Listening Session 2: *Financial Incentives for Improving Care Transition Management*

Presenters:

Subject Matter Experts

- **Richard J. Gilfillan, MD, MBA** – Former President, Trinity Health and Geisinger Health Plan, and Director, Center for Medicare and Medicaid Innovation (Retired)

- **Mary D. Naylor, PhD, RN** – Marian S. Ware Professor, Gerontology, School of Nursing, and Director, NewCourtland Center for Transitions and Health, Penn Nursing, University of Pennsylvania

- **Grace Terrell, MD, MMM** – Chief Product Officer, IKS Health

Listening Session 3: *Addressing Care Transitions in Alternative Payment Model Design*

Presenters:

Subject Matter Experts

- **John Birkmeyer, MD** – President, Sound Physicians

- **Marc Rothman, MD, CMD** – Chief Medical Officer, Signify Health

- **Lewis G. Sandy, MD, FACP** – Co-Founder, SuLu Consulting LLC (former SVP, Clinical Advancement, UnitedHealth Group)

A Context for Value Transformation/Care Coordination/Transitions Management APMs

Rick Gilfillan, MD

PTAC Listening Session 2: *Financial Incentives for Improving Care Transition Management*

June 13, 2023

APM Story Line to date is one of very impressive engagement but limited results

- 13 Years of Discussion, Innovations and Evaluations since ACA
- Massive work by CMS and thousands of organizations
- Extensive Engagement, Investments and Innovation by all:
  Hospitals   CMS   PCPs   Specialist Providers   ACOs   Entrepreneurs
- But most models offered limited provider business opportunity
- Resulting limited provider commitment in many instances
- Private Payers have not followed CMS lead limiting Commercial and Medicaid Uptake
- Covid Pandemic stalled progress
- Post Covid – Providers still emerging from financial challenges

APM Results after 13 years

- ACO Growth has been dramatic – MSSP + ACO Reach > 12 M
- ACO Model has demonstrated proof of concept: Best Performers save >10%
- But overall ACOs savings are limited – 2-3% and modest quality improvement
- PCP Based Models CPC, CPC + – increase costs & small impact on quality
- BPCI – BPCI decreases costs but no CMS savings if voluntary
- CCTP Transitions Model – limited impact on costs and readmissions
- Readmission Reduction Program – ? impact due to observation status
- Medicare Per Capita FFS Trend has been lowest in history – many causes
- No improvement and possible worsening of inequities

APM Learnings to date

- Providers have been willing to participate but limit investment
  - Physician based more effective than hospital based
- Clinicians of all types like doing the APM driven care delivery work
- Voluntary APMs have limited impact overall
- ACOs model works but incentives are weak
- PCP Initiatives alone are not sufficient to improve cost and quality
- We understand many key care delivery interventions to improve costs
- Addressing inequities requires explicit, focused attention
- Care Delivery interventions vary by population – Medicare vs. Medicaid vs. Commercial
- Digital provides most value when integrated into care delivery
- Plans are reluctant participants – unwilling to share profits except MA
- Plan & Provider attention flows to the easiest money – subsidized MA

APM - Current Stance of Participants

- Payers – "Value Based Care" = MA Risk Coding Money Machine deals
- Integrated Health Systems: Recovering FFS business, poor financial results, maintain some commitment to APM's, expanding MA
- ACOs – blending efforts with MA opportunities
  - Hospital – continuing limited investment and results – grow MA
  - Physician Based – continuing limited investment – grow MA
  - ACO Entities – expanding to MA, limited investments in actual care delivery changes
  - ACO Reach – expanding networks & growing – Investor and MA backed entities
- PCP's – 75% employed – ? Viability of stand-alone practice – MA Acquisitions
- Small Disruptors – PCP focus financially driven via MA Money Machine Model
- Large Disruptors – early in game trying to build volume – unclear strategy – just too much money to ignore

We have created an unlevel playing field between MA and ACOs – dulling the interest in APMs

Issue	Medicare Advantage	ACOs
Benchmarks	Subsidized above FFS	Flat with FFS Trend
Quality Payments	Above Benchmarks	Discounted from Savings
Risk Score Driven Payment	10-20% above FFS	Limited to 3% Increase
Member Benefits	Improved due to subsidies c OOP Max	Standard Indemnity – no OOP Max
Claims Denials/Downgrades	20 – 30% Inpatient Claims	None
Premium	Subsidized to Zero Premium	None
Member Benefits	Improved due to subsidies	Standard Indemnity

Conclusion: Voluntary Models promising potential payments or penalties 18 months later do not drive aggressive investment, implementation or transformation – particularly in an environment dominated by MA subsidies and easy profits. *

*(Risk coding addressed in recent CMS 2024 MA Rate Announcement)

Why don't we see more impact from large scale programs?

- Limited investment in intervention
  - Returns are not worth it
  - Investments with better ROIs are available
  - Rebasing benchmarks makes it non-sustainable
  - Uncertainty about persistence of models
- Change is hard and most won't do it without being forced
- Lack of a clear evidence based clinical delivery model
- Evaluations focus on overall average result vs. those that are successful
- Real Care Delivery changes take time –
  - Mandatory DRGs – 5 to 15 years to get maximal results
- Provider Focus on MA not ACOs

Questions for New Models

- What are we testing – care delivery model/payment model/both?
- What is the objective of the test?
- How does it impact health inequities?
- Who are the target providers?
- Why will the target providers make a serious and effective investment & effort?
- How should we structure test to make it fast and adaptable?
- What will be considered positive – overall savings, improved quality, proof of concept by some participants?
- If positive test what is next step?
- Is the test structured to justify the next step?

EVIDENCE-BASED TRANSITIONAL CARE IS NOT JUST A "GOOD IDEA"

Mary Naylor, PhD, RN, FAAN
Director, NewCourtland Center for Transitions and Health
University of Pennsylvania School of Nursing

What incentives are needed?

Medicare FFS

- Implement an episodic (60 day) case rate per member for evidence-based transitional care services provided to hospitalized at-risk older adults and their caregivers
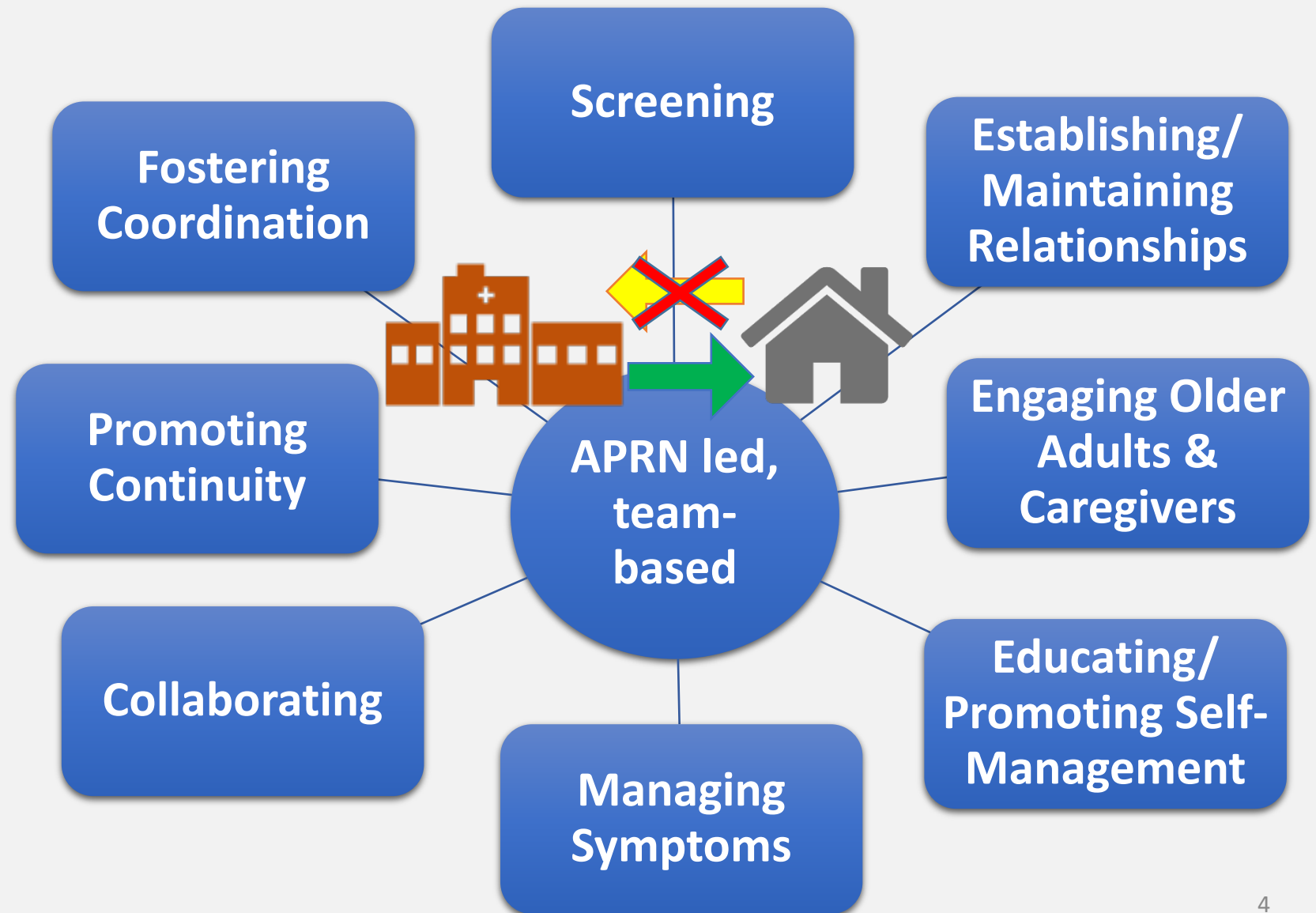
Medicare Advantage

- Strengthen the criteria for the Transitions of Care (TRC) star rating measure

Why is Mrs. Jones At-Risk for Poor Outcomes?

- An 84-year-old widow with more than 5 chronic conditions
- Who also has at least two of the following risks:
  - ❑ New diagnosis of advanced illness
  - ❑ ADL deficits (e.g., bathing, feeding, toileting, transferring, etc.)
  - ✓ Recent fall
  - ✓ 2 or more SDoH risks (i.e., food insecurity, transportation, health literacy)
  - ❑ Moderate to severe cognitive impairment
  - ❑ History of depression
  - ✓ Limited or no social support (i.e., daughter living in other state)
  - ✓ 1 or more hospitalization in the last 30 days
  - ❑ 2 or more hospitalizations within the last 6 months

What are key features of the Transitional Care Model (TCM)?

