

# An Alternative Payment Model for CHRONIC CONDITIONS

Every chronic disease is different. Different treatments are needed for different diseases, the cost and effectiveness of treatments varies across different diseases, there are more alternative treatments for some diseases than others, and the severity of complications from overtreatment and undertreatment vary. There are additional differences and complexities when patients have additional health problems or face barriers in accessing healthcare services.

However, despite these differences, there are also many similarities in the opportunities for improvement, in the barriers that current payment systems create to improving care delivery, and in the ways in which payments could be changed to support higher-quality, more affordable care across a wide range of chronic diseases and combinations of diseases. This section will focus on some of the opportunities, barriers, and payment changes that are common to a number of different chronic diseases and combinations of diseases and how an Alternative Payment Model might address them. For simplicity, the term “chronic condition” will be used here to describe either a single chronic disease or a combination of two or more chronic diseases that need to be managed in close coordination.

## OVERVIEW OF THE APM

Under this APM, an individual who has the symptoms of a serious chronic disease or who has been diagnosed with the disease would choose one or more teams of providers that are participating in the APM to diagnose, treat, and manage the individual’s condition. Seven types of payments would be available under the APM in order to match the different kinds of services that the patient would need and the different outcomes that can be achieved during five different phases of care:

- 1. Diagnosis and Initial Treatment.** A Diagnosis Team would receive a one-time bundled Diagnosis and Initial Treatment Payment to cover most of the services needed to determine if the patient has the chronic disease, and if so, to treat the disease for an initial period of time. The payment would be higher for those patients who are diagnosed with the disease and initiate treatment.
- 2. Continued Treatment for Patients with Well-Controlled Conditions.** A Treatment Team would receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services for patients whose condition can be well-controlled with standard medications or other treatments. In some cases, the Treatment Team would be the same as the Diagnosis Team and in other cases it might be a different group of providers.
- 3. Continued Treatment for Patients With Difficult-to-Control Conditions.** If the patient’s condition proved

difficult to control during the initial treatment period or if it could only be controlled using special medications or treatments that require careful monitoring, a Treatment Team would receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services. The payment amounts would be higher than for patients with well-controlled conditions, reflecting the greater risk of complications and higher level of services needed.

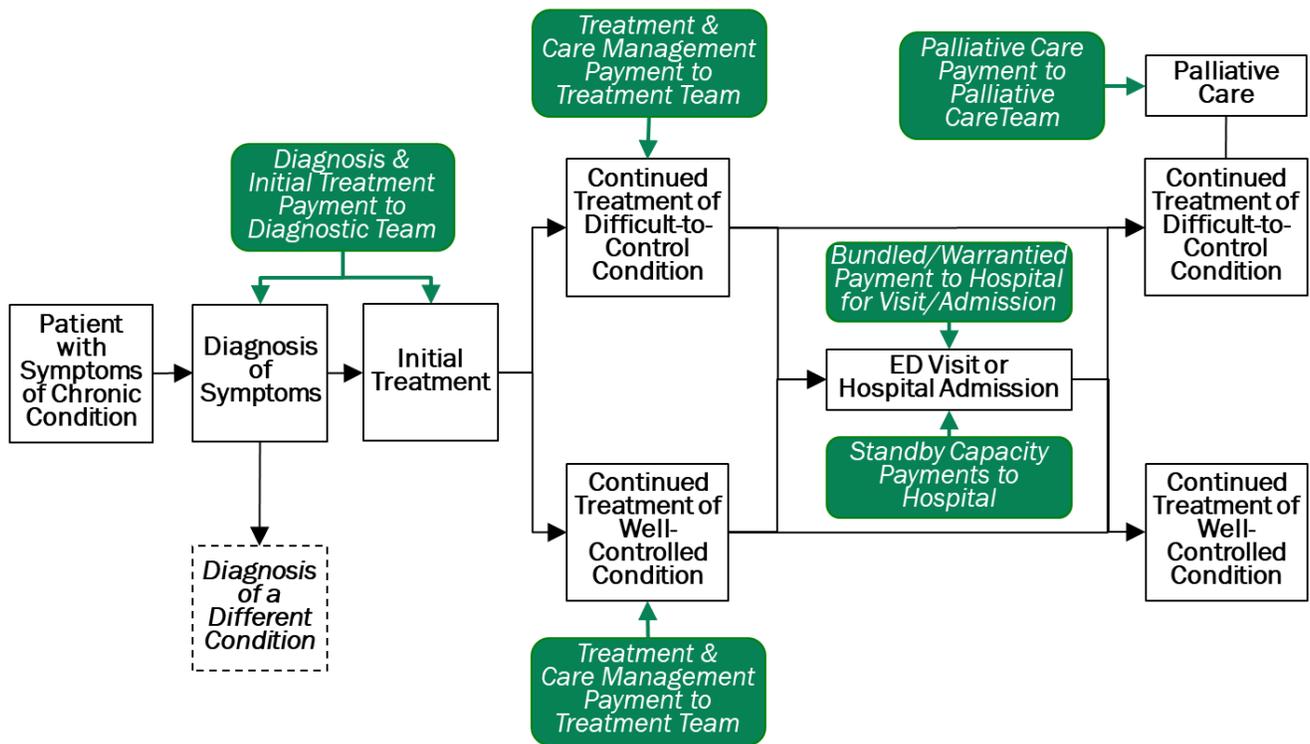
- 4. Hospitalization for an Exacerbation of the Condition.** Hospitals would receive three separate types of payments to cover the costs of their services to patients who need to be hospitalized for exacerbations of their condition:
  - a. A Standby Capacity Payment for each patient who has the chronic condition, regardless of whether they needed to be hospitalized.
  - b. A Bundled/Warranted Payment if the patient requires a visit to the Emergency Department or an inpatient admission for symptoms related to their chronic condition. This would cover all of the costs of the ED visit or hospital admission and any post-acute care services needed for 30 days following discharge that were not provided by the patient’s Treatment Team.
  - c. An Outlier Payment if a patient required an unusually large number of services.
- 5. Palliative Care for an Advanced Condition.** For patients whose condition has reached an advanced stage, a Palliative Care Team could receive a monthly Palliative Care Payment to provide palliative care services to the patient in addition to any treatment or care management services the patient was receiving from a Treatment Team.

The payments in each phase would be stratified into several need/risk-based categories so that higher payments are made for patients who have characteristics that typically require additional or more expensive services. The patient’s need/risk classification could change at any time, and subsequent payments would reflect the new need/risk category.

Diagnosis Teams, Treatment Teams, hospitals, and Palliative Care Teams would receive no payment for a patient if the Team failed to meet evidence-based care standards in providing services to that patient. Payments to a Team or hospital would be reduced if desirable outcomes were not achieved. Treatment Teams would receive no payment for low- and moderate-risk patients if the patient visited the ED or was hospitalized.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable emergency department visits and hospital admissions and by reducing the utilization of unnecessary medications, tests, and other services.

