C-TAC
COALITION TO TRANSFORM ADVANCED CARE

On behalf of the Coalition to Transform Advanced Care (C-TAC), which represents over 190 organizations across the country, we appreciate the opportunity to respond to the request for information that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) solicited in March 2022 to inform the role that population-based total cost of care (TCOC) models can play in optimizing healthcare delivery and value-based transformation in the context of alternative payment models (APMs) and physician-focused payment models (PFPMs), specifically. In 2017, C-TAC was an active participant in the development and proposal of the Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model and remains fully supportive of the PTAC's role in evaluating APMs and PFPMs. Most recently, C-TAC participated as a panelist in a March 8, 2022, PTAC public meeting during the TCOC session. Our comments in this letter are meant to expand on that presentation, which focused on the need to address disparities in care for patients and family caregivers living with serious illness via: (1) systematically identify people living with serious illness, (2) building capacity among community-based organizations (CBOs) to partner with health systems and (3) exploring opportunities for both standalone care models and integrated, "nested", interventions across existing care models.

What are the options for defining and calculating TCOC?

Our starting point in addressing quality of care for those with serious illness is always focused on aligning care with what matters most to patients, as defined by them. This is best achieved through conversations over time using best practices in advance care planning and shared-decision-making. Within this context, the presence and accountability of a provider team that can solicit and then act on a person's holistic goals of care is critical for addressing Total Cost of Care (TCOC). Payers (MCOs or state Medicaid agencies) can delegate responsibility for cost and quality outcomes to these accountable networks of providers. Within TCOC tracks or options available to ACOs, Direct Contracting Entities, and managed care health plan participants, efforts should be made to create a more holistic concept of TCOC in general around meeting the needs of the patient and family, that includes (e.g.) home-based primary care, palliative care, hospice, dialysis, and community-based supports. Further, we urge federal partners to create sub-analyses or TCOC benchmarks for people with serious illness in particular to best assess outcomes. In other words, "success" for populations with serious illness might look like improved quality and reduced cost *trends* over time rather than reduced costs in a single year.

What services are typically included in population based TCOC models (as defined by the PCDT), and how does that set of services differ across payer types, multi-payer models, and model types?

Typically medical services incurred by the beneficiary have been included in population-based total cost of care models, rather than all forms of case management, community services, and other vendor services that may be offered by a beneficiary's health system or health plan. Additionally, while there has been an evolution in Medicare and Medicaid to incorporate some care management efforts like CCM and health homes, APMs do not consistently incorporate these programs. Team-based care is another notable gap. People with serious illness usually require the care of interdisciplinary teams, such as nurses, social workers, community health workers, spiritual care professionals, personal care aides, and other providers, often operating through community-based organizations (CBOs). These teams are essential in order to enable beneficiaries and their caregivers to remain at home and to manage their holistic needs. Because these teams are not always documented through claims or encounters if the team-

based approach does not align with a reimbursable model (e.g., collaborative care), their value is often lost when evaluating impacts to TCOC.

Further, when it comes to serious illness, critical services such as those cited above (home-based primary care, hospice, spiritual support etc) are often excluded from TCOC evaluations across payer types. Within Medicaid, direct reimbursement for social services such as in lieu of services or value-add services are also not consistently included in APMs.

These calculations are yet more complicated in the case of individuals who are enrolled in multiple insurance programs, like dually eligible individuals or individuals enrolled in separate prescription drug programs; in these cases costs/savings may occur across Medicare and Medicaid contexts and no single network of accountable providers has comprehensive lines of sight. In the case of dual eligibles, long-term care costs are often incurred by one plan (Medicaid) and acute/hospitalization related savings accrued by the other (Medicare). For models like home-based primary care, palliative care and hospice, this is even more pronounced, as multiple studies have demonstrated significant TCOC reduction, much of the savings accrues to Medicare, due (e.g.) to earlier and more timely referrals to hospice. C-TAC proposes that TCOC models consider all Medicare and Medicaid utilization in order to understand true model impacts.

Despite these challenges, we believe the raw ingredients are present in order to facilitate more holistic TCOC models moving forward. In the private sector, more payers are expanding benefits and services to include supplemental benefits for their beneficiaries and are turning to private vendors to manage unsustainable costs. These shifts ensure that more non-traditional types of services are increasingly being catalogued by payers and can be included in benchmark calculations.

Finally, we urge federal partners to consider up-front investment or pre-payment strategies alongside a reconsideration how TCOC is calculated. In many instances, savings or losses are calculated on the back-end, after a performance year and savings, if achieved, are not available to provider networks until many months later. This payment lag is challenging for incorporating social supports that may not be traditionally reimbursable by health payers or require some infrastructure supports to commence formal health system partnerships. TCOC models that consider these expenditures up-front and incorporate costs into pre-payment calculations will enable better and more consistent investment into such services and subsequent evaluations of comprehensive care models. For this reason, C-TAC also proposes that community-based services and health-plan based quality improvement programs be included in TCOC calculations, payments, and evaluations, as they are an integral part of the success of these models.

How can we establish measures to measure success among population based TCOC models based on providers, patients, and payers' perspectives?