- Hospital to Home Service (admission through 60 days)
- Care delivered and coordinated by Advanced Practice Registered Nurse (APRN) in collaboration with existing team members (SW, Pharm, CHW)
- 7 day per week availability (in-person, virtual, telephone)
- Focus on longer-term outcomes (e.g., earlier transition to home, palliative care)
- Protocols based on rigorous evidence of quality and cost outcomes

- Screening
- Establishing/ Maintaining Relationships
- Fostering Coordination
- APRN led, team-based
- Engaging Older Adults & Caregivers
- Promoting Continuity
- Educating/ Promoting Self-Management
- Collaborating
- Managing Symptoms

Mrs. Jones is Hospitalized: TCM is Initiated

4 Day Hospital Stay (at least 2 in-person visits by the APRN*) to:

- Establish a trusting relationship with Mrs. J and her daughter

- Assess Mrs. Jones' /daughter's goals/ preferences/priority needs

- Collaborate with staff to prevent poor hospital outcomes
    - 23% Delirium during inpatient stays (19%-26%)[1]
    - 30% Hospital-associated disability (24%-33%)[2]
    - 35% Sepsis diagnosis[3]

- Coordinate transitional care plan with Mrs. Jones, her daughter, the clinical team, and community-based organization (CBO) staff

- Prepare Mrs. Jones for discharge

* or facilitated video visits in rural communities

[1] Gibb et al. 2020 Age and Ageing; [2] Loyd et al. 2020. Journal of the American Medical Directors Association; [3] Frank et al. 2021 Crit Care Med
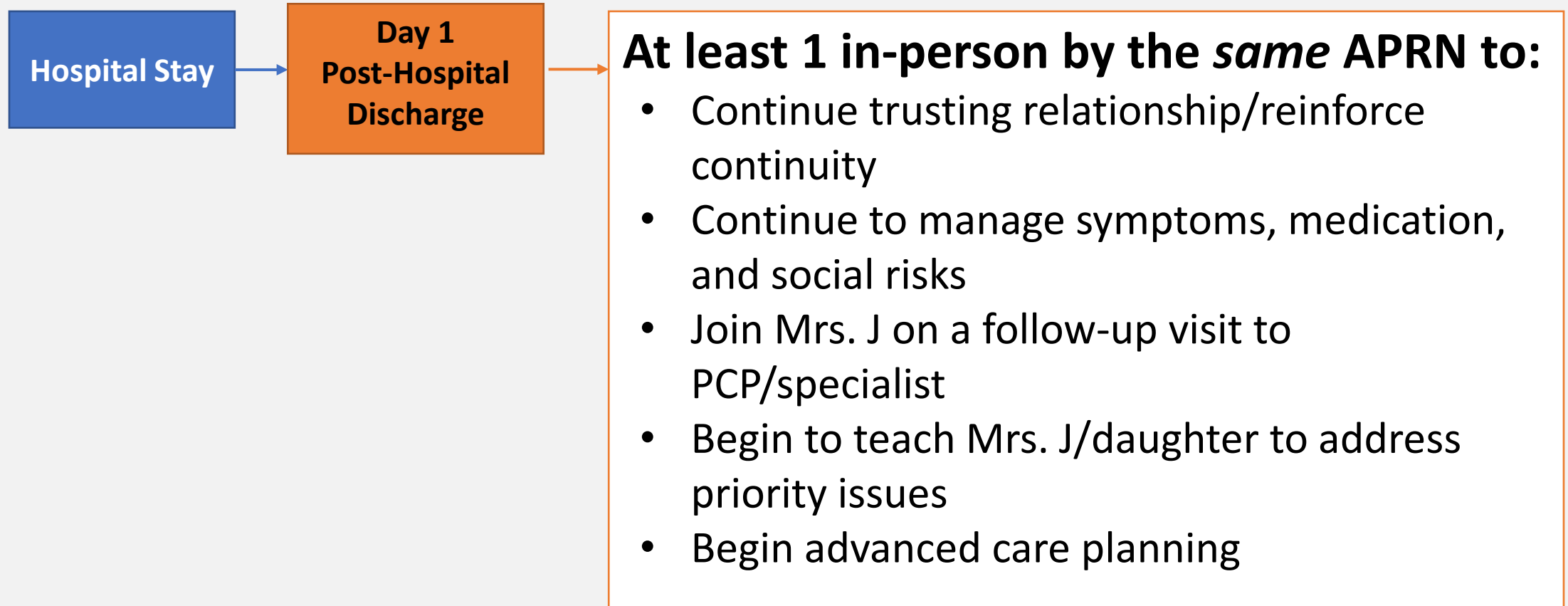
Mrs. Jones Day 1 Post-discharge

Hospital Stay →

In-person visit by *same* APRN to:
- Continue to build trusting relationships
- Assess health status/home/new risks
- Address immediate concerns
- Complete medication reconciliation
- Establish a communication plan
- Initiate new or follow-up on requested health/community services
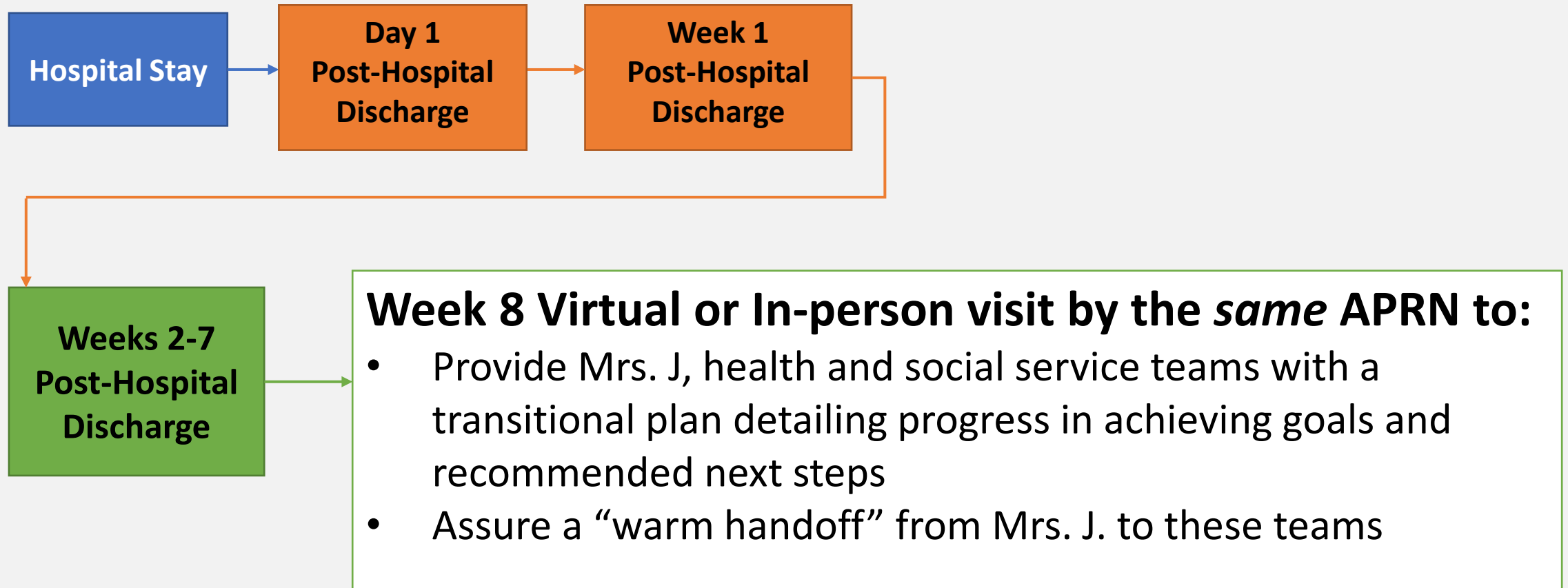
Mrs. Jones Week 1 Post-discharge

Hospital Stay → Day 1 Post-Hospital Discharge →

At least 1 in-person by the *same* APRN to:
- Continue trusting relationship/reinforce continuity
- Continue to manage symptoms, medication, and social risks
- Join Mrs. J on a follow-up visit to PCP/specialist
- Begin to teach Mrs. J/daughter to address priority issues
- Begin advanced care planning

Mrs. Jones Weeks 2-7 Post-discharge

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┌──────────────┐      ┌──────────────┐      ┌──────────────┐
│              │      │    Day 1     │      │   Week 1     │
│ Hospital Stay│ ───► │ Post-Hospital│ ───► │ Post-Hospital│
│              │      │  Discharge   │      │  Discharge   │
└──────────────┘      └──────────────┘      └──────────────┘
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Virtual or in-person visits* by the *same* APRN to:

- Monitor progress in health status/achieving goals
- Reinforce teaching/assess understanding (teach back)
- Coordinate/assure quality of health and social services
- If aligned with goals, coordinate the transition to palliative or hospice services

*may be provided telephonically after week 4 based on patient's preferences and progress in meeting goals

Mrs. Jones Week 8 Post-hospital Discharge

Hospital Stay → **Day 1 Post-Hospital Discharge** → **Week 1 Post-Hospital Discharge**

Weeks 2-7 Post-Hospital Discharge →

Week 8 Virtual or In-person visit by the *same* APRN to:
- Provide Mrs. J, health and social service teams with a transitional plan detailing progress in achieving goals and recommended next steps
- Assure a "warm handoff" from Mrs. J. to these teams

What will it take for Mrs. J and *all* at-risk Medicare beneficiaries to benefit from evidence-based TCM services?

Medicare FFS

- CMMI demonstration
- Availability of tools that support widespread implementation of the evidence-based Transitional Care Model
- Advanced investment payment to an accountable entity (ACO, CBO, post-acute or hospital provider) to build cross-site partnerships/infrastructure
- Calculation of episodic (60 day) case rate per member and shared savings methodology
- Change in risk adjustment methodology to account for medical and social complexity

Medicare Advantage

- Conduct a review of criteria used to measure Transitions of Care (TCR) star rating and revise based on available evidence

What are key design features to receive episodic case rate during demonstration?

Participating entities must agree to provide the following:

- Evidence of cross-site partnership

- Plan to implement an evidence-based solution

- Commitment to assess key process (e.g., documentation of fidelity to entity's proposed solution) and outcome measures (e.g., acute care hospitalizations, patient's care experience, patient's goal attainment, days at home)

- Commitment to absorb acute care costs (emergency department and hospitalization costs) from index hospital discharge to 3 months post-index hospital discharge

What are the key recommendations?

Medicare FFS

- Implement an episodic (60 day) case rate per member for evidence-based transitional care services provided to hospitalized at-risk older adults and their caregivers

Medicare Advantage

- Strengthen the criteria for the Transitions of Care (TRC) star rating measure

Transitional Care Model
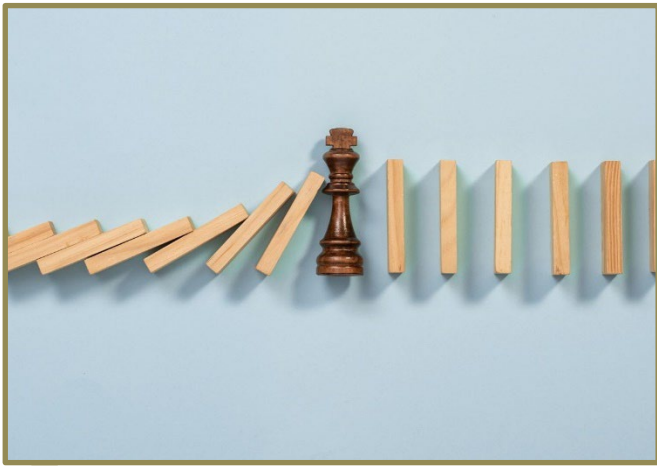
Achieving high-quality care through nurse-led teams

What's at stake?