## PHASES OF CARE AND ASSOCIATED PAYMENT COMPONENTS IN AN APM FOR MANAGEMENT OF A CHRONIC CONDITION



## DETAILS OF THE APM

### 1. Opportunities for Savings and Quality Improvement

Treatments for chronic diseases represent a large proportion of total healthcare spending for most payers, particularly Medicare. There are a number of important opportunities for reducing unnecessary and avoidable spending on patients who have chronic diseases in ways that would improve outcomes for the patients:

- Many individuals visit multiple physicians and undergo repeated or unnecessary testing before receiving a diagnosis and initiating treatment.
- Many individuals are incorrectly diagnosed, resulting in unnecessary, expensive, and potentially harmful treatment for the wrong disease and delays or failure to receive the correct treatment.
- A variety of expensive new drugs have been developed to treat chronic diseases; these drugs are more effective than traditional drugs for some patients, but using them for every patient increases spending without any benefit for many patients.
- Many patients with a chronic illness are admitted to the hospital because the symptoms of their illness become uncontrolled and sufficiently severe that they require inpatient treatment. Reducing the frequency

of these unplanned, expensive hospital admissions would reduce spending for both the patient and their health insurance plan. In addition, avoiding the hospitalizations will reduce the risk of the patient developing additional health problems during their hospital stay (e.g., a hospital-acquired infection) that could require additional treatment and spending.

- Many patients who are hospitalized for a chronic disease exacerbation, particularly older patients, spend time in a skilled nursing facility (SNF) after discharge rather than returning directly home. These SNF stays are also expensive, and they can also cause additional health problems, so finding ways to provide post-acute care services in the home can be better for patients as well as reducing spending for payers.
- In some cases, patients are not receiving treatments or assistance that could slow the progression of their disease and delay the need for more intensive and expensive treatments.
- Patients with advanced illnesses often receive expensive treatments that have little clinical benefit and can result in reduced quality of life and increased rates of hospitalization in the days and months prior to their death.

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## 2. Changes in Care Delivery Needed and Associated Costs

### a. New and Different Services to Be Delivered

A variety of demonstration projects have shown that delivering additional services and delivering services in different ways can improve care and reduce spending in these various opportunity areas. For example:

- Electronic consults and telehealth visits with specialists can enable many patients to be diagnosed more efficiently and accurately, particularly patients who live in rural areas where there are shortages of specialists and patients who have difficulty traveling to medical appointments.
- Taking the time to consult evidence-based guidelines and to engage in shared-decision making processes with patients can enable physicians to reduce utilization of expensive treatments that would have little or no benefit for the patient.
- Patient education and self-management supports can help patients reduce the frequency and severity of exacerbations.
- Proactive monitoring of patient symptoms and rapid response to exacerbations by physician practices can reduce the severity of problems and the need for emergency department visits and hospital admissions.
- Delivery of home-based services can avoid the need for hospitalizations and skilled nursing facility stays.
- Palliative care services can help patients with advanced illnesses control the severity of symptoms and reduce the need for expensive treatments.

### b. Cost of Delivering the New Services

The exact costs of delivering new and different services will vary from community to community and provider to provider depending on the type of staff used to deliver services, the number of patients with the chronic conditions, the population density of the community, and other factors. For example, home-based services are more expensive to deliver in rural areas because of the long distances between homes, the greater difficulties of attracting staff with specialized skills, and the limited access to public transportation and broadband internet services.

The cost of services will be lower if they can be used for a larger number of patients, so the more types of chronic diseases that can enable patients to qualify to participate, the lower the cost of the services can be, particularly if there are ways for multiple providers to share the same staff to deliver services.

There will also be startup costs involved when new services first begin. New staff will need to be recruited and trained before they can deliver any services, and initial caseloads may be lower while patients are first enrolling in the service.

Although it will be desirable to minimize the number of patients who are hospitalized, there will always be a

need for some patients to receive inpatient care or emergency medical care on short notice, and the fixed costs associated with maintaining that capacity will cause the average cost of the inpatient and ED services to increase when the rate of utilization decreases.

### c. The Business Case for an Alternative Payment Model

An APM will be feasible for a particular chronic disease if an analysis shows that the expected savings from reduced spending on office visits, tests, medications, procedures, emergency department visits, hospital admissions, skilled nursing facility stays, etc. would be larger than the cost of delivering the new and different services needed to achieve those savings.

## 3. Barriers in the Current Payment System

In general, there is either no payment at all for the kinds of new and different services discussed above, or the payments that are available are insufficient to cover the costs of delivering those services in various circumstances. For example:

- Physician practices are paid for face-to-face visits between a clinician and the patient, but they are generally not paid for assistance delivered through a phone call or email. There is generally no payment for services delivered to a patient by a nurse, educator, or community health worker unless it is under the direct supervision of a physician or other clinician. If a physician practice can address a patient's need without the patient making an office visit with a clinician, revenues to the practice will decrease even though costs will not change.
- There is generally no payment to support telephone and electronic consultations between physicians to discuss and resolve alternative diagnoses, to determine what to do when standard treatments are ineffective, and to coordinate treatment plans and services for patients with multiple chronic conditions or multiple health problems. Specialists are only paid for consultations when patients visit the specialty practice, and primary care practices are only paid when patients visit the PCP, so if the patient only visits one of the practices, the other will lose revenues.
- Hospitals are not paid for maintaining the minimum capacity needed to treat patients in the emergency department and in an inpatient unit; the hospital only receives revenue to cover those costs when a patient actually visits the ED or is admitted to the hospital, and the payment is the same regardless of how many patients visit the ED or are admitted. As a result, reducing the frequency of ED visits and hospital admissions could leave the hospital with insufficient revenue to cover the fixed costs of its standby capacity.
- There is generally limited or no payment for various kinds of intensive home-based services that could serve as an alternative to an admission to a hospital or a skilled nursing facility.

- There is generally no payment to support delivery of community-based palliative care services in conjunction with treatment; although hospice programs deliver palliative care services, patients are generally required to forego treatment in order to be eligible for hospice services.

## 4. Design of the APM

For many chronic conditions, care delivery can be divided into five phases:

- 1. Diagnosis and initial treatment.** The first phase of care is focused on assessing symptoms to determine whether the patient has the chronic condition, establishing an initial treatment plan if they do, and delivering the initial treatment. In some cases, it is difficult to ensure an accurate diagnosis other than by determining whether treatment is effective (e.g., if there is no test that can definitively establish that the patient has the disease or if there is no test that is safe, feasible, and affordable to administer routinely), so diagnosis and initial treatment will often need to be considered as a single phase.
- 2. Continued treatment for patients with a well-controlled condition.** Ideally, after an effective treatment is identified during the initial phase of care, the patient's chronic condition will be able to be well-controlled through continued use of that treatment and through basic care management services.
- 3. Continued treatment for patients with a difficult-to-control condition.** Some patients may not respond well to standard, low-risk treatments and they may require special treatments that have higher risks of complications, or they may need more intensive care management services or services from additional or different providers in order to adequately address symptoms and minimize exacerbations of their condition.
- 4. Hospitalization for an exacerbation of the condition.** Although the goal of chronic condition treatment and management would be to avoid hospitalizations, it is likely that at least some patients will need to be hospitalized for exacerbations of their condition, and when that occurs, they will need to receive quality inpatient care at the most affordable cost.
- 5. Palliative care for an advanced condition in addition to or instead of treatment.** Patients with more advanced disease will likely experience more severe symptoms that cannot be adequately controlled through standard treatments, and in addition to treatment, they will need palliative care, i.e., services to address their symptoms. For chronic diseases that normally progress to death, patients will need to have effective end-of-life care when treatment is no longer effective and/or has unacceptable side effects.

Different services will need to be delivered by different providers during each of those phases. The costs and outcomes in each phase will differ, and so the structure and amount of payments will also need to be different in each phase.

The payments described below for each phase should be viewed as a general template for an APM that could be used to support high-quality care for many different types of chronic diseases and combinations of disease. Additions and modifications would likely be needed in order to fully address all of the opportunities for improvement associated with a specific chronic condition and to align care delivery and payment with the unique characteristics of patients, treatments, and outcomes associated with that condition. However, building APMs for different chronic conditions from a common template will make it easier for payers and multi-specialty providers to implement the APMs and will also make it easier to structure services for patients with multiple diseases.

