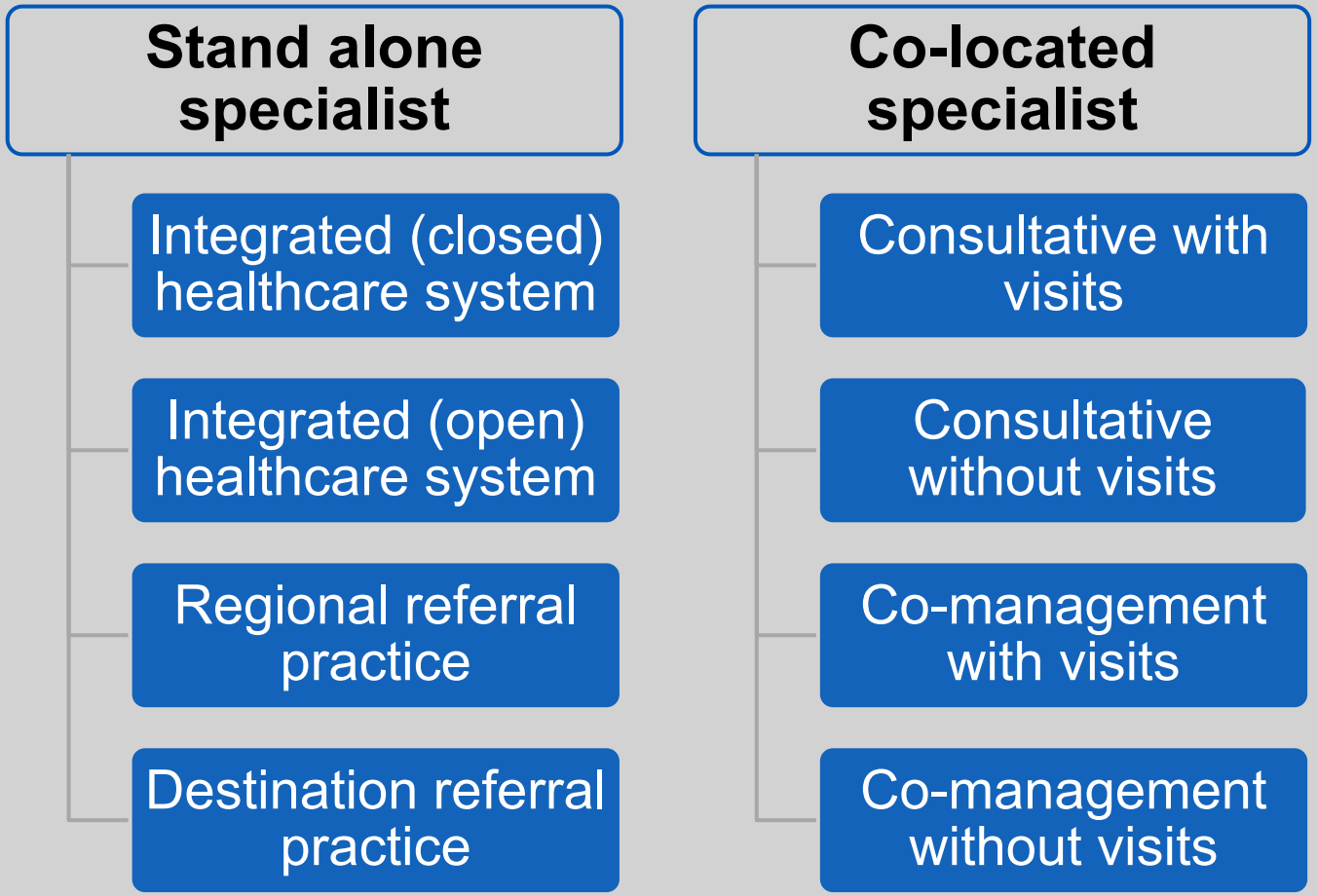
- **Specialist involvement**
  - Increasing patient multimorbidity and growing complexity of chronic disease management have resulted in greater specialist involvement and higher number of involved specialists
- **Team-based care**
  - Advanced Practice Providers (APPs): Nurse Practitioners (NPs), Physician 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

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 Integration within Primary Care