For the foreseeable future, chronic illness will be the major health challenge confronting the U.S. More than one-third of older adults in the U.S. have four or more chronic conditions,[1] commonly complicated by other health and social risks such as low health literacy and poverty.[2] Unfortunately, multiple studies reveal that the healthcare needs of these patients are poorly managed, often with devastating human and economic consequences.[3]
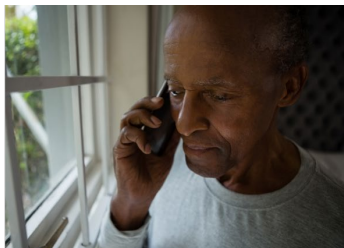
The **Transitional Care Model (TCM)** is a care management strategy proven to enhance the care experience, improve health and quality of life outcomes and reduce total costs of care among at risk, chronically ill older adults. Designed and tested by a multidisciplinary team based at the University of Pennsylvania (Penn), the TCM is best known for improving outcomes of hospitalized older adults who transition to skilled nursing facilities (if referred) or directly home.[4]

In recent years, testing of the TCM has expanded to prevent emergency department visits (ED) and hospitalizations of older adults in partnership with primary care practices, ACOs, long-term care facilities and other community-based organizations.[5] Most recently, the TCM has been expanded to include a longitudinal, population health strategy. The TCM was recognized by the Coalition for Evidence-Based Policy as a Top-Tiered Evidence based approach to care that, if scaled, could accelerate efforts to move from a fragmented to a more integrated, high performing healthcare system.[6]

How it works

The TCM is centered on trusting relationships established between each patient, family caregiver and health and social care team members and an Advanced Practice Registered Nurse (APRN)—a master's prepared nurse with expert knowledge and skills in the care of chronically ill older adults and their family caregivers—serving as a Transitional Care Nurse (TCN). The TCN utilizes an evidence-based protocol to

design and implement individualized care plans for chronically ill older adults and family caregivers throughout common transitions in health (e.g., acute episode of heart failure) and health care (e.g., hospital to home).[7]

The goal of the TCM is to improve the health and quality of life of at-risk, chronically ill older adults, and interrupt patterns of frequent and costly acute care use. The TCM is delivered through hospital and skilled nursing facility, home and follow-up visits to primary care clinicians and specialists augmented by telehealth services and 7-days per week telephone availability. Table 1 provides a description of the TCM Core Components and definitions.[7]

Table 1. Transitional Care Model (TCM) Components and Definitions[7]

COMPONENT	DEFINITION
Screening	Targets older adults at risk for poor outcomes.
Staffing	Uses APRNs who assume primary responsibility for care management throughout episodes of acute illness and oversees longitudinal care of at-risk patient groups.
Maintaining Relationships	Establishes and maintains trusting relationships with patients and family caregivers involved in the patients' care.
Engaging Patients and Caregivers	Engages patients in design and implementation of the plans of care aligned with their preferences and goals.
Assessing/ Managing Risks and Symptoms	Identifies and addresses patients' priority risk factors and symptoms and applies evidence-based interventions to address key risks and symptoms.
Educating/ Promoting Self-Management	Prepares older adults and family caregivers to identify and respond quickly to worsening symptoms.
Collaborating	Promotes consensus on current and advanced care plans between older adults and members of the care team.
Promoting Continuity	Prevents breakdowns in care by having same clinician involved across these sites.
Fostering Coordination	Promotes communication and connections between healthcare and social services/community-based staff and organizations.

The TCM experience

Following her third rehospitalization in the past 3 months for heart failure, Ada James was enrolled in the hospital's TCM program. The Transitional Care Nurse (TCN) met with Ada daily in the hospital to assess her needs and collaborate with the health care team in stabilizing her and preparing her for discharge. Ada reported she was unable to climb stairs due to severe shortness of breath, restricting her to the first floor of her home. She was depressed and greatly missed being able to attend church services. Her faith is her comfort, and her church the base of her network of friends.

Using this goal as a driver of the care plan, the TCN partners with Ada and her health care team to optimize her treatment plan and teaches Ada to implement it. Beginning with a home visit within 24 hours of discharge, the TCN earns Ada's trust, ensures that her home is safe, understands how to take her medications correctly, follows her low salt diet, and monitors her weight and symptoms to detect early signs of deterioration. Over the next 2 months, via weekly visits and phone contact, and regular collaboration with Ada's primary care provider, Ada's care plan is optimized, including treatment for previously undetected sleep apnea. Gradually, with diminished symptoms and improved stamina, she becomes comfortable using stairs and walking outside. The TCN also enlisted Ada's church friends to help with grocery shopping, cooking, transportation to her provider appointments, and provide the socialization Ada needed to lift her spirits.

Throughout, the TCN effectively engaged Ada in her health and care. Ada had no rehospitalization during this time and she learned how to manage any increase in symptoms. Ada joyfully attends church services with her friends again.

Based on science

Across three National Institute of Nursing Research funded randomized controlled trials (RCTs),[8] the TCM consistently demonstrated improvements in multiple dimensions of quality and reduced costs for high-risk, cognitively intact older adults when compared to similar groups of patients who receive standard care. The last of this series of funded RCTs found that all-cause rehospitalizations for older adults with heart failure who received the TCM were significantly reduced through one-year post-index hospital discharge when compared to control patients who received standard care at mean cost savings of $5,000 per older adult.

The TCM population focus was then extended to include hospitalized, cognitively impaired older adults. Unlike the earlier RCTs, this study compared the effectiveness of the TCM to other evidence-based approaches. Study findings revealed that community-based older adults with mild to severe cognitive deficits who received the TCM had significantly fewer all-cause rehospitalizations through six months post-index hospitalization when compared to other proven hospital-based strategies.[9] The Penn team also has expanded the context for testing the implementation of the TCM to Patient-Centered Medical Homes. With the support of multiple foundations, for example, primary care clinicians and APRNs co-managed at-risk older adults in the community; findings suggest that this approach has the potential to prevent hospitalizations and ED visits for this high-cost patient group.[10]

Clinical and economic benefit

Until recently, a number of organizational, regulatory, and financial barriers have limited interest in the adoption or adaptation of the TCM. To address these challenges (and with the support of multiple foundations and the guidance of a national advisory committee), the Penn team partnered with a health system and major insurer to assess the clinical and economic effectiveness of the TCM when applied with a high-risk Medicare managed care population.[11] The translational component of this effort included design and testing of multiple tools, including a screen to identify high-risk older adults, web-based modules to prepare nurses and other team members to implement the TCM, a clinical information system and performance improvement and monitoring protocols. Despite multiple challenges in 'real world' implementation, older adults in the TCM group demonstrated improved health outcomes, a decrease in number of re-hospitalizations through three months and cumulative per member savings at one-year, when compared with similar high-risk members receiving only telephonic services in another market.[12] Since the completion of this study, transitional care services have been established in many health systems and communities throughout the U.S.

In 2015, with the support of the Robert Wood Johnson Foundation (RWJF), the Penn team conducted a scan of the potential universe of implementers of the TCM in the U.S. More than half of the 582 unique respondents reported use of the TCM alone or in combination with other evidence-based transitional care interventions.[13] Additionally, the Penn team partnered with colleagues at the Stevens Institute of Technology to develop an online simulation tool designed to inform and influence decision making regarding wide scale implementation of the TCM. The simulator fuses aspects of scientific analysis, engineering, social science, and visualization toprovide decision makers

with a more comprehensive understanding of the consequences of implementation of the TCM.[14]

MIRROR-TCM

The Penn team is coordinating a large-scale RCT to replicate the TCM in collaboration with multiple hospitals, post-acute and community-based partners. This ongoing initiative[15] was launched in 2020 with funding from Arnold Ventures, the Missouri Foundation for Health, and the Health Services Research and Development Service, Department of Veteran Affairs. This multisystem trial recently completed enrollment of 962 older adults hospitalized with heart failure, chronic obstructive pulmonary disease, or pneumonia (480 intervention, 482 control) in three health systems across four states. Evaluation of the implementation of the TCM in the trial[16] and preliminary analyses are underway. Findings will support the sustainability and spread of the TCM at the partnering organizations and inform reimbursement decisions by public and private payers. Learn more about the trial and partners at www.nursing.upenn.edu/mirror-tcm/.

Using Evidence to Transform Practice

Transitional care services have been established in many health systems and communities throughout the U.S., though many are not well-defined or rely on evidence-based protocols. The lack of evidence-based practices in these implementation efforts further exacerbates a fragmented healthcare system and limits opportunities for promoting equitable, high-quality care for at-risk populations

The Penn team has supported organizations in designing and implementing a customized transitions program that capitalizes on the mission, vision and infrastructure of an organization, capitalizes on current strengths and anticipate future challenges. Strategies include an operational assessment, training and orientation of teams and partners to provide transitional care, performance improvement processes and evaluation protocols. A description of the process and tools that may guide and supports each strategy is highlighted below. It is important to note that the process implemented with each

organization is co-designed.

⚙ Operational Assessment

Essential to this process is open, transparent communication among all participants. The Penn team conducts a comprehensive assessment of each organization to understand current practices and available resources, and to identify potential process and knowledge gaps that may affect the program implementation (e.g., targeted population, services offered, available data). Surveys and interviews with leadership teams, post-acute and community-based partners, primary care clinicians and other system staff are conducted to identify strengths and potential threats to program success.

Implementation Plan

To optimize collaboration across all stakeholders and accountability of the program team, the Penn team facilitates co-design of an implementation plan, applying findings from the *operational assessment* to establish and refine protocols, work plan and milestones. The *implementation plan* is constructed based on the goals an organization selects as its top priority (i.e., reduce hospital readmissions in specific patient populations). The metrics used are designed to assess the implementation of the TCM's core components at patient-, provider- and system-levels. Templates of clinical and data protocols and milestones, and organization/program matrices are available for customization.

Training

Online Courses. Penn team experts have developed TCM case presentations and video simulations of care processes and patient responses. Two self-paced, online courses are available:

- 2-hour course provides an introductory overview of transitions in care and health.
- 25-hour comprehensive course provides individuals responsible for direct care of patients, and collaborators, other healthcare team members, with knowledge and skills to deliver transitional care using the TCM.

A clear description of the *Transitional Care Nurse* role is presented. Access to a wide range of evidence-based assessment and management tools, standards of care practices, and suggestions for measuring quality and cost outcomes is provided. Learners may start courses at any time and move through the material at any speed they choose. Upon successful course completion, learners earn continuing education credit that may be applied to their healthcare licensure requirements.

Orientation. Following completion of the comprehensive course, the Penn clinical experts provide an orientation session with team members to apply learning based on team members' roles, simulate protocol implementation and documentation, and review operational work plans. Manuals that detail program implementation along with resources such as patient screens, recruitment scripts and brochures/flyers are available for customization.