### a. Diagnosis and Initial Treatment

#### i. Eligibility of Patients and Designation of Diagnostic Team

Patients would be eligible to receive services supported by the APM in this phase of care if they have not been diagnosed with the particular chronic condition that is the focus of the APM but if they are experiencing symptoms that could be due to that chronic condition.

A patient who is experiencing the symptoms would choose a Diagnostic Team that participates in the APM to determine whether the patient has the chronic condition and to provide initial treatment if they do. Diagnostic Teams could vary in their willingness and ability to (1) diagnose all potential causes of symptoms or merely to determine whether symptoms are due to one of a specified group of conditions and (2) provide initial treatment for the condition that is diagnosed themselves or refer the patient to other providers for the initial treatment.

Before a patient chooses a Diagnostic Team to provide services, the Team would describe the services that it would deliver and the standards for service delivery that it committed to meet. The Team could also ask the patient to commit to actions that would support efficient and accurate diagnosis and good outcomes from initial treatment. In particular, the Team could ask the patient to only obtain diagnostic and treatment services related to their symptoms or condition from the members of the Team unless the Team specifically recommends that the patient receive services from other providers.

#### ii. Payments to the Diagnostic Team

The Diagnostic Team would receive a one-time bundled Diagnosis and Initial Treatment Payment to support all of the services needed to determine whether the patient has the particular chronic condition (or one of a group of chronic conditions) that is the focus of the APM and to provide initial treatment services if the condition is present.

The payment would be expected to cover the costs of office visits, laboratory tests, imaging studies, etc. used for diagnosis. If the patient is diagnosed with the condition, a higher payment would be made to cover the

costs of office visits or other patient contacts, tests and imaging studies, and procedures used to treat the patient during an initial period of time. In addition, the payment for initial treatment would be higher for patients with more severe symptoms who need more frequent treatment.

Physician practices on the Diagnostic Team would not bill or be paid for office visits or other traditional Evaluation & Management services; revenues would come through the bundled payment. If the patient receives diagnostic or treatment services related to the symptoms or condition from providers other than the members of the Diagnostic Team during the period of time in which the Diagnosis and Initial Treatment Payment is in effect, all or part of the payments the payer makes to those providers would be deducted from the Diagnosis and Initial Treatment Payment.

In general, the costs of any medications prescribed for treatment would not be included in the bundled payment, but would be paid for separately by the patient or the patient's insurance plan. Laboratory tests or imaging studies that are very expensive and only needed in certain circumstances would also be paid for separately. If the medications are purchased and administered by the Diagnostic Team, or if the expensive tests/studies are performed by the Diagnostic Team, the separate payment would be designed to cover the out-of-pocket costs incurred by the Team (e.g., the acquisition cost of the medication or of the materials required for tests).

The length of the initial treatment period would be based on the expected amount of time required to determine whether treatment is effective or which of several alternative treatments is most effective.

The Diagnostic Team would be responsible for dividing the Diagnosis and Initial Treatment Payment among the Team members to cover the costs they incur in delivering specific types of services to the patient. For example, a Diagnostic Team might consist of a primary care practice and a specialty physician practice located in a distant city; the specialty physician practice might take responsibility for determining the diagnosis and developing the treatment plan, and the primary care practice would supervise the initial treatment of the patient, but the primary care practice would consult with the specialty practice if the initial treatment is not working in order to determine how the treatment plan should be changed. One option would be for the specialty physician practice to bill the patient's health insurance plan for the Diagnosis and Initial Treatment Payment, and then use a portion of that Payment to pay the primary care practice for supervising the treatment of the patient. Another option would be for a primary care practice to bill for the payment, but contract with a specialty practice to assist in the diagnosis and treatment planning process.

### iii. Accountability for Utilization and Spending

The Diagnostic Team would be held accountable for utilization and spending in two ways:

- **Bundled Payment:** The structure of the bundled payment would make the Diagnostic Team directly accountable for utilization and spending on all planned services related to diagnosis and treatment other than the out-of-pocket costs of medications and infrequent, expensive tests.
- **Evidence-Based Care:** The Diagnostic Team would be required to follow evidence-based clinical guidelines in determining which tests, medications, and procedures to deliver or order. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, it would not receive the Diagnosis and Initial Treatment Payment for that patient.

### iv. Accountability for Quality and Outcomes

The Diagnostic Team would be held accountable for quality and outcomes in two ways:

- **Evidence-Based Care Standards:** In addition to defining which medications and tests were appropriate, the evidence-based clinical standards or guidelines would also define any other services or methods of delivery of services that had been demonstrated to result in more accurate diagnosis or better treatment outcomes for patients. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, or if the Team failed to meet the service standards that it had committed to meet when the patient chose the Team to deliver care, the Team would not receive the Diagnosis and Initial Treatment Payment for that patient.
- **Desirable Outcomes:** One or more measures of successful treatment would be defined that are relevant to the specific chronic condition being treated. The Diagnosis and Initial Treatment Payment would be reduced by a pre-defined amount for an individual patient when a desirable outcome did not occur or when an undesirable outcome did occur.

### v. Patient Cost-Sharing

The patient would be responsible for paying a fixed copayment for the services supported by the Diagnosis and Initial Treatment Payment that are delivered by the Diagnostic Team or by providers approved by the Diagnostic Team. This copayment would be set at a level that is at or below the total of the cost-sharing amounts that the patient might expect to pay currently for individual services they would receive as part of the diagnosis and initial treatment phase of care.

If the patient receives diagnostic or treatment services from other providers without approval from the Diagnostic Team during the period of time that the Diagnosis and Initial Treatment Payment is in effect, the patient would pay additional cost-sharing for those services.

## b. Continued Treatment for Patients with a Well-Controlled Condition

### i. Eligibility of Patients and Designation of Treatment Team

Patients would be eligible to receive services supported by the APM in this phase of care if they have been diagnosed with one of the chronic conditions targeted by the APM and if initial treatment had demonstrated that their condition could be controlled effectively through a standard treatment and care management regimen.

The patient would choose a Treatment Team that participates in the APM to provide ongoing treatment and care management for the condition. The Treatment Team might or might not be the same as the Diagnostic Team that provided initial treatment for the patient. For example, a physician practice specializing in the chronic condition might have diagnosed and provided initial treatment for the condition (supported by a Diagnosis and Initial Treatment Payment), but the patient might then choose to receive ongoing treatment for the condition from their primary care physician. A patient might have received diagnosis and initial treatment in one community but will receive their ongoing treatment in a different community and will need to find a new Treatment Team there.

Before a patient designated the Treatment Team to provide services, the Team would describe the services that it would deliver and the standards for service delivery that it committed to meet. The Team could also ask the patient to commit to actions that would support good outcomes from treatment. In particular, the Team could ask the patient to only obtain treatment services related to their condition from the members of the Team unless the Team specifically recommends that the patient receive services from other providers.

### ii. Payments to the Treatment Team

The Treatment Team would receive a single, pre-defined bundled quarterly Treatment and Care Management Payment to support all of the services required for treatment of the chronic condition and management of the patient's care for that condition. The payment would be expected to cover the costs of office visits and other patient contacts, tests and imaging studies, and any procedures performed by the members of the Team over a three-month period.

Physician practices on the Treatment Team would not bill or be paid for office visits or other traditional Evaluation & Management services. Revenues would come only through the quarterly bundled payment. If the patient receives treatment services from providers other than the Treatment Team during the three-month period in which a Treatment and Care Management Payment is in effect, all or part of the payments the payer makes to those providers would be deducted from the Treatment and Care Management Payment.