There are few cross-cutting measures to evaluate beneficiaries across settings, other than reduction in utilization and overall reduction of costs. For those with serious illness, many clinical measures do not apply, and the population is carved out. This includes measures for cancer screenings, hypertension, HBA1C, and others. However, what is most important to the beneficiary is their overall experience of care and their confidence that their care is managed. In addition, most measures are setting or disease-specific, making it difficult for care transitions

to be evaluated and for a person's and caregiver's holistic needs to be measured and addressed. C-TAC proposes that more measures be included to document a person's overall experience of care when participating in a TCOC model. Examples include measures developed and tested by RAND and the American Academy of Hospice and Palliative Medicine (AAHPM) to collect a beneficiary's experience of feeling heard and understood by their care team (based on Glen Elwyn's CollaboRATE tool). These measures have been tested in the private sector and are being proposed by AAHPM for National Quality Forum (NQF) endorsement. C-TAC also proposes that efforts be taken to measure the proportion of beneficiaries with an annual wellness visit and with advance care planning performed during or following those visits. In addition, it is important to measure the experience of care of a person's family caregiver, as caregiver burden has demonstrated correlation with a beneficiary's ability to remain at home and outside of the hospital when facing a serious illness.

Under these models, what are the best practices for improving affordability to beneficiaries (for example, for copayments, prescription drugs, etc.)?

Many TCOC model evaluations carve out prescription drugs due to the prohibitive cost of treatments for those with serious illness and the unsustainable costs of medications related to a chronic medical condition. Patients and families often must incur these costs themselves, often paying co-payments. In addition, literature has shown that 50% of people receive advance care planning services outside of an annual wellness visit, incurring co-payments for having these important and necessary conversations. C-TAC proposes removing the co-pay for advance care planning and other codes that support a beneficiary and their caregiver to be assessed and referred to additional services (e.g., transitional care management, chronic care management). C-TAC supports efforts made under the CHRONIC Care Act that removes the uniformity requirements for people with complex and serious health conditions and recommends that removal of the co-pay for these services be adopted across all payers. In addition, C-TAC proposes waivers that allow for a beneficiary and caregiver facing serious illness so that they can receive concurrent care while receiving hospice services so that they can benefit from the support a hospice team provides while continuing to pursue disease-modifying treatment. Concurrent palliative care alongside disease-modifying treatment has demonstrated value in the pediatric population under the Affordable Care Act and emerging CMMI demonstrations such as Direct Contracting, the Kidney Care Choices Model, the VBID hospice component, as well as the completed Medicare Care Choices Model (MCCM). For Medicare beneficiaries and adult beneficiaries under Medicaid or private health insurance, families often must pay out-of-pocket to receive respite care or other personal care services from community-based organizations or private agencies. C-TAC recommends that these services be able to be integrated into medical care and TCOC models. These out-of-pocket payments for services disproportionately affect people with serious illness, dual eligibles, and underserved populations.

What are different approaches for integrating primary care and specialist care under population based TCOC models (e.g., attribution, accountability, payment disbursement, etc.)?

People with serious illness have multiple clinicians and care teams involved in their care. This makes it difficult to attribute a person to the right program. We suggest that the federal partners consider hybrid voluntary alignment for individuals with serious illness and other underserved populations, whereby individuals may select alignment to traditional primary or

specialty medical providers (e.g. hospice or palliative care) and secondary alignment to community-based organizations (CBOs) if individuals choose CBOs as their foremost care relationship. In such cases of dual alignment, medical and CBO partners would be required to collaborate on care plans and subsequent care monitoring.

As it relates to quality and payment, we recommend reimbursement for assessments and referrals to document a beneficiary's and caregiver's holistic needs and to assess the impact of referrals made by primary care providers to specialists and community-based services. C-TAC proposes that CBOs and specialists that manage the pain and other symptoms that arise from a serious illness be eligible for reimbursement for these services and for a proportion of the savings that is accrued by the provider attributed to the beneficiary. This would further promote care coordination and reduce the siloes those beneficiaries and their families often face.

To what extent are specific services (e.g., disease specific care, behavioral health, ancillary services) excluded or "carved out" in population based TCOC models as defined by the PCDT, and what are the pros and cons of this approach?

Currently, many of the highest or most unmanageable costs are being "carved out" of the equation, either due to lack of data available or because it is believed that these costs cannot be contained. However, that only perpetuates the challenge we face in improving care for those with serious illness and complex health needs or for those facing significant social determinants of health challenges (Medicaid beneficiaries, those with cognitive impairment, people who are disabled or frail, homeless, socially isolated, and those with severe mental illness). While this can allow for more straightforward evaluation and easier attribution of savings in risk-based models, carving out services such as hospice and dialysis treatments do not account for savings that come from reduction in unwanted medical treatment or patient choice for their treatment.

Co-pay and coinsurance, and ancillary services delivered by community-based organizations (e.g., care navigation, respite care, transportation, meals, and home care services) have historically not been factored into the TCOC models for evaluation, leaving beneficiaries and their caregivers to often to pay out-of-pocket for things not covered by these models or to pay higher costs to access the services they need. Additionally, many private payers have begun to charge higher co-pays and co-insurance when a beneficiary utilizes the hospital or emergency department. These population health models must consider the beneficiary and caregiver costs that can be reduced through improved coordination—a central objective of TCOC models. C-TAC proposes that more be done to collect information on beneficiary and caregiver out of pocket costs so that these can also be factored into TCOC.

How have payment models and incentives influenced physician participation in population based TCOC models (as defined by the PCDT) to date?

C-TAC supports participation by physicians in population-based TCOC models. However, many of our smaller and non-profit member organizations have reported difficulties in model participation due to lack of funding to support infrastructure and to sustain that infrastructure once model demonstrations are completed. C-TAC proposes that additional funding be made available to support the development of infrastructure, especially to support connectivity and

interoperability between care teams and CBOS, provider workforce development and training, and public outreach and engagement to generate referrals to these models.

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