Webinars. Continuous learning and skill development is central to the success of any program seeking to improve the care paradigm. Select booster sessions (e.g., Advanced Care Planning; Motivational Interviewing) with clinical experts are routinely held to engage leaders and clinicians in their dynamic roles.

Performance Improvement Processes

All program dimensions are informed by data that provides a complete picture of the investment by program team members. At program launch, Penn experts engage team members weekly (via webinar) to address specific issues/concerns as well as successes to support a continuous learning environment for the organization. Quarterly and annual surveys are redeployed to capture organizational changes and other innovations that may affect the program. Site visits may also be conducted.

Documentation: The contributions of program team members (recruitment/ enrollment staff; TCM clinicians) are captured using Penn-developed forms that document interactions with patients, family members, and other healthcare team members. A summary dashboard report on program census is generated and provided to program teams for review.

Fidelity Monitoring. Using data provided by TCM clinicians via case documentation forms, routine surveillance of implementation of the TCM's components is evaluated. A monthly summary fidelity report is provided to program leads for discussion on strategies to improve and/or maintain fidelity to the intervention.

Clinical Case Conferencing. Penn team clinical experts examine documentation completed by clinicians and program leads weekly at launch and monthly thereafter. A summary report is provided to program teams to support the assessment of facilitators and barriers when applying root cause analysis techniques in case discussions. Over time, the goal is for the organization clinical leaders to lead these sessions independently.

Evaluation

Using a mixed methods approach, the Penn team examines '*what it takes*' for organizations to move from baseline readiness to achieving fidelity to the TCM Core Components. A final set of interviews with stakeholders is conducted to reflect on the program-to-date and inform new strategies. All data collected during the effort are analyzed and presented in a final evaluation report (and brief) including lessons learned and recommendations for ongoing improvements. Dissemination tools (data charts and elements; infographics) and templates are also available to maximize the distribution of key messages.

ACKNOWLEDGMENTS

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Partners

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University of Pennsylvania Health System

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Jonas Center for Nursing Excellence

The Robert Wood Johnson Foundation

Patient-Centered Outcomes Research Institute

Arnold Ventures

Health Services Research and Development Service, Department of Veteran Affairs

Missouri Foundation for Health

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Physician-Focused Payment Model Technical Advisory Committee

Listening Session 2: *Financial Incentives for Improving Care Transition Management*

Grace Terrell, MD, MMM

Chief Product Officer

IKS Health

Transitional Care Management

Grace E. Terrell MD

Real Change in Healthcare

Requires a fundamental change in three aspects of the healthcare delivery system:

1. The patient care model
2. The payment model
3. The operational model of the delivery system

...and these three aspects must be redesigned in tandem...

Approaches to Payment Redesign

"Pay Doctors Right and They Will Do the Right Thing"

These approaches tend to focus on the logistics of fees, coding, bundles, shared savings, risk payments, global payments.

"Pay for the Right Things"

These approaches tend to focus on care models that could provide services to patients in more effective ways.

3

Transitional Care Management

Fee for Service Payment Model Approach

- ➔ Transition Care Codes are an attempt to "pay for the right things"
- ➔ These codes do not address the fundamental problem that contemporary primary care practices are not set up well to provide comprehensive transitional care management
- ➔ Creates documentation burden and compliance concerns
- ➔ May not be flexible enough to adequately address specific patient follow up needs.

One Patient Care Model Approach:

A Transition care clinic for patients in Medicare Advantage and MSSP risk contracts with high risk of readmissions

- ➔ This was an attempt to "do the right thing"
- ➔ A team was developed consisting of a group of general internists, advanced practice providers, clinical pharmacists, social workers, certified medical assistants, phone triage and front desk staff, who would see these patients within 72 hours of discharge, and do comprehensive care needs assessment
- ➔ The clinicians would see the patients quite frequently until they are deemed stable enough to be transitioned back to their primary care medical home.

4

Recommendations

Start with basic questions of "is this the right thing to pay for"? AND IF SO "what is the right way to pay for this"?

Begin incorporating information integration approaches that will be possible from machine learning technologies that can measure care model effectiveness and payment model efficiency together rather than as distinct workstreams.

Pay attention to how payment model changes lead to delivery system operational changes (as has happened in the past – hospitalists, SNFists, extensivists.)

Consider transitional care delivery an ongoing innovation space that can be an effective area to understand how best practice care models, if properly paid for, can markedly improve patient outcomes.

Thank You

Physician-Focused Payment Model Technical Advisory Committee

Listening Session 3: *Addressing Care Transitions in Alternative Payment Model Design*

John Birkmeyer, MD

President

Sound Physicians

Payment Models for Improving Acute and Post-Acute Care

## Lessons learned from BPCI-A

PTAC meeting, June 13, 2023

Overview of Presentation

- Transforming acute and post-acute care
  - o Sound Physicians' experience in managing TCOC around acute care episodes
  - o Lessons learned: What are the key clinical levers and how do you impact them?

- Nested episode payment models
  - o What are the options?
  - o 4 recommendations for embedding bundled payments in population framework

Who is Sound Physicians?

National scale medical group designed to deliver value-based outcomes to hospital, primary care, and payer partners across the acute care episode
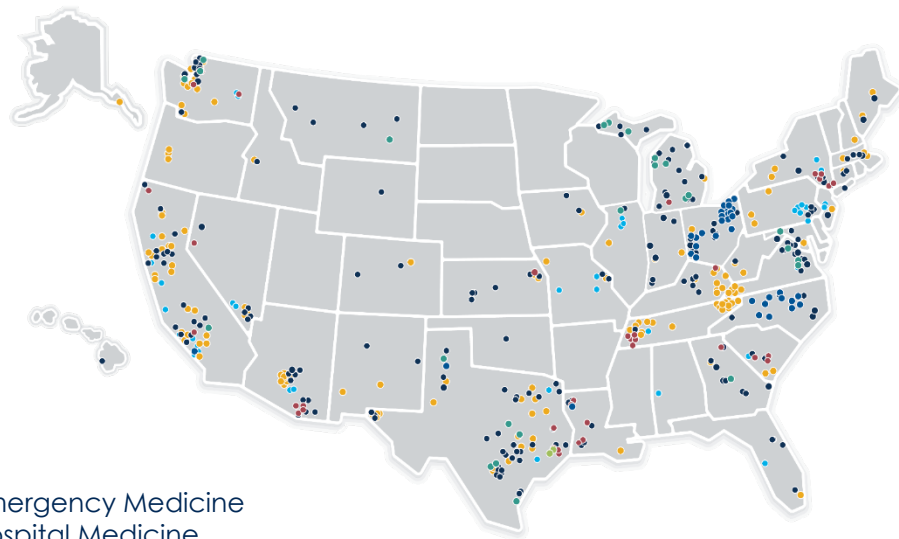
Emergency Medicine
Hospital Medicine
Critical Care
Anesthesia
Physician Advisory Services
Telemedicine

350+ hospital-based practices

Largest hospitalist group in the US

Initiated **300,000 episodes in BPCI-A** before exit in 2022

15,000 member long-term care ACO

National VBC contracts with **United** and **Humana**

$75 million invested value-oriented education and training

Learning how to manage acute episode spending

Sound BPCI Trend vs. National Non-Participating Hospitals (Medical Bundles Only)
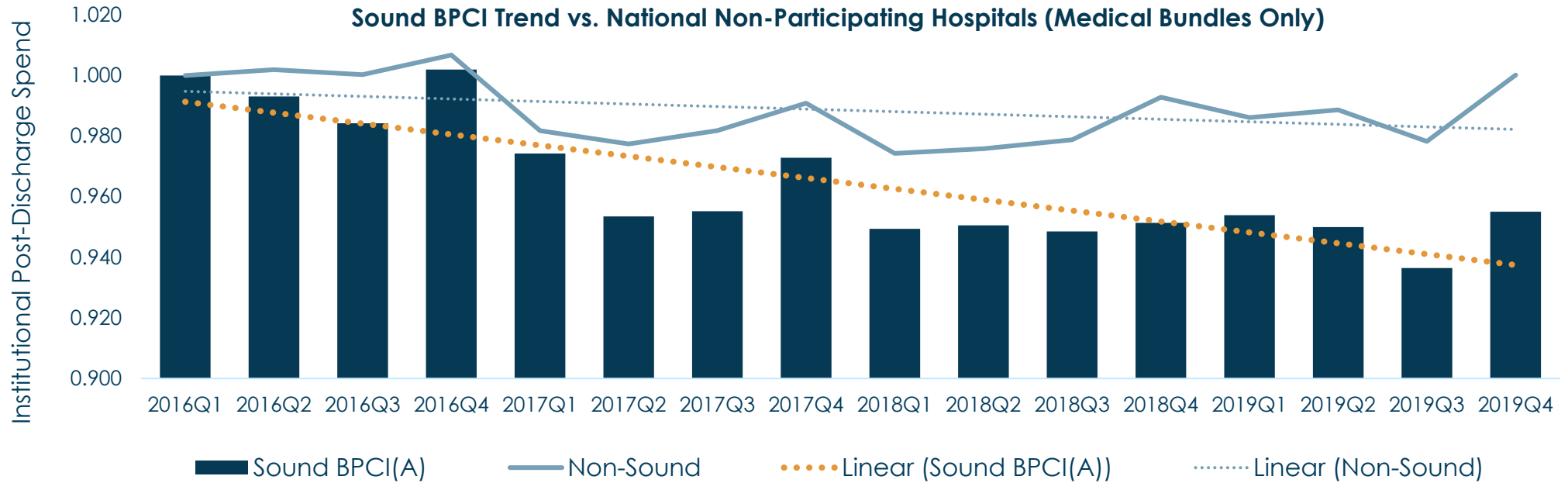
Episode Savings:

- **$1,000**/episode in 2018
- Sound costs decrease **4X faster** than trend

30-Day Readmissions:
2016-2019

26%
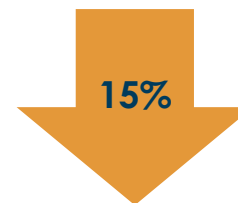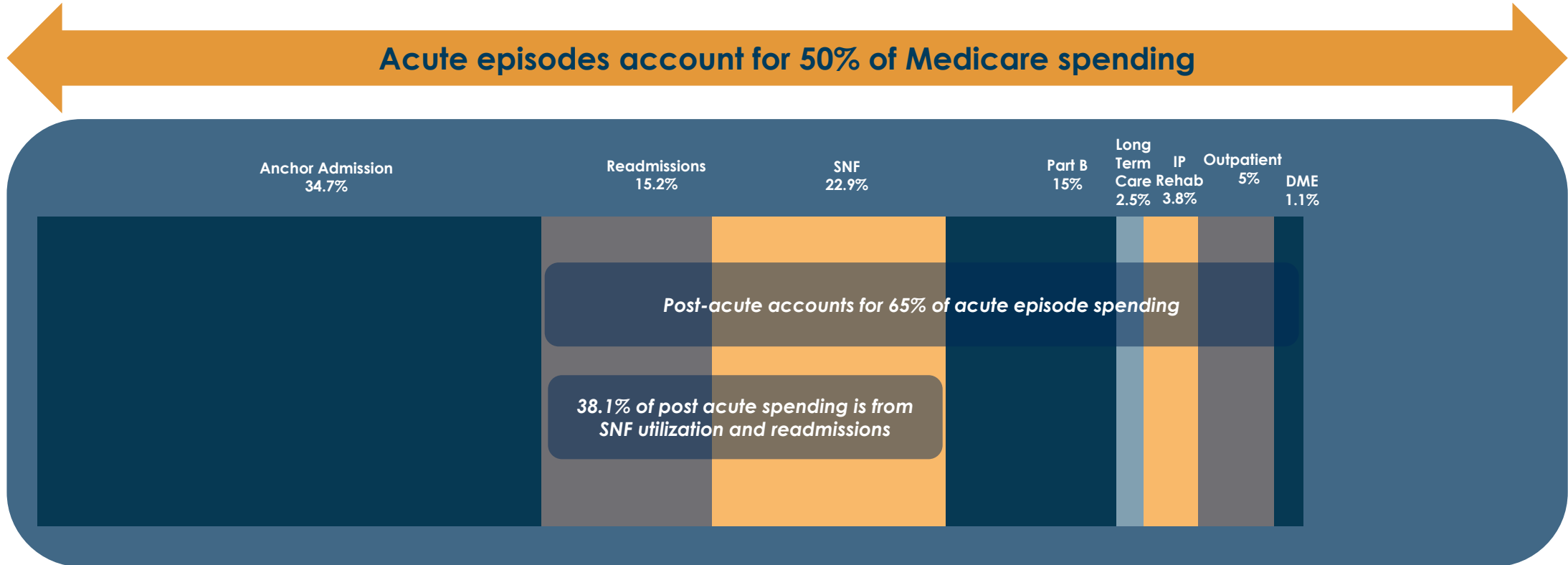
LTACH Utilization:
2016-2019

60%

SNF Utilization:
2016-2019

15%

Advance Care Planning:
2016-2019

10x

4

Understanding acute episode spend in Medicare

Acute episodes account for 50% of Medicare spending

| Anchor Admission 34.7% | Readmissions 15.2% | SNF 22.9% | Part B 15% | Long Term Care 2.5% | IP Rehab 3.8% | Outpatient 5% | DME 1.1% |

Post-acute accounts for 65% of acute episode spending

38.1% of post acute spending is from SNF utilization and readmissions

sources: Institute of Medicine, Dartmouth Atlas of Healthcare, & Sound Physicians BPCIA episodes analysis

Clinical levers: Sound experience in one slide

	Opportunity	Sound care model*
Home discharge	Large – 30+% of total, wide variation in hospital practices	Physicians take ownership from hospital case management
Readmissions (general)	Small – <7% of spending, flat of the curve?	Usual stuff
Readmission (from SNFs)	Low/Medium– 5% of spending, but wide variation, actionable	Hospitalist telemedicine in SNFs (Sound in 1,000 SNFs)
Specialist use	Medium – 10-20% depending on accounting. Highly variable & discretionary	"ConsultRight" – tech-enabled, diagnosis-specific "guidelines with teeth"
End of life care	Medium – hard to quantify spend opportunity, but almost 25% of BPCI-A patients expire during 90-day episode	Real advance care planning (vs. the CMS / MIPS check box version)

Other lessons learned

1. **First things first – focus on care processes applicable to all patients**

2. **Good technology – IT-enabled punchlists, performance analytic platform**

3. **Focus on the right patients – predictive analytics**

4. **Alignment between hospital and physician groups**

5. **Success requires more than just "good care" – Sound cost $200 per discharge, needs payment model to support**

NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

Transitioning to Value-Based Hospital Medicine: A Sound Investment?

John D. Birkmeyer, MD, Robert M. Bessler, MD

Vol. 1 No. 4 | June 17, 2020

Scan to read the article

Overview of Presentation

- Transforming acute and post-acute care
  - Sound Physicians' experience in managing TCOC around acute care episodes
  - Lessons learned: What are key clinical levers and how do you impact them?

- Nested episode payment models
  - What are the options?
  - 4 recommendations for embedding bundled payments in population framework

3 Options for CMS/CMMI to consider

	Advantages	Downsides
Do nothing – Sunset bundles altogether and let ACOs treat specialists (and hospitals) as cost centers	• Easiest option • Most hospitals would be grateful; most specialists would be indifferent	• Too much spending/variation in acute care episodes to ignore • PCPs have little impact
MIPS on steroids – Put more weight on episode cost metrics, tied to FFS reimbursement	• MIPS framework already includes cost metric	• Practical nightmare – Too much heterogeneity at individual provider level • MIPS adjustment dollars <u>way</u> too small relative to time investment (and relative to just seeing more patients)
Nested bundles	• Keeps hospitals and specialists in the game	• Design complexities and value tradeoffs

Rec #1: Start where the money is—hospitalists

Hospitalists

- Hospital-based PCPs
  - Same training (IM)
  - Take allcomers / diseases
  - Gatekeepers for specialists, post-acute referrals

- Practical advantages
  - Tightly aligned with hospitals
  - Homogenous group

- Account for over **70%** of Medicare inpatient admissions

Specialists

- Impossibly heterogenous group
  - Both within and across specialties

- Inpatient admissions account for small minority of their practices
  - Even more so as ortho moves to ASCs

- Biggest impact on acute care spend is N episodes, not episode efficiency

Hospitalists: 80% of the spend, 20% of the complexity
Specialists: CMMI should develop specialty-specific spend metrics at the population level, rather than bundles

Rec #2: Move from bundles to all admissions

Diagnosis-specific bundles (historical BPCI-A)

- Small percentage of total work for most specialists

- Pricing has been problematic (small N's, risk adjustment)

- Coding change snafus, gaming?

Case for all-in approach

- All acute medical discharges with weird stuff carved out (like Sound's national contracts with commercial payers)

- Much larger sample size for pricing stability & risk adjustment

- Enough upside / risk to justify meaningful investments by providers

Rec #3: Lose the discount, lose the ratchet

Historical BPCI-A model

- Participants take 2-3% discount

- Prices reset ("ratchet") every year

Problems with historical model

- <u>Nobody</u> reduces episode spend by 2% year over year
  - o Almost half of episode spending is fixed (DRG-based hospital payment)
  - o Sound only got to 1% annual improvement

- Participants stayed in as long as they could identify favorably priced bundles (and bailed en masse when they couldn't)

Rec #4: Leverage bundles to accelerate ACO adoption

Recommended Pathway – Summary Table		
Episodic Track A:	**Episodic Track B:**	**Episodic Track C:**
Hospitals participating in MSSP Basic Track A, B, C, D or Track 1 or not participating in a population-based model	Hospitals participating in MSSP Basic Track E or Track 1+ and 2+ models	Direct Contracting Entities (DCEs) and Hospitals participating in Enhanced Track or NextGen MSSP models
Episodic Risk Requirement • Mandatory bundles • 8 BPCI-A bundles + "all medical" super-bundle option	• Same as Track A	• DCEs, MSSPs required to enter episodic risk-sharing with attending PGPs responsible for 60% of admissions • CMS calculates savings
Episode Attribution • Willing PGPs can select any/all bundles • Hospital retains all risk not selected by PGPs • Hospital must establish risk-sharing pool with non-participating attending physicians	• Same as Track A	• DC/MSSP attributes episodes to contracted PGPs
Episodic Risk Sharing (at episode category level) • CMS retains 50% • Participating PGPs retain share of remainder in proportion to their respective share of total episode volume • Of remainder, hospital retains 50% of upside, and all of downside, and remaining 50% of upside is divided by non-participating attendings in proportion to their respective volume.	• CMS retains 40% • Participating PGPs, retain an amount equal to the lesser of 70% or their relative share of episodes. • Of remainder, hospital retains 70% of upside and all downside, and remaining 30% is divided by non-participating attendings in proportion to their respective volume	• CMS retains its share per DCE/MSSP agreement • Of remainder, DCE/MSSP retains greater of 50% or an amount equal to its non-contracted share of episodes • Contracted PGPs divide remainder in proportion to their relative share of episodes

Take home points: 1) mandatory bundles for non-adopters, 2) include both hospitals and providers, and 3) risk/savings models depend on ACO level

Physician-Focused Payment Model Technical Advisory Committee

Listening Session 3: *Addressing Care Transitions in Alternative Payment Model Design*

Marc Rothman, MD, CMD

Chief Medical Officer

Signify Health

Transition to Home (TTH)

Reducing Readmissions in Alternative Payment Models

Marc Rothman, MD, CMD

PTAC Listening Session 3
June 13th, 2023

Homeward

The Science of Readmission Reduction

No shortage of evidence-based high-touch interventions

Several well-studied readmission reduction programs, when implemented in their entirety, have proven that high quality transitional care can:

- Reduce readmissions[1]
- Improve outcomes & patient satisfaction[2]
- Lower healthcare costs[3]

The National Transitions of Care Coalition[4] outlines 7 components of an effective transitional program as:

- Transition Planning
- Information Transfer
- Patient & Family Engagement
- Follow-up Care
- Medication Management
- Healthcare Provider Engagement
- **Shared Accountability Across Providers & Organizations**

Key Challenges of *High Touch* Programs

- Local hospitals and health systems struggle to implement, scale and sustain face-to-face transitional care programs
- Common problems include:

Viability   **Cost Effectiveness**   **Poor Outcomes**

Viability	Cost Effectiveness	Poor Outcomes
Panel size is hard to grow quickly relative to other service lines	Dependence on high cost providers making fewer visits	Lack of focus when team resources are shared across departments
Absence of clear funding & FFS admin support	Potential value of readmissions and a lack of shared accountability	Inadequate coverage across broad geographies

Design Principles
Key Enablers of Early Success for the TTH Program

Engagement / Oversight
- **Expand** program duration to 90 days
- **Virtual** first (tele) for cost and safety
- **Evidence** based tools/techniques
- Social determinant (**SDOH**) emphasis
- Weekly **interdisciplinary** RTA review
- Comprehensive **QA** program

Implementation & Scaling
- In first 8 months went live with:
  - **> 8,000 patients** discharged from
  - **73 hospitals** in
  - **15 states**
- Steadily reduced go-live times
- Fine-tuned **staffing model**
- Shortened new-hire training

Tech & Product Resources
- Innovative environment
- Rapid **EMR customization**
- Telephonic call center mentality
- Next best action approach
- **Rapid cycle** quality improvement

Learning → Action
- Quick pivot to **multilingual** RN's
- New role (CCA) to reduce RN and SCC **prep time** before each call
- Reduce **implementation** to <30 days
- Flag **proxy decision making** issues

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TTH Enrollment in First 12 Months