Similar to the Diagnosis and Initial Treatment Payment, the costs of any medications prescribed for treatment would not be included in the bundled payment; they would be paid for separately by the patient or the pa-

tient's insurance plan. Laboratory tests or imaging studies that are very expensive and only needed in certain circumstances would also be paid for separately. If the medications are purchased and administered by the Treatment Team, or if the tests/studies are performed by the Treatment Team, the separate payment would be designed to cover the out-of-pocket costs incurred by the Team (e.g., the acquisition cost of the medication or the materials required for tests).

Patients would be stratified into three categories – Low Need/Risk, Moderate Need/Risk, and High Need/Risk – based on characteristics that affect the time or costs of delivering evidence-based treatment or care management or that affect the ability to achieve desirable outcomes. Payments would be higher for patients in categories that require more time or more services. For example, payments might be higher for patients with more severe symptoms or other health problems that require additional time or services.

A Treatment Team would be responsible for dividing the Treatment and Care Management Payment among the Team members to cover the costs they incur in delivering specific types of services to the patient. For example, a Treatment Team might consist of a primary care practice and a specialty physician practice; the primary care practice would provide most of the direct services to the patient, but it would consult with the specialty practice as needed to ensure that the most appropriate treatments are being used and to revise treatment plans when the patient's circumstances change. The primary care practice could bill the patient's health insurance plan for the Treatment and Care Management Payment each quarter, and then use a portion of that Payment to pay the specialty practice a quarterly retainer fee for the patient.

### iii. Accountability for Utilization and Spending

The Treatment Team would be held accountable for utilization and spending in three ways:

- **Bundled Payment:** The structure of the Treatment and Care Management Payment would make the Treatment Team directly accountable for utilization and spending on all planned services related to treatment other than the out-of-pocket costs of medications and of infrequent, expensive tests.
- **Outcome-Based Payment:** The Treatment Team would be accountable for avoiding exacerbations of the chronic condition that require an emergency department visit or hospitalization. If a patient in the Low Need/Risk or Moderate Need/Risk categories visits the ED or is hospitalized during a calendar quarter, the Treatment Team would not receive a Treatment and Care Management Payment for that patient in that quarter. If a patient in the High Need/Risk category visits the ED or is hospitalized, the Treatment and Care Management Payment would be reduced by a pre-defined percentage (e.g., 25%). The amounts of the Treatment and Care Management Payment for each category of patients would be set based on the costs of delivering services and the expected rates of ED visits/hospitalizations in each category.

- **Evidence-Based Care:** The Treatment Team would be required to follow evidence-based clinical standards or guidelines in determining which tests, medications, and procedures to perform or order. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, it would not receive the Treatment and Care Management Payment for that patient in that three-month period.

#### iv. Accountability for Quality and Outcomes

The Treatment Team would be held accountable for quality and outcomes in two ways:

- **Evidence-Based Care Standards:** In addition to defining which tests, medications, and procedures were appropriate, the evidence-based clinical standards or guidelines would also define any other services or methods of delivery of services that had been demonstrated to result in better treatment outcomes for patients. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, or if the Team failed to meet the service standards that it had committed to meet when the patient chose it to deliver care, the Team would not receive the Treatment and Care Management Payment for that patient.
- **Desirable Patient-Reported Outcomes:** One or more patient-reported outcome measures would be defined that are relevant to the specific chronic condition being treated. The Treatment and Care Management Payment would be reduced by a pre-defined amount for an individual patient when a desirable outcome did not occur for that patient or when an undesirable outcome did occur. In addition, for chronic conditions where effective treatment can slow the progression of the condition, the Treatment Team could receive a bonus payment for each patient that did not progress to a higher level of severity.

#### v. Patient Cost-Sharing

The patient would be responsible for paying a fixed quarterly copayment for the services supported by the Treatment and Care Management Payment that are delivered by the Treatment Team or by providers approved by the Treatment Team. This copayment would be set at a level that is at or below the total of the cost-sharing amounts that the patient might expect to pay currently for individual services they would receive as part of treatment for their chronic condition.

If the patient receives treatment services from other providers without approval from the Treatment Team during the period of time that the Treatment and Care Management Payment is in effect, the patient would pay additional cost-sharing for those services.

### c. Continued Treatment for Patients with a Difficult-to-Control Condition

#### i. Eligibility of Patients and Designation of the Treatment Team

Patients would be eligible to receive services supported by the APM in this phase of care if they have been diagnosed with one of the chronic conditions targeted by the APM and if standard treatments and care management regimens were not controlling the patient's symptoms effectively or if special treatments were needed that required more intensive supervision. Patients might become eligible for this category of care after having received care for their condition for a period of time if the condition worsened or if the patient developed other health problems that made the condition more difficult to manage. Patients might also "graduate" from this category and move to the "Well-Controlled Condition" category if a new type of treatment was developed that worked more effectively or if another health problem was resolved.

The patient would choose a Treatment Team that participates in the APM to provide ongoing treatment and care management for the condition. The Treatment Team might or might not be the same as the Diagnostic Team that provided initial treatment or a Treatment Team that previously provided treatment for the patient. For example, a primary care practice might only provide treatment and care management for patients in the well-controlled category, and refer a patient to a different physician practice that specializes in the chronic condition if the patient's condition becomes more difficult to control. A specialty physician practice might treat both types of patients or decide to focus solely or primarily on the patients with more difficult-to-control conditions.

Before a patient designated the Treatment Team to provide services, the Team would describe the services that it would deliver and the standards for service delivery that it committed to meet. The Team could also ask the patient to commit to actions that would support good outcomes from treatment. In particular, the Team could ask the patient to only obtain treatment services related to their condition from the members of the Team unless the Team specifically recommends that the patient receive services from other providers.

#### ii. Payments to the Treatment Team

The Treatment Team would receive a single, pre-defined bundled quarterly Treatment and Care Management Payment to support all of the services required for treatment of the chronic condition and management of the patient's care for that condition. The payment would be expected to cover the costs of office visits and other patient contacts, tests and imaging studies, and procedures performed by the members of the Team to treat the patient during a three-month period of time.

Similar to the Diagnosis and Initial Treatment Payment and the Treatment and Care Management Payment for patients with a well-controlled condition, physician practices on the Treatment Team for a patient with a difficult-to-control patient would not bill or be paid for office

visits or other traditional Evaluation & Management services; revenues would only come through the quarterly bundled Treatment and Care Management Payment. If the patient receives treatment services from providers other than the Treatment Team during the three months in which a Treatment and Care Management Payment is in effect, all or part of the payments the payer makes to those providers would be deducted from the Treatment and Care Management Payment.

Similar to the other payments, the costs of any medications prescribed for treatment would not be included in the bundled payment, but would be paid for separately by the patient or the patient's insurance plan. Laboratory tests, imaging studies, or procedures that are very expensive and only needed in certain circumstances would also be paid for separately. If the medications are purchased and administered by the Treatment Team, or if the tests/studies/procedures are performed by the Treatment Team, the separate payment would cover the out-of-pocket costs incurred by the Team (e.g., the acquisition cost of the medication or of the materials required for tests).

Patients would be stratified into three categories – Moderate Need/Risk, High Need/Risk, and Very High Need/Risk – based on characteristics that affect the time or costs of delivering evidence-based treatment or care management or that affect the Team's ability to achieve desirable outcomes for the patient. Payments would be higher for patients in categories that require more time or more services. For example, payments would be higher for patients with more severe symptoms or other health problems that require additional time or services.

