PAYMENT MODELS FOR ADVANCING SERIOUS ILLNESS CARE

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DISCERN HEALTH

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Table of Contents

Executive Summary

Context

Under traditional fee-for service payment programs, people with serious illness (i.e., chronic conditions plus functional limitations) often receive care that is poorly aligned with their goals and preferences. Fragmented fee-for-service payment often leads to high costs due to poorly coordinated, and sometimes unnecessary or undesired, treatments. The recent shift to more patient-centered care delivery and payment approaches, such as Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), bundled payment, and global payment, provides an opportunity to improve payment models for serious illness care.

The Moore Foundation contracted with Discern Health to conduct an analysis of the degree to which emerging payment models provide the necessary resources and flexibility to support community-based serious illness programs. Based on the findings of this analysis, Discern proposed a series of next steps to advance payment model design for serious illness care.

Methodology

Building on previous work by the Coalition to Transform Advanced Care, the National Academy of Medicine, the National Quality Forum, and other organizations, Discern developed a conceptual framework to assess relevant payment models. The framework includes four essential design components: (1) specification of the target population to be served, in this case, people with serious illness (2) an implementation and delivery structure appropriate for the target population, (3) a payment and incentive structure that provides adequate resources, flexibility to assemble the most appropriate mix and volume of services for each patient, and provider incentives aligned with quality, and (4) accountability and performance measures to detect problems in access or quality.

Discern conducted an environmental scan and identified 31 payment models that provide some degree of support for community-based serious illness programs. These payment models were grouped into seven categories that generally correspond to the type of base unit responsible for the serious illness program:

- Primary care-based (3)
- Specialty care-based (4)
- Hospital/health system-based (4)
- Post-acute care-based (7)
- Health plan-based (4)
- Accountable care organizations (ACOs) (5)
- Global payment models (4)

We then compared each of the models to the components of the conceptual framework and developed a list of advantages and limitations for each payment model category.

Findings

Based on the analysis of each payment model category, Discern identified several common threads. Our analysis found that all of the models have at least some elements that address the four components in the conceptual framework, but no one model fully addresses every component. Below are findings for each of the four components.

Serious Illness Care Population Defined. Payment models vary in the extent to which they target the sub-population of people with serious illness. Models that focus specifically on this population tend to include more relevant care delivery elements, incentives, and measures. We found that about two-thirds of the payment models focus explicitly on serious illness populations.

Implementation and Delivery Structure. To best meet the needs of the serious illness population, payment models should provide serious illness programs with the necessary flexibility to provide care in community settings that is driven by a patient care plan and uses a multi-disciplinary team-based approach. More than one-third of the reviewed models include services provided in the patient's home. Care coordination was common across the models, but interdisciplinary care teams were used in less than half. In addition, delivery models designed specifically for the serious illness population are more likely to include a significant number of patient-centered elements, such as care plans that capture patient preferences, palliative care, and discharge planning.

Payment and Incentive Structure. Payment models should be performance-based, simple, and give providers the necessary resources and flexibility to support transformation and delivery of desirable care elements. A small but growing number of payment models are providing flexibility through advanced payments, although very few use multi-payer structures and aligned incentives across the care continuum. About half of the models reviewed provide upside provider risk, although few have sufficient downside risk to drive major changes in care delivery and coordination with other providers in other care settings. Most of the payment structures are highly complex, leading to administrative difficulty and uncertainty for the provider.

Accountability and Performance Measures. The use of robust quality measurement is a critical element for establishing accountability, monitoring for unintended effects, and promoting performance improvement within a payment model. Measure sets should include meaningful measures of patient-reported quality of life, adherence to patient preferences, and utilization and cost. Desirable measures are more often found in models designed specifically for the serious illness population, regardless of the category of the model.

Next Steps

Building on the findings from our analysis, Discern identified a series of next steps to support progression toward high quality payment models.

1. *Engage stakeholders to further model development.* The conceptual framework and findings should be shared with payers, providers, patients, subject matter experts, and other stakeholders as part of an advisory group. This group should be engaged on an ongoing basis to provide feedback on this analysis and to identify barriers and policy changes to facilitate further development.
2. *Enhance data availability and alignment.* Existing data resources are not being used to their full potential to support payment models and high quality care delivery. Data should be aligned across various sources, and patient-reported outcomes should be utilized more effectively in accountability and reporting programs. Gaps in data need to be better understood and addressed.
3. *Define milestones.* To measure progress over time, milestones should be set for the implementation and spread of various components of the conceptual framework and for overall adoption rates of priority serious illness care payment models. Milestones should be developed through a multi-stakeholder consensus process that includes a balance of perspectives from across the health care system.
4. *Establish monitoring mechanisms.* Monitoring will be necessary to assess the extent to which milestones are being met and the full effects of model implementation, including unintended consequences such as negative impacts on benefit coverage and patient cost sharing. Regular surveys of patients and providers should be used for these monitoring purposes.