Physician & Advanced Practice Provider (APP) Collaborative Models

Each model results in different E&M claims patterns

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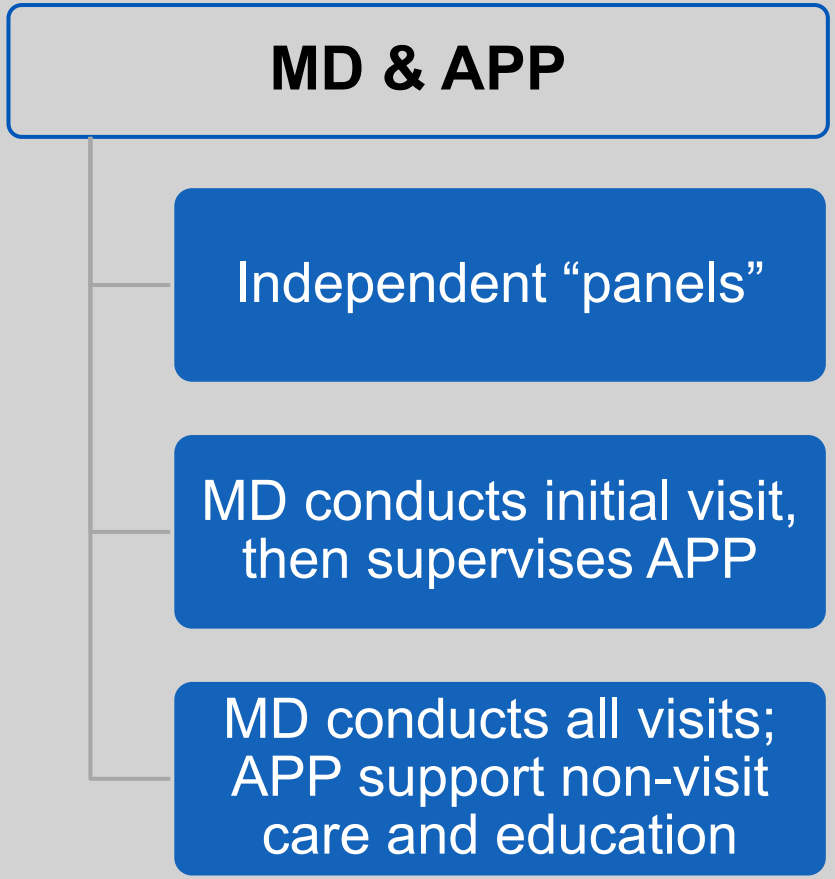
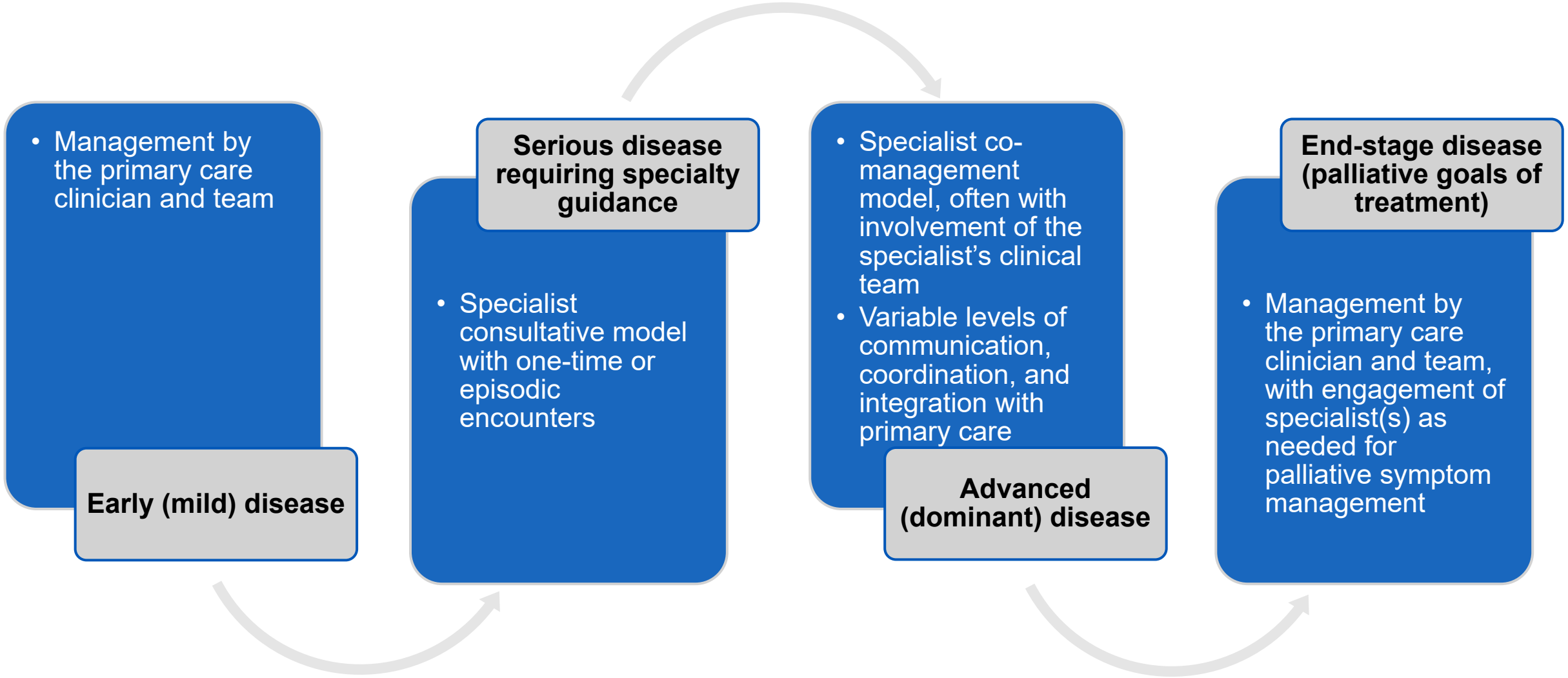
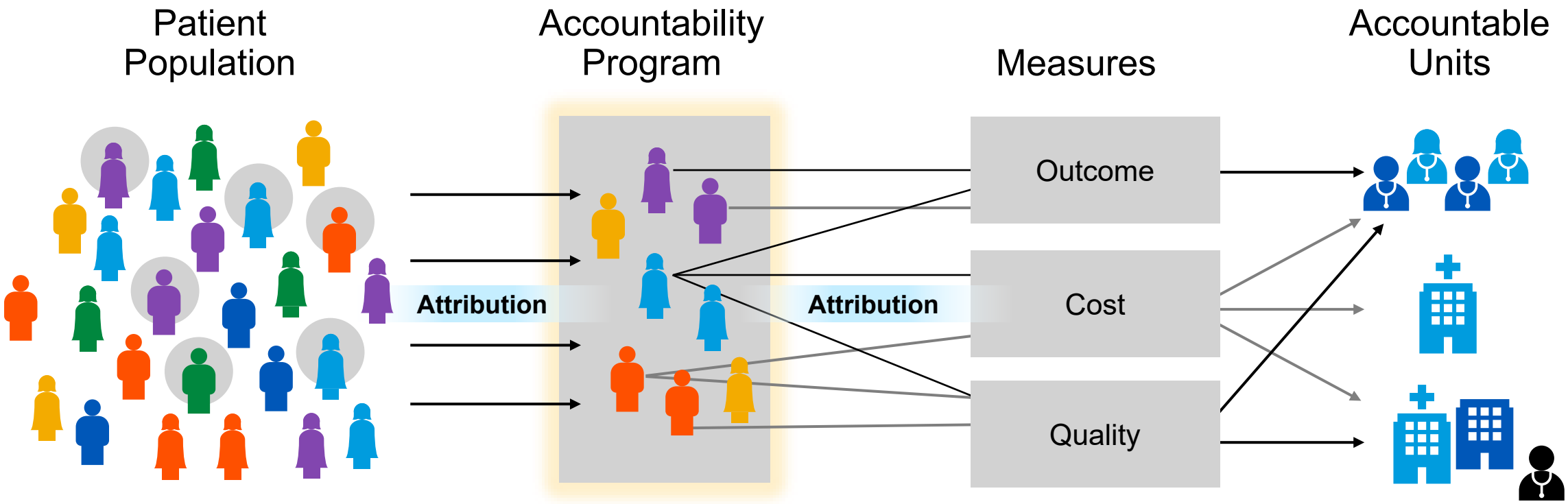


Specialist Engagement Level Is Not Static



Different Attribution Models for Different Needs



Ryan A, et al. National Quality Forum 2016

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

Cantor MN. JGIM. 2020;35: 3691–3693

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

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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

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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

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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

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Thank You

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