### iii. Accountability for Utilization and Spending

The Treatment Team would be held accountable for utilization and spending in three ways:

- **Bundled Payment:** The structure of the Treatment and Care Management Payment would make the Treatment Team directly accountable for utilization and spending on all planned services related to treatment other than the out-of-pocket costs of medications and infrequent, expensive tests.
- **Outcome-Based Payment:** The Treatment Team would be accountable for avoiding exacerbations of the chronic condition that require an emergency department visit or hospitalization. If a patient in the Moderate Need/Risk or High Need/Risk categories visits the ED or is hospitalized during a calendar quarter, the Treatment Team would not receive a Treatment and Care Management Payment for that patient in that quarter. If a patient in the Very High Need/Risk category visits the ED or is hospitalized, the Treatment and Care Management Payment would be reduced by a pre-defined percentage (e.g., 25%). The amounts of the Treatment and Care Management Payment for each category of patients would be set based on the costs of delivering services and the expected rates of ED visits/hospitalizations in each category.
- **Evidence-Based Care:** The Treatment Team would be required to follow evidence-based clinical guidelines in determining which tests, medications, and procedures to perform or order. If the Team failed to follow

the guidelines for a patient and did not document the reason for deviating from the guidelines, it would not receive the Treatment and Care Management Payment for that patient.

### iv. Accountability for Quality and Outcomes

The Treatment Team would be held accountable for quality and outcomes in two ways:

- **Evidence-Based Care Standards:** In addition to defining which medications and tests were appropriate, the evidence-based clinical standards or guidelines would also define any other services or methods of delivery of services that had been demonstrated to result in better treatment outcomes for patients. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, or if the Team failed to meet the service standards that it had committed to meet when the patient chose it to deliver care, the Team would not receive the Treatment and Care Management Payment for that patient.
- **Desirable Patient-Reported Outcomes:** One or more patient-reported outcome measures would be defined that are relevant to the specific chronic condition being treated. The Treatment and Care Management Payment would be reduced by a pre-defined amount for an individual patient when a desirable outcome did not occur for that patient or when an undesirable outcome did occur. In addition, for chronic conditions where effective treatment can slow the progression of the condition, the Treatment Team could receive a bonus when a patient did not progress to a higher level of severity.

### v. Patient Cost-Sharing

The patient would be responsible for paying a fixed quarterly copayment for the services supported by the Treatment and Care Management Payment that are delivered by the Treatment Team or by providers approved by the Treatment Team. This copayment would be set at a level that is at or below the total of the cost-sharing amounts that the patient might expect to pay currently for individual services they would receive as part of treatment for their chronic condition.

If the patient receives treatment services from other providers without approval from the Treatment Team during the period of time that the Treatment and Care Management Payment is in effect, the patient would pay additional cost-sharing for those services.

## d. Hospitalization for an Exacerbation of the Chronic Condition

### i. Eligibility Criteria for Patients

Patients would be eligible to receive services supported by the APM in this phase of care if they have been diagnosed with the chronic condition and make a visit to a hospital Emergency Department or are admitted to the hospital for symptoms related to their chronic condition or problems that are determined to be due primarily to that chronic condition or the treatments being used.

### ii. Payments to the Hospital

Hospitals would receive three separate types of payment to cover the costs of their services to patients with the chronic condition:

- Standby capacity payments;
- Bundled/warranted payments for ED visits and hospital admissions; and
- Outlier payments.

#### *Standby Capacity Payment*

The hospital(s) in the community where the Treatment Teams are located would receive a standard, pre-defined Standby Capacity Payment on a quarterly basis for each patient who is receiving Treatment and Care Management Services from a Treatment Team. A higher amount would be paid for patients in higher need/risk categories. The revenues from these payments would be designed to support the cost of maintaining minimum ED and inpatient capacity at the hospital(s) to address exacerbations of the condition when they occur.

The hospitals would determine the amount of the quarterly Standby Capacity Payment by (1) calculating the minimum fixed cost each hospital would have to incur on a quarterly basis to provide minimum staff and equipment for its ED and inpatient services (i.e., the cost that it would incur if it had only one patient), (2) multiplying that fixed cost by the proportion of the hospital's total patients who come to the hospital for exacerbations of the chronic condition, and (3) dividing the product by the estimated total number of patients in the community with the chronic condition. The amount that any hospital would receive would be smaller if there were more hospitals providing services in the community.

#### *Bundled/Warranted Payment for ED Visits/Hospital Admissions*

If a patient with the chronic condition who was receiving services supported by Treatment and Care Management Payments went to a hospital ED or was admitted to the hospital, the hospital would receive a single, standard, pre-defined Chronic Condition Hospital Care Payment to support (1) all of the services the patient needed from the hospital and (2) any post-acute care services needed in the 30 days following the visit or admission that were not being provided by the patient's Treatment Team, such as a stay in a skilled nursing facility, home health services, or a hospital readmission. The hospital would

be responsible for dividing the revenues from the Chronic Condition Hospital Care Payments among any providers who were involved in the patient's care during this phase, including the physicians who would manage the patient's care in the hospital, the skilled nursing facility if the patient received services there, etc. The hospital would not charge for or receive any additional payments for any services delivered to patient, unless the circumstances qualified for an Outlier Payment.

A higher Chronic Condition Hospital Care Payment amount would be paid to the hospital for a patient classified in the higher need/risk categories for the Treatment and Care Management Payments. The amount of the Chronic Condition Hospital Care Payment for a patient in a particular need/risk category would be based on the average additional cost the hospitals would incur for a patient beyond the fixed costs supported by the Standby Capacity Payments, except for the services or costs that would be covered by outlier payments. The expected cost would be determined by estimating (1) the cost for patients who visit the ED but are not admitted to the hospital, (2) the cost for patients who are admitted but do not need post-acute care, and (3) the cost for patients who are admitted and need post-acute care or require a hospital readmission after discharge, and weighting those estimated costs by the estimated percentage of patients that could be expected to need those different combinations of services.

The Chronic Condition Hospital Care Payment would be significantly lower than the typical amount a hospital would receive for an inpatient admission because (1) the payments would be designed for patients who only needed care in the ED as well as those who needed an inpatient admission, and (2) the hospital would also be receiving Standby Capacity Payments.

#### *Outlier Payments*

The hospital could receive an Outlier Payment in addition to the Standby Capacity Payment and Chronic Condition Hospital Care Payment for a patient who:

- experienced an unavoidable event during the ED visit or hospital admission that occurs infrequently but typically requires a significant number of additional services or additional time or costs; or
- had unusual characteristics that required additional services or additional time or costs in the delivery of typical services during the ED visit or hospital admission.

For events that occur infrequently but require predictable responses, the hospital would receive a standard, pre-defined Outlier Payment. For unusual events, there would not be a pre-defined payment; instead, the amount of the Outlier Payment would be based on the additional costs that the hospital incurred in delivering care to the patient. The hospital would calculate the actual costs it incurred for the patient's care, and subtract the payments it had otherwise received; the Outlier Payment would be equal to 90% of that amount.

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### iii. Accountability for Utilization and Spending

The hospital would be held accountable for utilization and spending in two ways:

- **Bundled Payment:** The structure of the Standby Capacity Payment and Chronic Condition Hospital Care Payment would make the hospital directly accountable for utilization and spending on all planned services related to hospital and post-acute care.
- **Warranted Payment:** The hospital would be accountable for avoiding any complications resulting from the hospital treatment that require an emergency department visit or hospitalization, since there would be no additional payment for any additional ED visits, hospital readmissions, etc. during the 30 days following an admission.