Introduction

Through a Serious Illness Care Initiative, the Moore Foundation is considering supporting work to encourage the development of community-based, comprehensive care programs that provide high-quality, affordable services to individuals with serious illness. To move this agenda forward, Moore has focused on a number of strategies, including payment models that provide the necessary resources and flexibility for sustainable, accountable care. In addition to payment and accountability, Moore has also prioritized strategies for public education, workforce development, promotion of model programs, and monitoring system.

To explore payment models for advancing serious illness care, Moore asked Discern Health to scan the environment for relevant, promising models. The next step was to critically evaluate the design elements of the payment models against a conceptual framework for optimal serious illness care. Potential barriers to advancing payment models were also considered. Once the essential design elements were identified, we proposed approaches for spreading and scaling the most promising payment models.

The objectives of this white paper are to:

- Provide background and context for payment models that support serious illness care in the rapidly evolving value-based environment.
- Present a serious illness care conceptual framework and the essential payment model components for driving the availability and quality of comprehensive serious illness care.
- Catalog existing and proposed serious illness care payment models and their primary elements.
- Prioritize issues and analyze the advantages and limitations of each payment model type against the essential characteristics of the serious illness care framework.
- Identify and plan for potential barriers to spreading and scaling effective payment models.
- Highlight opportunities for payment strategies to align with the other serious illness care strategies.

Background and Context

Defining Serious Illness

Serious illness, which is sometimes referred to as advanced illness, has several related but nuanced definitions. According to the Coalition to Transform Advanced Care (C-TAC), it is defined as "occurring when one or more conditions become serious enough that general health and function decline, and treatments begin to lose their impact." A person with serious illness experiences poor prospects for health recovery often due to a recurrent or extensive disease, comorbidities, and/or advanced age. The nature of the decline leads into the end of life for the patient. Models of care for serious illness generally include patients that are two to three years from end of life.[1] Figure 1 shows the progression of serious

[1] http://www.thectac.org/wp-content/uploads/2015/06/ACP-Report-6-18-15-FINAL.pdf

illness care, which includes curative care for chronic conditions, treatment to address declining function, palliative care, and end of life care.

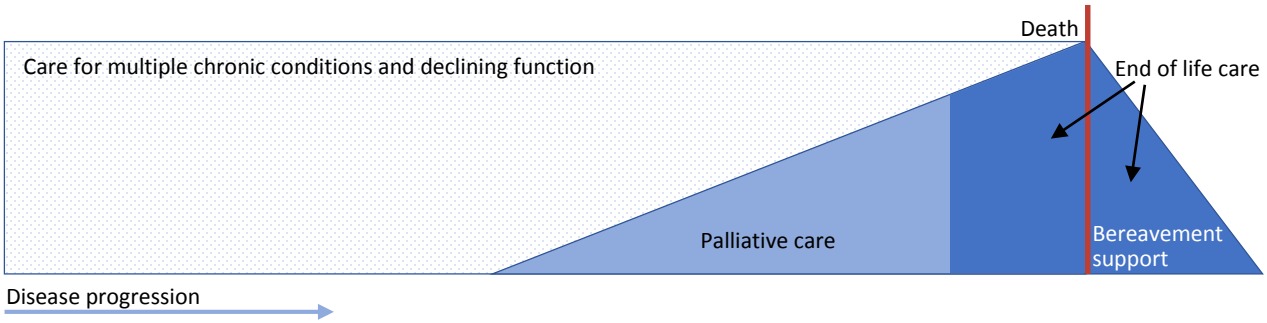

Figure 1. Serious Illness Care Progression
Adapted from National Quality Forum, "National Framework and Preferred Practices for Palliative and Hospice Care Quality"

The Serious Illness Population

Statistically, serious illness disproportionately affects frail older adults. Medicare beneficiaries with four or more chronic conditions represent the fastest growing segment of the population and account for more than three quarters of all Medicare spending (see Figure 2).[2] It is projected that by 2030, over nine million Americans will be 85 years or older and will be diagnosed with multiple chronic conditions. This correlates to high cost and utilization rates due to hospitalizations and intensive care treatments that are often unnecessary and not always aligned with patient care preferences. [3]

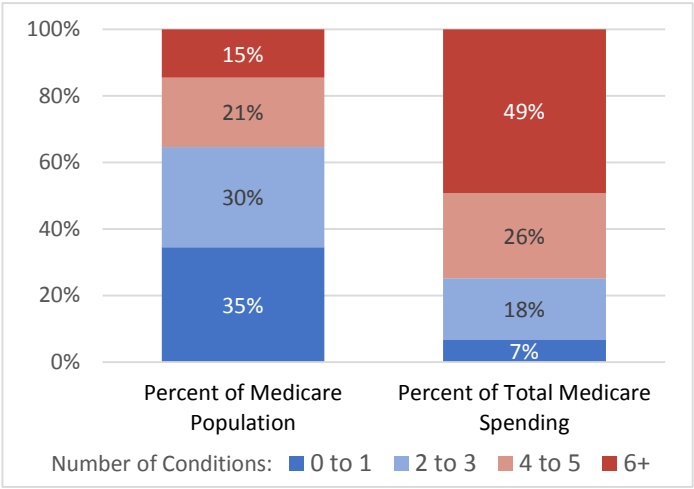

Figure 2. Medicare Spending by Number of Chronic Conditions, 2014
Data Source: CMS, Medicare Chronic Conditions Dashboard