TTH-Engaged for FEB 1, 2021 - JAN 31, 2022
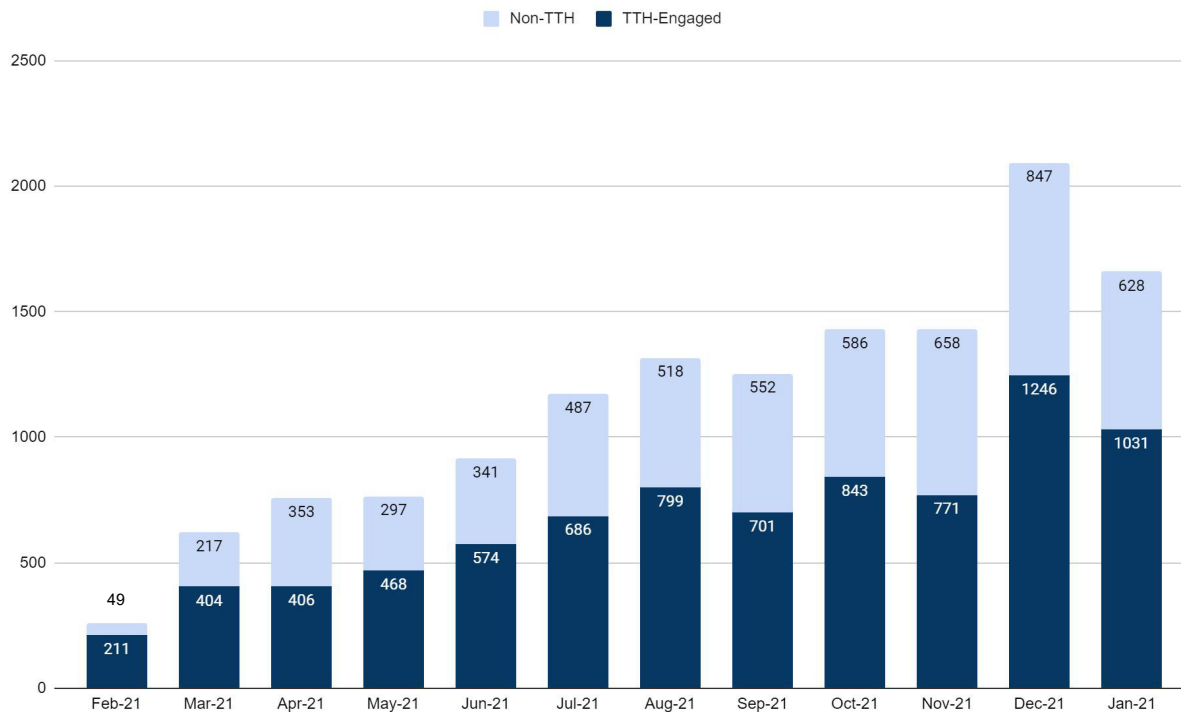
TTH Patient Population Demographics

Characteristics of TTH-Engaged and Non-TTH Populations Hospitalized
Between FEB 1, 2021 - AUG 31, 2021
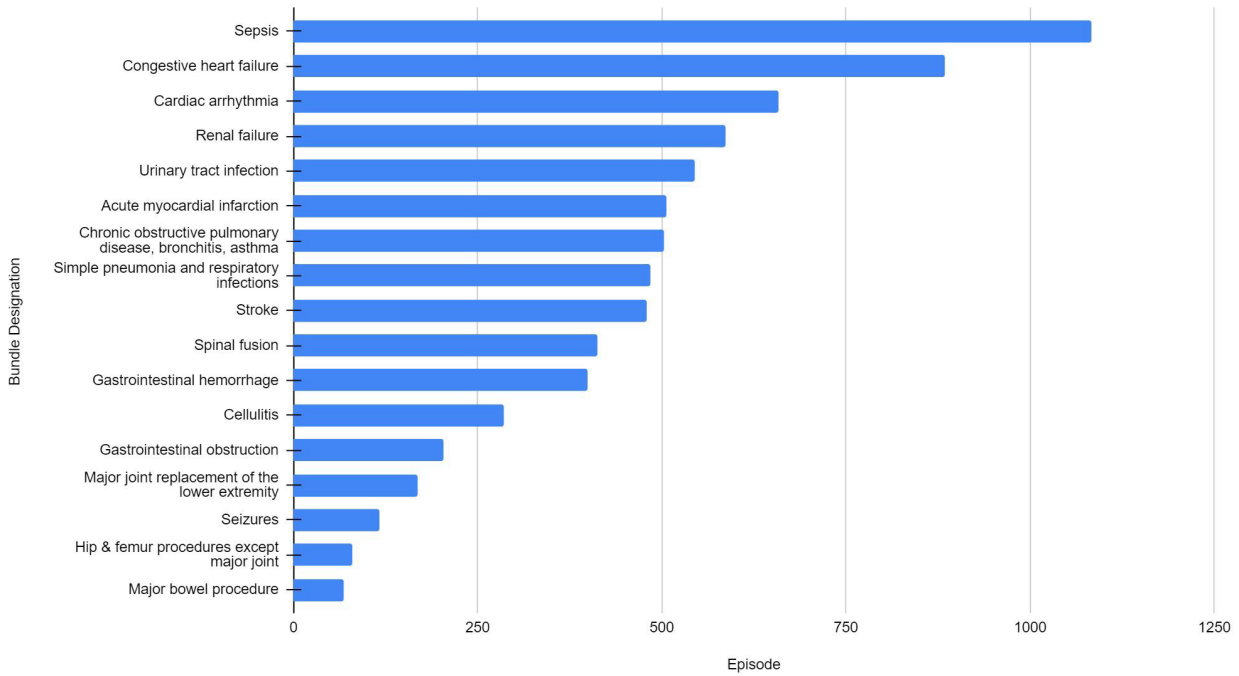
Population Composition		
	TTH-engaged (N = 2,122)	**Non-TTH (N = 6,990)**
Average Age (years)	76.03	77.12
% Female	57.60%	56.00%
% Dual Eligible	15.80%	20.00%
% w/Medicare through Disability	21.90%	20.40%
Avg. PCMA	1	1.05
PCMA = Patient Case Mix Adjustment		

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TTH Major Hospital Discharge Diagnoses
FEB 1, 2021 - JAN 31, 2022

Episode vs. Bundle Designation

TTH 90-Day Relative Readmission Rates
All Clients Thru March 2022

Population	90 Day RR, Actual	90 DAY RR (Risk Adjusted Benchmark)	90 Day Relative Performance
TTH Engaged (N = 4855)	24.00%	28.00%	14.80%
Total Non-TTH (N = 26,718)	26.80%	28.00%	2.11%
Modeled Readmission Savings = $4.6M			
RR = Readmission Rate			

- Both 30- and 90-day TTH-engaged readmission rates outperformed the non-TTH population over all periods studied
- Greater reductions in readmission rates were seen in lower acuity patients and those with at least one PCP/specialist follow up appointment
- Claims-match rates for Medicare BPCIA files were a challenge, reducing reach- and engagement rates throughout the study period

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90-Day Readmission Rates, by Post-Acute Utilization
FEB 1, 2021 - AUG 31, 2021

Population	90 Day Readmission Rate	90 Day Risk-Adjusted Readmission Benchmark	90 Day Relative Performance
TTH Engaged (N = 2,122)	24.40%	28.00%	-12.86%
Total Non-TTH (N = 6,990)	29.20%	29.70%	-1.68%
Received Home Health			
TTH Engaged (N = 476)	23.10%	28.20%	-18.09%
Total Non-TTH (N = 1,201)	31.10%	30.50%	1.97%
Received Skilled Nursing			
TTH Engaged (N = 303)	32.00%	29.50%	8.47%
Total Non-TTH (N = 1,464)	35.40%	31.50%	12.38%
Received Inpatient Rehab.			
TTH Engaged (N = 68)	22.10%	25.80%	-14.34%
Total Non-TTH (N = 285)	29.10%	28.00%	3.93%

TTH intervention's effectiveness is most apparent when comparing the relative 90 day performance of TTH Engaged patients discharged with Home Health compared to Non-TTH (18.09% reduction vs 1.97% increase) and IRF's TTH Engaged patients with Non-TTH patients (14.34% reduction vs. 3.93% increase.

Rehospitalizations among patients who used SNF services increased for both TTH-Engaged and Non-TTH patients but to a lesser degree in those who engaged TTH.

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90-Day Readmission Rates, by Service Line Group
FEB 1, 2021 - March 31, 2022
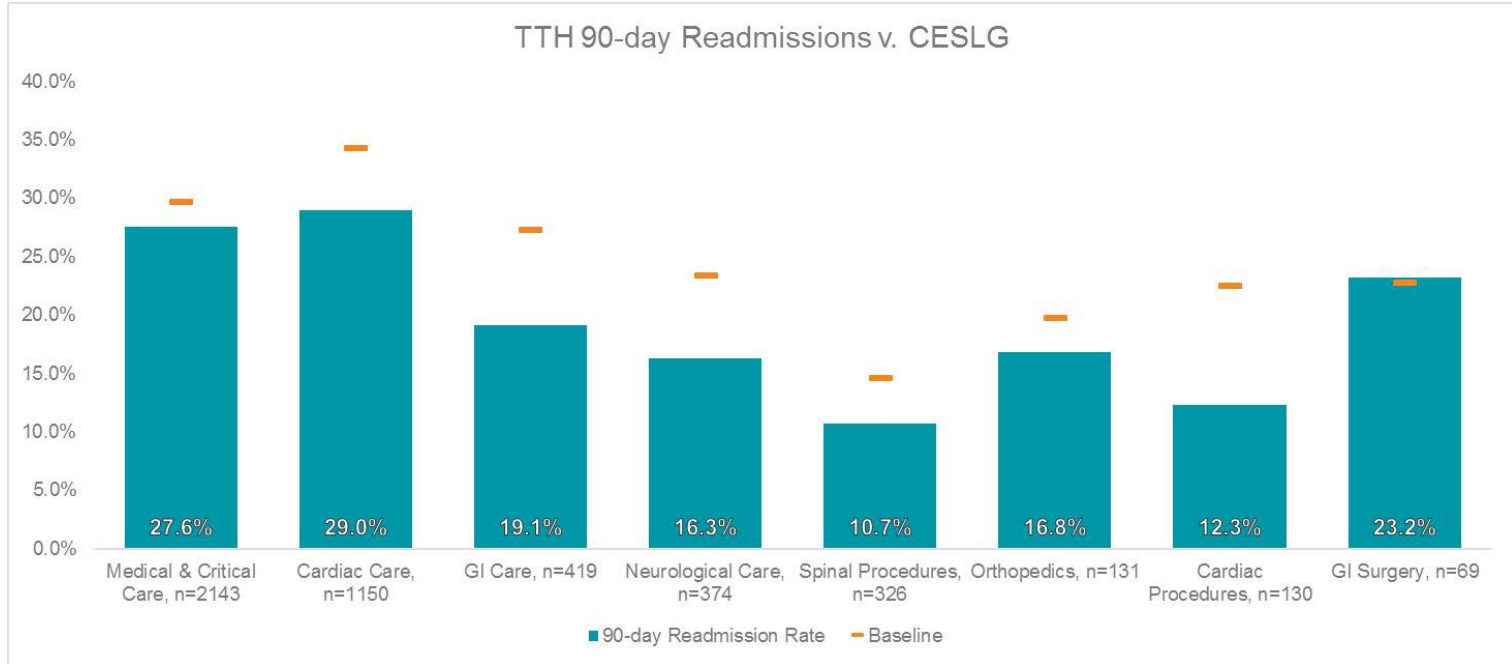
TTH Care Coordination Activities
FEB 1, 2021 - JAN 31, 2022