### iv. Accountability for Quality and Outcomes

The hospital would be held accountable for quality and outcomes in two ways:

- **Evidence-Based Care Standards:** The hospital would be expected to follow evidence-based clinical standards or guidelines that had been demonstrated to result in better treatment outcomes for patients. If the hospital failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, it would not receive the Chronic Condition Hospital Care Payment for that patient.
- **Mortality:** In order to ensure that the hospital is not undertreating patients, the rate of death among the patients will be measured during the 30-day period following the ED visit or hospital admission. If the rate of mortality in one or more patient categories increased by a statistically significant amount, the hospital's Standby Capacity and Chronic Condition Hospital Care Payments would be reduced.

### v. Patient Cost-Sharing

The patient would be responsible for paying a fixed copayment when a hospital bills for a Chronic Condition Hospital Care Payment. This copayment would be set at a level that is at or below the average total of the cost-sharing amounts that the patient might expect to pay currently for an ED visit or hospital admission.

### e. Palliative Care for an Advanced Condition

#### i. Eligibility of Patients and Designation of Palliative Care Team

Patients would be eligible to receive services supported by the APM in this phase of care if they have been diagnosed with the chronic condition and if the condition has progressed to the point where the patient is experiencing significant pain, rapid functional decline, or other symptoms that would benefit from palliative care services in addition to treatment for the chronic condition itself.

The patient would choose a Palliative Care Team that participates in the APM to provide palliative care for the

condition in addition to or instead of treatment. The Palliative Care Team might or might not be the same as the Treatment Team. For example, a large multi-specialty physician practice might serve as both the Treatment Team and Palliative Care Team, providing both types of services, whereas a small primary care practice or a physician practice specializing in treatment of the condition might serve as the Treatment Team and the patient would choose a separate Palliative Care Team, such as a hospice and palliative care services agency, to provide palliative care.

Before a patient designated the Palliative Care Team to provide services, the Team would describe the services that it would deliver and the standards for service delivery that it committed to meet. The Team could also ask the patient to commit to actions that would support the ability of the Team to most effectively address the patient's palliative care needs. In particular, the Team could ask the patient to only obtain palliative care services related to their condition from the members of the Team unless the Team specifically recommends that the patient receive services from other providers.

#### ii. Payments to the Palliative Care Team

The Palliative Care Team would receive a single, pre-defined bundled monthly Palliative Care Payment to support all of the services required for palliative care. The payment would be expected to cover the costs of home visits and other patient contacts and services performed by the members of the Team during the month. Services ordinarily expected to be provided for treatment of the chronic condition and management of the patient's care for that condition would not be included unless the patient is no longer receiving treatment for the condition. If the patient receives palliative care services from providers other than the Palliative Care Team during the month in which the Palliative Care Payment is in effect, all or part of the payments the payer makes to those providers would be deducted from the Palliative Care Payment.

Similar to the other payments, the costs of any medications prescribed for palliative care would not be included in the bundled payment, but would be paid for separately by the patient or the patient's insurance plan. If the medications are purchased and administered by the Palliative Care Team, the separate payment would be designed to cover the out-of-pocket costs incurred by the Team to acquire the medication.

Patients would be stratified into four categories – Low Need, Moderate Need, High Need, and Hospice – based on the severity of the patient's symptoms and other characteristics that affect the time or costs of delivering evidence-based palliative care services. Payments would be higher for patients in categories that require more time or more services.

Payments for patients in the Hospice category could be based on the payments currently made for patients eligible for hospice care. In particular, the Palliative Care Team would be expected to pay directly for any ED visits or hospitalizations for patients who are in the Hospice category.

### iii. Accountability for Utilization and Spending

The Palliative Care Team would be held accountable for utilization and spending in three ways:

- **Bundled Payment:** The structure of the Palliative Care Payment would make the Palliative Care Team directly accountable for utilization and spending on all planned palliative care services other than the out-of-pocket costs of medications.
- **Hospital Care:** For patients who are not in the Hospice category, the patient's Treatment Team (not the Palliative Care Team) would be accountable for avoiding exacerbations of the chronic condition that require an emergency department visit or hospitalization, not the Palliative Care Team. (The Treatment Team would have the option of contracting with a Palliative Care Team or serving as the Palliative Care Team itself in order to share accountability for avoiding hospitalizations with the palliative care providers.) For patients in the Hospice category, the costs of hospital services would be included in the bundled payment for the Palliative Care Team.
- **Evidence-Based Care:** The Palliative Care Team would be required to follow evidence-based clinical guidelines in determining which palliative care medications and services to deliver or order. If the Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, the Team would not receive the Palliative Care Payment for that patient during the month.

### iv. Accountability for Quality and Outcomes

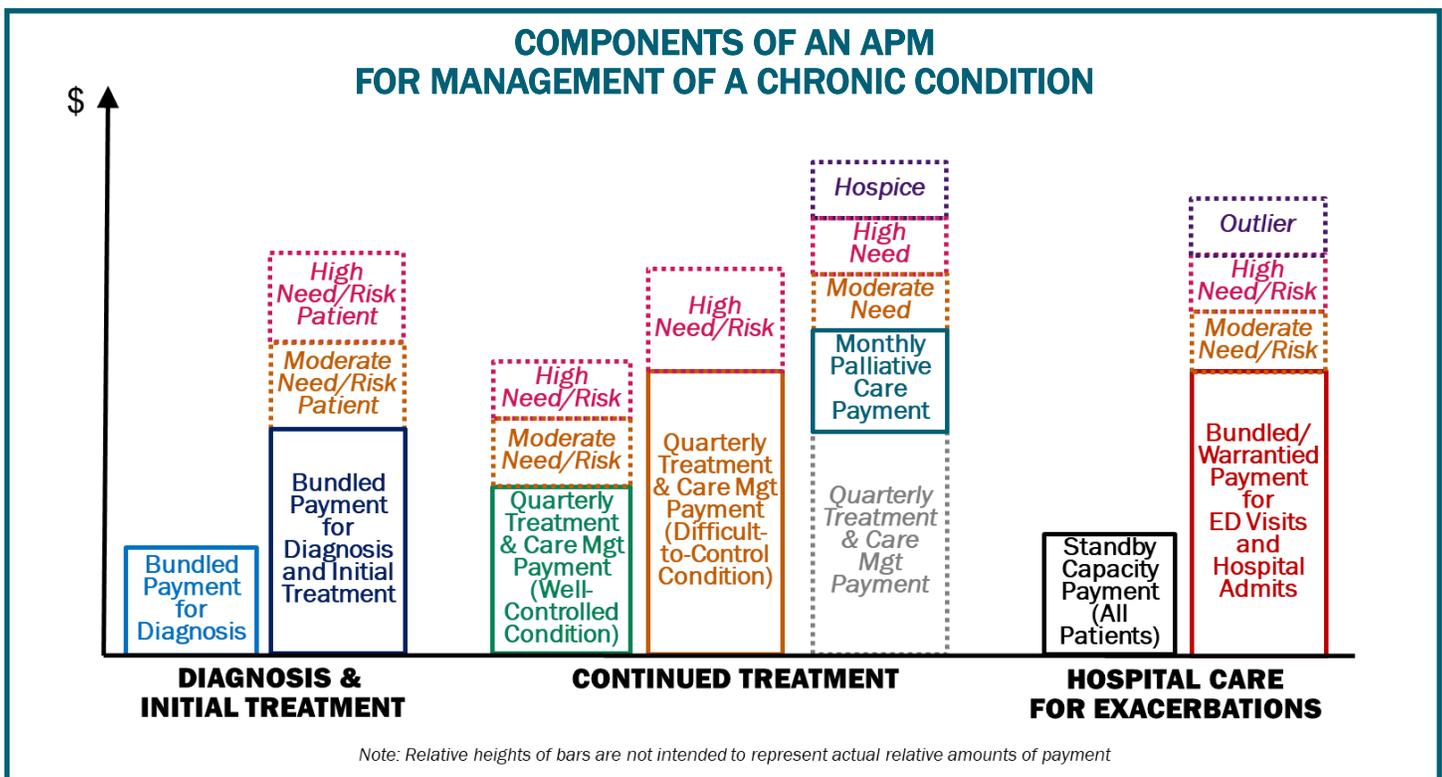
The Palliative Care Team would be held accountable for quality and outcomes in two ways:

- **Evidence-Based Care Standards:** In addition to defining which medications and tests were appropriate, the evidence-based clinical standards or guidelines would also define any other services or methods of delivery of services that had been demonstrated to result in better outcomes for patients. If the Palliative Care Team failed to follow the guidelines for a patient and did not document the reason for deviating from the guidelines, or if the Team failed to meet the service standards that it had committed to meet when the patient chose the Team to deliver palliative care, the Team would not receive the Palliative Care Payment for that patient for that month.
- **Desirable Patient-Reported Outcomes:** One or more patient-reported outcome measures would be defined that are relevant to the chronic condition being treated. The Palliative Care Payment would be reduced by a pre-defined amount for an individual patient when a desirable outcome did not occur for that patient or when an undesirable outcome did occur.

### v. Patient Cost-Sharing

The patient would be responsible for paying a fixed co-payment each month for the services supported by the Palliative Care Payment that are delivered by the Palliative Care Team or by providers approved by the Team.

If the patient receives palliative care services from other providers without approval from the Palliative Care Team during the period of time that the Palliative Care Payment is in effect, the patient would pay additional cost-sharing for those services.



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## 5. Operationalizing the APM

In order for Diagnosis Teams, Treatment Teams, Palliative Care Teams and hospitals to be paid for services under the APM, they would submit claims forms for each eligible patient using a series of new codes. Penalties for failure to achieve Desirable Patient-Reported Outcomes would be operationalized as “withholds,” i.e., the default amount of payment for a service code would be calculated by including the maximum penalty for failure to achieve the outcomes, and then additional codes would be created to enable the Team to recoup the penalty when one or more Desirable Outcomes were actually achieved.

### Diagnosis and Initial Treatment Payments

- CC011: evaluation of a patient who has not been previously diagnosed with the chronic condition, and who has symptoms of the chronic condition, but is determined not to have the chronic condition
- CC012: initial treatment of a patient newly diagnosed with the chronic condition who is in the low-need/complexity category
- CC013: initial treatment of a patient newly diagnosed with the chronic condition who is in the moderate-need/complexity category
- CC014: initial treatment of a patient newly diagnosed with the chronic condition who is in the high-need/complexity category
- CC015-CC018: additional payments for achieving Desirable Patient-Reported Outcomes
- CC019: maximum additional payment for achieving Desirable Outcomes. If the Diagnosis Team had achieved multiple Desirable Outcomes, it would submit individual codes (CC015-CC018) for each of those outcomes, and if the total additional payments for those codes exceeded the maximum additional payment per patient, the Team would also submit code CC019 and the payment would be made for that code instead of the others. (All of the codes would still be submitted so it was clear which outcomes had been achieved.)

### Treatment and Care Management Payments – Well-Controlled Conditions

- CC021: three months of treatment for a patient with a well-controlled condition who meets the criteria for the Low Need/Risk category
- CC022: three months of treatment for a patient with a well-controlled condition who meets the criteria for the Moderate Need/Risk category
- CC023: three months of treatment for a patient with a well-controlled condition who meets the criteria for the High Need/Risk category
- CC025-CC028: additional payments for achieving Desirable Patient-Reported Outcomes
- CC029: maximum additional payment for achieving Desirable Outcomes. If the Treatment Team had achieved multiple Desirable Outcomes, it would sub-

mit individual codes (CC024-CC028) for each of those outcomes, and if the total additional payments for those codes exceeded the maximum additional payment per patient, the Team would also submit code CC029 and the payment would be made for that code instead of the others. (All of the codes would still be submitted so it was clear which outcomes had been achieved.)

### Treatment and Care Management Payments – Difficult-to-Control Conditions

- CC031: three months of treatment for a patient with a difficult-to-control condition who meets the criteria for the Moderate Need/Risk category
- CC032: three months of treatment for a patient with a difficult-to-control condition who meets the criteria for the High Need/Risk category
- CC033: three months of treatment for a patient with a difficult-to-control condition who meets the criteria for the Very High Need/Risk category
- CC034-CC038: additional payments for achieving Desirable Patient-Reported Outcomes
- CC039: maximum additional payment for achieving Desirable Outcomes.

### Chronic Condition Hospital Care Payments and Outlier Payments

- CC041: hospital care for a patient receiving Treatment and Care Management services in the Well-Controlled Phase and the Low Need/Risk category
- CC042: hospital care for a patient receiving Treatment and Care Management services in the Well-Controlled Phase and the Moderate Need/Risk category
- CC043: hospital care for a patient receiving Treatment and Care Management services in the Well-Controlled Phase and the High Need/Risk category
- CC044: hospital care for a patient receiving Treatment and Care Management services in the Difficult-to-Control Phase and the Moderate Need/Risk category
- CC045: hospital care for a patient receiving Treatment and Care Management services in the Difficult-to-Control Phase and the High Need/Risk category
- CC046: hospital care for a patient receiving Treatment and Care Management services in the Difficult-to-Control Phase and the Very High Need/Risk category
- CC047-CC049: outlier payments

### Palliative Care Payments

- CC051: one month of palliative care services for a patient in the Low Need category
- CC052: one month of palliative care services for a patient in the Moderate Need category

- CC053: one month of palliative care services for a patient in the High Need category
- CC054: one month of palliative care services for a patient receiving hospice services
- CC055-CC058: additional payments for achieving Desirable Patient-Reported Outcomes
- CC059: maximum additional payment for achieving Desirable Outcomes.

## Submission of Claims

The date of service on the claim would be the last day of the month or quarter in which the services were delivered.

Submission of a claim form for a patient with one of these billing codes would represent a certification by the Team or hospital that:

- The patient met the eligibility criteria for the APM and for the assigned Need/Risk category.
- The patient had received services that met all required evidence-based standards or guidelines for that phase and month or quarter of care.
- The patient had not visited an ED or been admitted to the hospital during the quarter covered by the payment (for those payments that are contingent on avoiding use of hospital services).

If a Team wished to charge patients more than the amount that would be paid by their health plans, the Team would publish its charge for each of the billing codes, and the patient would agree to those charges at the time that the patient was enrolling to receive services from the Team. A single Team would charge the same amount to all of the Team's patients, regardless of their health insurance plan, and the Team would bill the patient for the difference between the charge and the amount paid by the patient's insurance plan.

On a quarterly basis, each Team would calculate its performance on all of the quality measures (both Evidence-Based Care measures and Desirable Patient-Reported Outcome measures). These measures would be calculated separately for patients in each of the need/risk categories. The measure data would be provided to the team's patients and to the health insurance plans for those patients.

The Team would make information on its performance on the quality measures and its charges for services publicly available so that patients seeking a Team could compare the cost and performance of different Teams.