Two key components of an effective transitional care program[5] include:
- Adequate follow-up with PCPs/Specialists
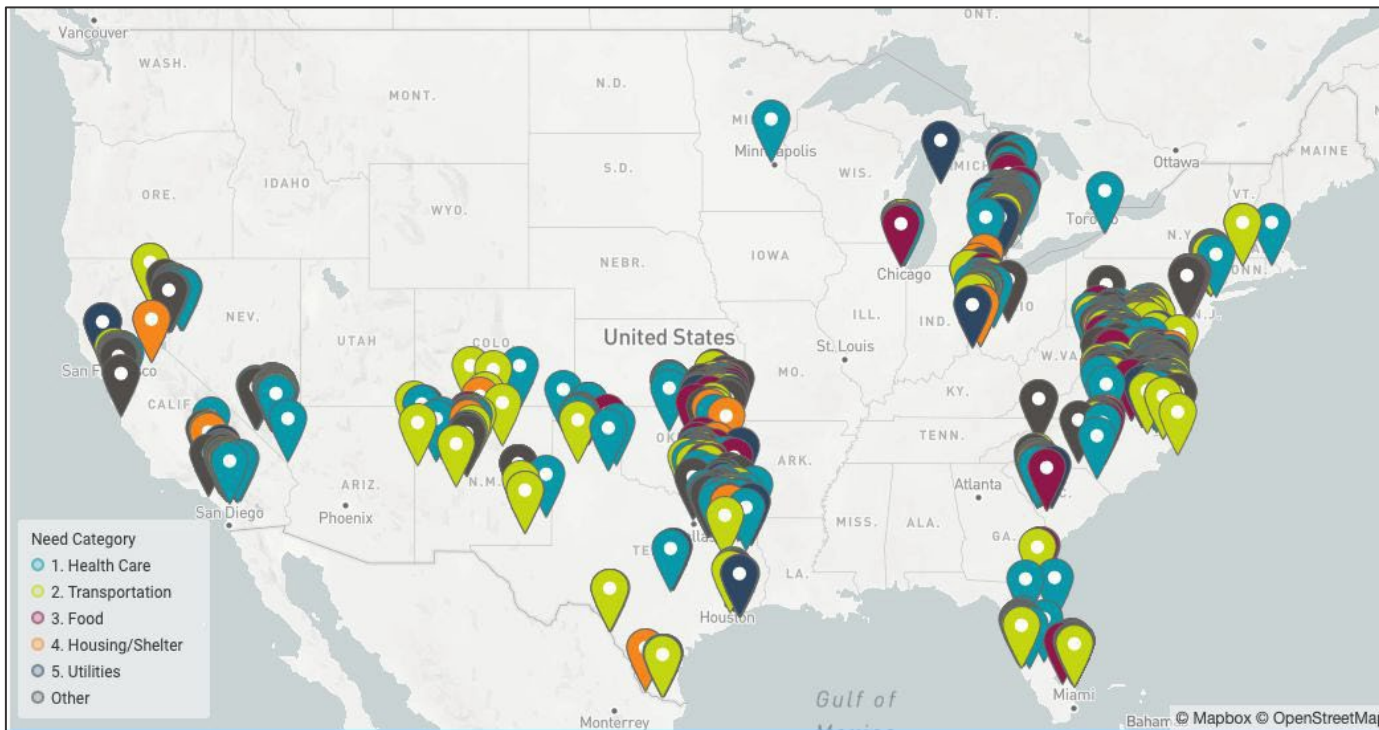- Medication adherence by patients in both pathways

Coordinated Care for over 8,000 patients

Over 1,400 PCP/specialists follow up appointments scheduled on behalf of patients

Type of Care Coordination Calls Made on Behalf of TTH-Engaged Patients from FEB 1, 2021 - JAN 31, 2022	
Contact Type	**Successful Calls**
Community Based Organization (CBO)	892
PCP	777
Specialty Provider	713
Home Health Agency	558
Pharmacy	204
Other	149
Related Contact	67
DME Vendor	55
Total	**3415**

Social Determinants Reach
Over 3,000 SDOH Needs Identified (Feb 2021 - Jan 2022)

Need Category
- 1. Health Care
- 2. Transportation
- 3. Food
- 4. Housing/Shelter
- 5. Utilities
- Other

© Mapbox © OpenStreetMap

Scalable & sustainable national reach w/ interdisciplinary professionals to address social needs

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TTH Financial Metrics
FEB 1, 2021 - JAN 1, 2022
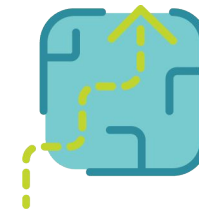
- As readmission prevention increased, total savings outpaced costs
- All results pre-date performance improvement initiatives that reduced operating expense and overhead, improved efficiency of the model
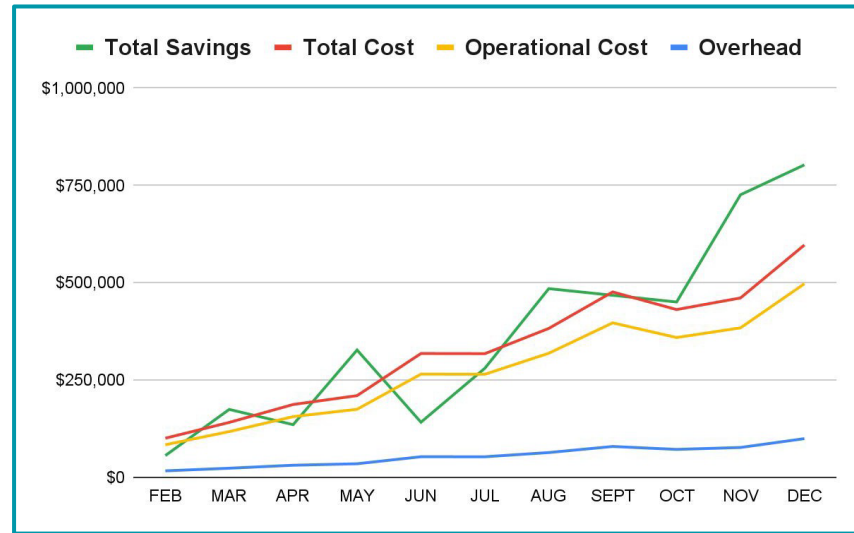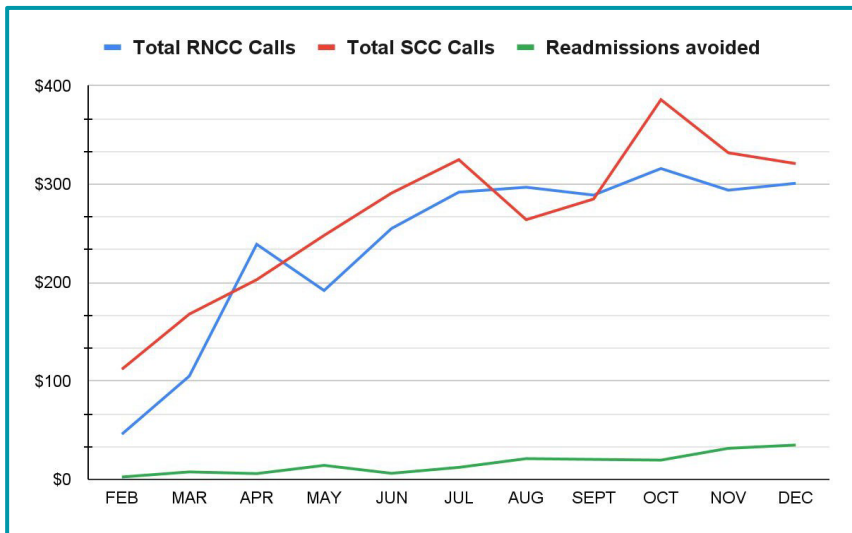
Appendix

The Team

NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

Transition to Home: Rapid Scaling of a Multistate Readmission Prevention Program for Advanced Alternative Payment Model Participants

Marc Rothman, MD, Theresa Bretz, NP-C, MSN, CPA, Angela Farinella, FNP-BC, Justin Rock, MBA, John Kliewer, CHES, CSPO, Lisa Brian, Brenda Tsai Meu Chong, CBAP, POPM, RAP, CSPO

Vol. 3 No. 7 | July 2022

DOI: 10.1056/CAT.21.0409

Reducing unnecessary readmissions to acute care hospitals is a key lever of success in many advanced alternative payment models. Despite the proven effectiveness of evidence-based transitional care, hospitals and health systems often have difficulty scaling and sustaining postdischarge transitional care programs. As the United States' largest convener of Medicare's Bundled Payments for Care Innovation Advanced (BPCI-A) program, Signify Health implemented and rapidly scaled a virtual-first, evidence-based, interdisciplinary transitional care program now serving patients in

Contributors

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signify health.

Our Approach

Rehospital Reduction Across Value-Based Clients

- **The Goal:**
  - Design, implement and *rapidly scale* a *multi-state*, *evidence-based*, *virtual-first* 90-day transitional care program for bundle (BPCI-A) and accountable care (ACO) clients nationwide

- **The Team:**
  - We assembled a team of social workers, care coordinators, product and technology specialists, data and financial analysts, pharmacists, client success executives, implementation teams, senior nurse practitioners and the Chief Medical Officer

TTH Clinical Services

We identify opportunities <u>pre-discharge</u>. TTH services begin at the point of hospital or post-acute facility discharge, when patients are transitioning home with or without Home Health within the first 72 hours at home.

Patients discharged to Skilled Nursing Facilities (SNFs) and Inpatient Rehabilitation (IRFs) are <u>monitored closely</u> for discharge orders and TTH is activated once they reach their home or Assisted Living.

TTH is provided telephonically by licensed professionals and seeks to *augment local care coordination by communicating directly with local resources and providers* on behalf of patients. Frequent touchpoints with the patient throughout a 90-day episode.
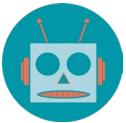
TTH <u>does not</u> utilize any automated telephonic triage or symptom assessment systems. PCPs are notified of Signify's engagement with their patients at the beginning and end of the program and as needed for urgent issues.

Signify's advanced practitioners (MDs/NPs/PharmDs) conduct ongoing case reviews of all high risk patients and engage in peer-to-peer discussions with local providers when necessary.
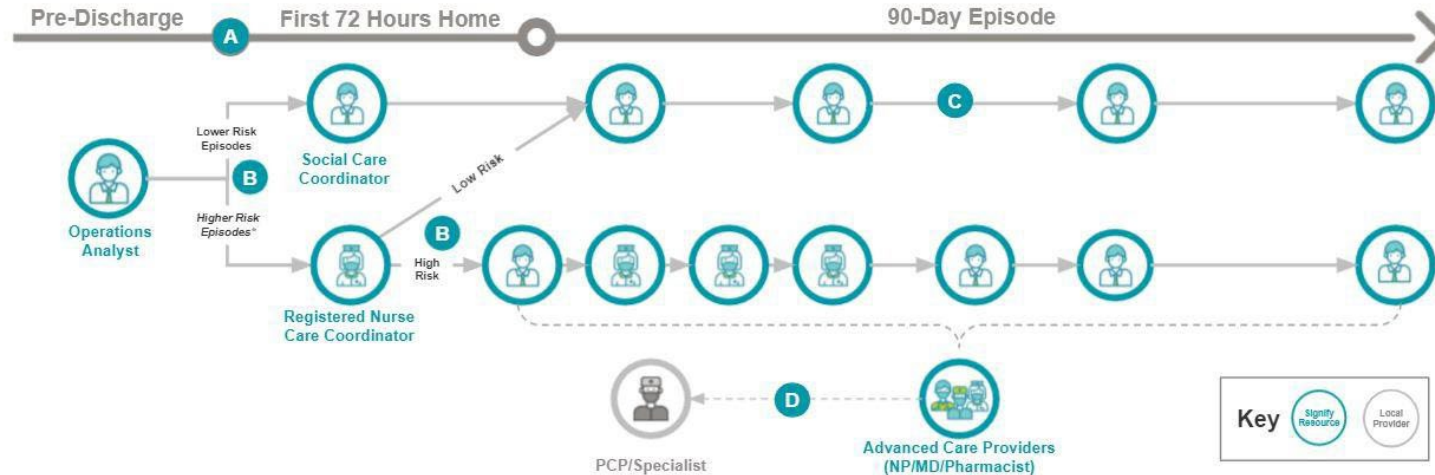
TTH Workflow

TTH Study Population and Treatment Group

Study Population consists of Medicare beneficiaries admitted to hospitals who trigger episodes under the BPCI-A model. Beneficiaries are excluded if they:
- Are eligible for Medicare on the basis of end-stage renal disease
- Do not have Medicare as their primary payer
- Expire during the anchor admission or procedure
- Are covered under managed care plans or United Mine Workers, or
- Have been diagnosed on/after February 2020 with COVID-19 during the anchor admission or procedure during the 90 day post-anchor time period

The treatment group consists of any eligible patient who:
- Received a phone call from a TTH coordinator, and
- Accepted TTH services

'TTH-engaged' beneficiaries

The comparison group consists of eligible patients who either:
- DID NOT receive a phone call from a TTH coordinator
- Received a phone call but did not pick up or respond, or
- Picked up the phone but declined services

'non-TTH' beneficiaries

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TTH Data Sources

Two primary data sources are utilized in the course of the program and its evaluation:

- Direct HL7 data feeds from health systems participating in BPCI-A are used to:
  - Identify eligible Medicare beneficiaries
  - Determine underlying conditions/DRGs
  - Establish a discharge disposition for the episode
  - Provide patient's contact information

- Medicare claims files, provided directly from CMS through the BPCI-A model are used to validate episode status, calculate the program's 30- and 90-day readmission rates and evaluate other outcomes.

This data is ingested into Signify's proprietary documentation and operations platform (Signify Community™) where the workflows for patient outreach, tiering and care coordination are housed and utilized by the interdisciplinary team.
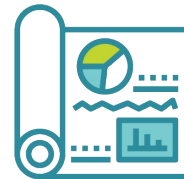
Statistical Analysis & Risk Adjustment
Calculation Details

The primary outcome of interest is the **relative reduction in 30- and 90-day readmission rates** compared with risk-adjusted (RA) historical benchmarks for both TTH-engaged and non-TTH populations.

- The RA methodology utilized to calculate the historical comparative benchmark uses the patient case mix adjustment (PCMA) methodology[6] used in the BPCI-A model. The individualized PCMA score, in the monthly claims dataset, is used to calculate the 90-day historical readmission benchmark by:
  - Aggregating historical baseline performance data at the hospital and DRG level based on the current model year's baseline data set
  - Calculating an estimated linear slope of performance based on PCMA
  - Applying the calculated slope to performance period episodes based on the episode's actual CMS certification number, DRG and calculated PCMA as provided by CMS.

TTH program performance is then evaluated using a **simple difference-in-difference comparison** of relative readmission reduction rates between TTH-engaged and non-TTH populations.

Acronyms

BPCI-A	Bundled Payments for Care Improvement Advanced
CCA	Care Coordination Assistant
CMS	Centers for Medicare and Medicaid Services Diagnostic
DRG	Related Group
EMR	Electronic Medical Records
FFS	Fee for Service
HL7	Health Level 7
IRF	Inpatient Rehabilitation Facility Medical
MD	Doctor
Non-TTH	Non-Engaged Transition to Home
NP	Nurse Practitioner
PCP	Primary Care Physician
QA	Quality Assurance
PharmD	Doctor of Pharmacy
RA	Risk Adjusted
RR	Readmission Rate
SDOH	Social Determinants of Health
SCC	Social Care Coordinator
SNF	Skilled Nursing Facility
TTH	Transition to Home
TTH-Engaged	Transition to Home Engaged

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5. https://www.ntocc.org/knowledge-and-resource-center
6. https://innovation.cms.gov/media/document/bcpiadvanced-targetprice-specs-my4-v2

Physician-Focused Payment Model Technical Advisory Committee

Listening Session 3: *Addressing Care Transitions in Alternative Payment Model Design*

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Perspectives on Care Transitions and APMs

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PTAC Listening Session 3 June 13, 2023

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Summary:

- APMs can help, hinder, or be neutral regarding improving care transitions
  - What is your "theory of the payment model?"
  - What is your vision of the ideal care transition?
  - Care transitions: information flows, hand-offs, risks, gaps
- Attribution, benchmarking, and other APM "componentware":
  - The more specific, and the more prospective, the better
  - Shorter line of sight between the component and the incentive, the better
  - Emphasize what "good work" looks like, align incentives around the work; don't expect incentives alone to drive the work

Theory of the Payment Model:

- What does your payment model incentivize?
- What is the relationship (if any) between your payment model and your desired care model?
- Why do you think a change in payment will change system, provider, or patient/caregiver behavior?
- What could get in the way of your desired change?
- Typical challenges:
  - "I'm in an APM? What's that?"
  - "I don't know how to do it"
  - "I don't want to do it...[x] should do it"
  - "I have more important work to do"

Vision of the ideal care transition:

Seven Essential Intervention Categories for Designing Transitions Strategies for Patients & Caregivers Across the Continuum
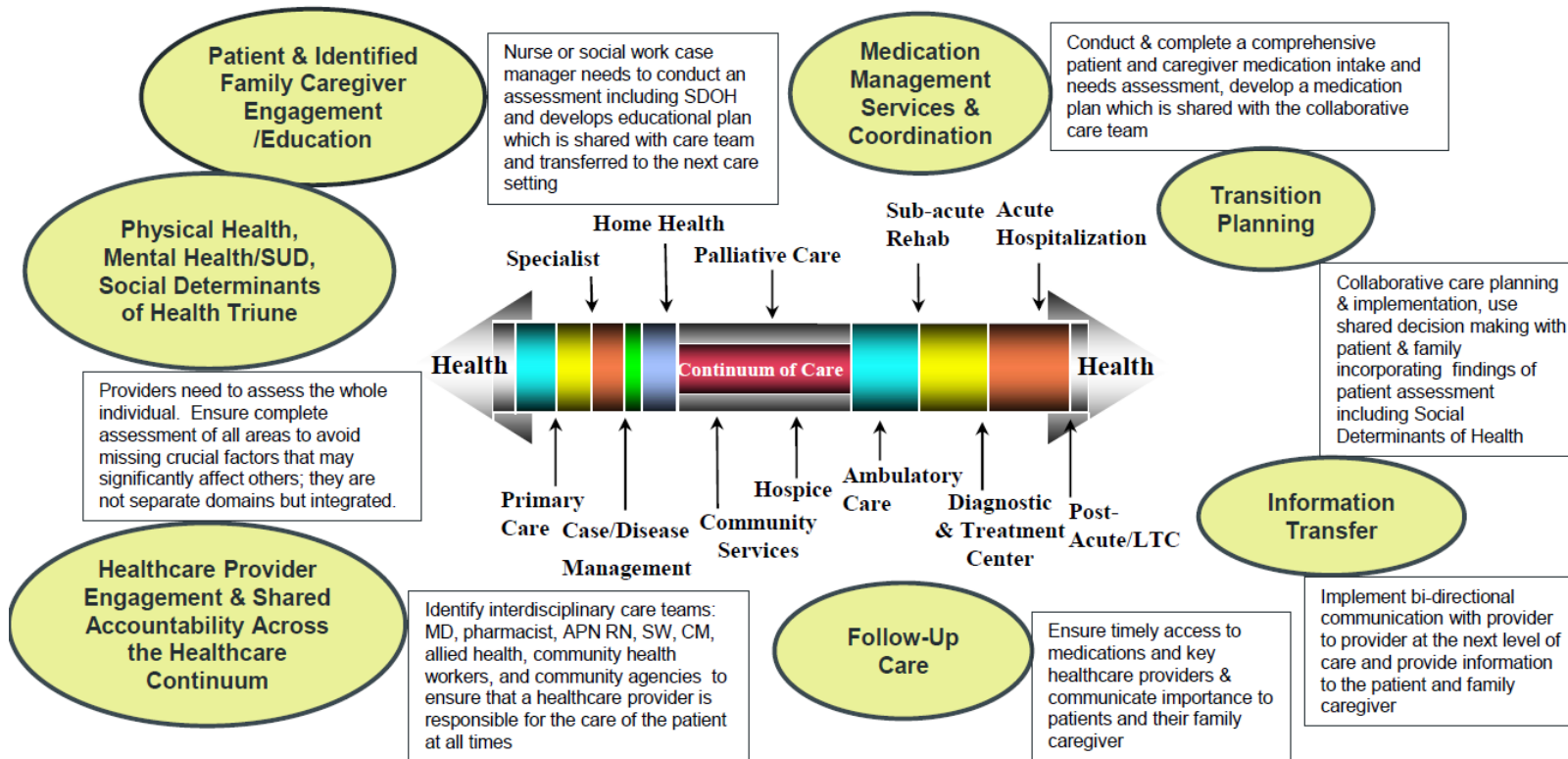
- What's essential?
- How do you know it's present?
- How do you know what's missing/been missed?
- Idealized designs vs. imperfect but implementable

Source: https://www.ntocc.org/knowledge-and-resource-center (graphic only)

Attribution, Benchmarking and other "Componentware":

- APM Componentware-important; better to be simpler, understandable
- Many technically complex refinements and additional elements don't matter all that much
- Attribution: specific, prospective is better
- Benchmarking: mixed feelings
  - Can be helpful in setting realistic performance improvement goals
  - Can anchor performance in mediocrity
- Care transitions as: process metrics, quality metrics, prescriptive elements in an APM?

Design Principles:

- Better to have shorter line of sight between an incentive and the desired behavior

- APMs (and care delivery models) benefit from ongoing iteration and refinement

- Leaders should focus more on what "good care" looks like, and align incentives around good care; don't expect an APM by itself to drive behavior change

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Thank you!

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