## Identifying Chronic Disease-Related ED Visits and Hospital Admissions

A Treatment Team would only be eligible to receive a quarterly Treatment and Care Management Payment for a patient if the patient did not visit an ED and was not admitted to a hospital during the quarter for an exacerbation of the chronic disease. Periodically (e.g., either monthly or quarterly), the patient's health insurance plan would determine whether it had received a claim from a

hospital for a Chronic Condition Hospital Care Payment and a claim from a Treatment Team for a Treatment and Care Management Payment for the same patient during the same quarter, and if so, it would reject payment or request a refund for the Treatment and Care Management Payment.

In order to ensure that patients who made ED visits or had hospital admissions related to the chronic condition were being billed for properly, a hospital participating in the APM would submit to a periodic audit of medical records and claims forms by an independent entity to determine whether patients were being correctly coded.

## Payment and Withholds for Reconciliation

If a Diagnosis Team, Treatment Team, or Palliative Care Team submitted a billing code on a claim form, the payer would immediately pay the Team 90% of the pre-defined payment amount assigned to that billing code. The remaining 10% would be held back for a period of 60 days to determine if any claims from other providers were submitted for similar services to the same patients; if so, the total amount withheld would be reduced by the payments made to those providers, and the balance would then be paid to the Team.

## Hospital Standby Capacity Payments

Because the hospitals participating in the APM would receive a Standby Capacity Payment for a patient receiving services supported by the APM regardless of whether the patient was actually admitted to the hospital or visited the ED, it would be difficult for the hospital to bill directly for all of these payments. Instead, since the payments would be made if and only if a patient was receiving services supported by Treatment and Care Management Payments, the submission of a claim by a Treatment Team to a participating health insurance plan for a Treatment and Care Management payment would also automatically trigger a Standby Capacity Payment from the health insurance plan to each participating hospital.

The amount of the Standby Capacity Payment should be higher for patients classified in categories that have a higher risk of exacerbations that can lead to ED visits and hospital admissions, so different Standby Capacity Payments should be associated with each of the different codes listed above for different types of patients.

To distinguish the payment made to the Treatment Team from the Standby Capacity Payment made to a hospital, a modifier would be added to the codes listed earlier:

- -OP: Treatment and Care Management Payment to a Treatment Team
- -IP: Standby Capacity Payment to a hospital

For example, if a Treatment Team submits a claim with a CC022 code for a well-controlled, medium need/risk patient, the health plan would issue a payment to the Treatment Team with the amount assigned to the CC022-OP code and modifier, and the health insurance plan would also issue a payment to each participating

hospital with the amount assigned to the CC022-IP code and modifier.

Since the Standby Capacity Payments to hospitals would be tied to claims submitted by Treatment Teams, this means that if the patient is admitted to the hospital and the Treatment Team does not submit a claim for a Treatment and Care Management Payment, the hospital would not receive a Standby Capacity Payment for that patient during that quarter. In this situation, the hospital could submit its own claim for that patient with the modifier -IP attached, since the hospital would know that the patient was participating in the APM and that the hospital had not received a Standby Capacity Payment for that patient.

## 6. Implementing the APM

### a. Obtaining Participation by Payers, Providers, and Patients

The APM would have a number of advantages for payers, providers, and patients that should encourage payers to implement the APM, encourage providers to participate in the APM, and encourage eligible patients to seek care from providers who are participating in the APM.

#### i. Advantages for Payers

- Participating health insurance plans could reduce spending on plan members who have one or more of multiple types of chronic conditions.
- Participating health insurance plans could eliminate prior authorization programs for medications and procedures, since participating providers would be accountable for following evidence-based treatment guidelines.
- Health insurance plans could implement the APM by creating new billing codes in their existing claims payment system.

#### ii. Advantages for Providers

- Participating physician practices would have the flexibility to deliver services to their patients in the ways that are most feasible for the practice and most effective for their patients, including office visits, phone calls, and emails with a physician or clinician, and visits and calls with nurses and other types of staff.
- Participating physician practices would receive higher payments to cover the additional time they would spend with patients with greater needs.
- Participating physician practices would be held accountable for whether a patient they had explicitly enrolled for services had visited an ED or was hospitalized for an exacerbation of the chronic condition the practice had committed to manage. The practice would not be held accountable for the total cost of the hospitalization or for other services the patient is receiving from the practice or from other providers. The practice would know in advance what rate of hospitalizations it would be expected to achieve for its patients.

- Participating physician practices would be responsible for following evidence-based clinical guidelines, but would not be penalized for delivering care that their patients needed nor would they be penalized for increases in the amounts that other providers charged for their services or for increases in the prices of drugs and medical devices.
- Participating physician practices would know when to expect payment and how much to expect based on the bills they submit to payers and the cost-sharing charged to patients. The largest financial loss the practice could experience would be the loss of the payments under the APM.
- Physician practices could charge more for their service if they could deliver better outcomes that patients were willing to pay more for.
- Participating hospitals would no longer have all of their revenues tied to the number of patients admitted to the hospital; the hospital could support efforts to reduce hospital admissions and readmissions without losing money by doing so.
- Hospice agencies and other palliative care providers could deliver palliative care services to patients who needed them without requiring the patient to give up treatment services.
- Participating physician practices and hospitals could bill for services using their standard billing systems.

#### iii. Advantages for Patients

- Patients would have the choice of whether to receive the services supported by the APM based on a clear understanding of what services they would receive, the actions they would need to take, and the results they could expect to achieve.
- Patients could choose different teams of providers in different phases of their care needs, and they could change to different teams multiple times if they wished to do so.
- Patients would know that their physician would be rewarded for helping the patient avoid exacerbations of their chronic condition but would have no financial incentive to withhold needed care.
- Patients would know how much they would need to pay for the services before choosing to receive them.
- Participating patients would experience fewer severe symptoms from their chronic disease. They would receive more care at home and require fewer visits to emergency departments and fewer admissions to hospitals to treat severe symptoms.
- Patients would have the ability to compare the performance and prices of different Diagnostic Teams, Treatment Teams, and Palliative Care Teams in order to choose the Teams they would use.

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## b. Finalizing the APM Parameters

A “beta test” of the APM will likely be needed with willing providers in order to finalize several key parameters of the APM:

- **Criteria defining the categories of need/risk.** The categories should be defined so that they distinguish which patients will be at higher risk of exacerbations and which patients will need more time and care management services in order for a Team to follow evidence-based care guidelines, to avoid hospitalizations, and to improve patient outcomes. However, data may not be available on all of the factors that would be expected to affect need and risk, and the APM will need to be implemented first in order to enable those data to be collected.
- **Dollar amounts of the various payments.** The payment amounts in each phase of care and for each need/risk level should be based on the cost of the services that would be delivered to patients in that phase and level, but the cost of the services will depend on the number of patients a participating Team could manage and the number of patients in each of the need/risk categories, and this can only be estimated after the services are actually implemented with support from the APM.

- **Benchmark rates of condition-related ED visits and hospital admissions.** The performance targets and payment amounts will depend on the benchmark (baseline) rates of ED visits and hospital admissions in each need/risk category, but this can only be determined after actual patients are classified into the need/risk categories.
- **Benchmark rates of desirable outcomes.** Data are not currently being collected for many types of desirable outcomes for chronic diseases because there is no means of paying for the costs of doing so. Consequently, performance targets and payment amounts for many types of desirable outcomes can only be determined after services under the APM begin.

Best estimates of these parameters would be used to initiate the beta test process, and the participating Teams would gather and share data from their actual experience in implementing care changes with payments under the APM in order to make adjustments to the parameters.