Patients with serious illness have a range of chronic conditions. Among patients with serious illness utilizing acute care or nursing care in the last year, 21 percent had diabetes, 19 percent had COPD, 15 percent had end-stage renal disease, 13 percent had congestive heart failure, 9 percent had cancer, and 31 percent had Alzheimer's disease or dementia. Among the population, 95 percent had three or more comorbid conditions.[4]

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html
[3] http://www.thectac.org/wp-content/uploads/2014/10/Advanced-Illness-Key-Statistics-12-22-2012.pdf
[4] http://www.ncbi.nlm.nih.gov/pubmed/26990009

A Fragmented and Costly System for Serious Illness Care

The U.S. healthcare system has traditionally been fragmented in the treatment of serious illness. In addition to fragmented care, payment is heavily based on a fee for service (FFS) structure that rewards volume rather than value of care. FFS incentivizes providers to deliver more clinical services, including diagnostics, treatments, office visits, procedures, and hospitalizations. This increases burden on patients and the health system, increases spending, and decreases the quality of care received by patients.

Within serious illness care, FFS incentives result in expensive acute care services and persistent, intensive treatments for multiple chronic and/or life-limiting illnesses. Despite the high rate of intensive services, half of caregivers of patients hospitalized due to serious illness have reported less than optimal care. Moreover, it is often the most vulnerable patients that fall through the cracks of the health system, prohibiting them from receiving appropriate care.[5]

Significant changes to the healthcare delivery and payment systems are necessary for patients with serious illness to receive high-quality, affordable, and person-centered care that is tied to their documented goals and preferences. Research indicates that patients with serious illness typically want to be at home with loved ones with their symptoms managed and spiritual needs honored, while avoiding emotional and financial hardship. Instead, many patients receive aggressive treatments that are inconsistent with patient and family requests and values,[6] resulting in significant burdens for patients and their families, the healthcare system, and society.

The Impact of Health System Transformation

The U.S. healthcare delivery and financing system is in a period of rapid transformation. Prior to passage of the Patient Protection and Affordable Care Act (ACA) in 2010, cost containment strategies were mostly limited to managed care and small Medicare demonstration projects. The ACA has accelerated transformation through the creation of the Center for Medicare and Medicaid Innovation (CMMI), which was given significant authority and funding to implement and scale innovative models. These efforts have been guided by the National Quality Strategy's three-part aim of better care, healthier communities, and affordable care[7] and the goal of the Department of Health and Human Services (HHS) to have 90 percent of FFS payments tied to value and 50 percent of all Medicare payment in alternative payment models (APMs) by 2018.[8] In 2015, Congress passed a new law which will move all physicians not in APMs to the Merit-Based Incentive Payment System (MIPS), which will make significant upward and downward adjustments to payment based on quality and resource use.

These changes to payment provide opportunities to transform serious illness care to be more patient-centered and focused on care planning, coordination, and team-based care. In order for a payment model to effectively serve the serious illness population, it must methodically bridge from FFS payments

[5] https://reportcard.capc.org/wp-content/uploads/2015/08/CAPC-Report-Card-2015.pdf
[6] http://www.thectac.org/wp-content/uploads/2015/04/Advanced-Illness-Policy-Review-Landscape-for-Improving-Advanced-Illness-Care-in-America.pdf
[7] http://www.ahrq.gov/workingforquality/about.htm#aims
[8] http://www.nejm.org/doi/full/10.1056/NEJMp1500445

to a risk, performance, and value-based payment structure that incorporates population healthcare needs. At the same time, patient-centered care requires attention to individual needs and preferences.

Payments tied to value-based care and quality measures will require providers to think beyond the clinical aspects of care and begin to treat patients more holistically. Providers will also need to work with patients and their families to establish priorities and achievable goals for care through skilled communication that is culturally sensitive. In terms of structure, programs and payment models that promote coordination across primary, specialty care, and community-based services through interdisciplinary care teams will yield greater success in improving patients' experience of care.

Public and private sector policymakers have developed a range of payment and delivery models focused on improving the quality of chronic and serious illness care. The Appendix includes an environmental scan of payment models under seven distinct categories, including primary care, specialty care, post-acute care, hospital/health system, health plan, accountable care organization, and global payment models. Each of these models consists of a delivery and implementation structure for its target population, however not all of the models are currently tied to payment. Those that are not tied to payment are primarily sustained through cost savings due to effective implementation strategies. For those that are tied to payment, the payment models span a variety of methodologies including FFS, pay for quality reporting, performance-based incentives, and capitated payment.

Serious Illness Care Conceptual Framework

A conceptual framework for serious illness care was developed for assessing individual payment models and their relative advantages and limitations. This framework consists of components that are critical to advancing serious illness care. These components were drawn from the work of C-TAC,[9] the National Academy of Medicine, the HHS Health Care Payment and Learning Action Network (HCPLAN)[10], the World Health Organization (WHO),[11] and the National Quality Forum (NQF).[12, 13]

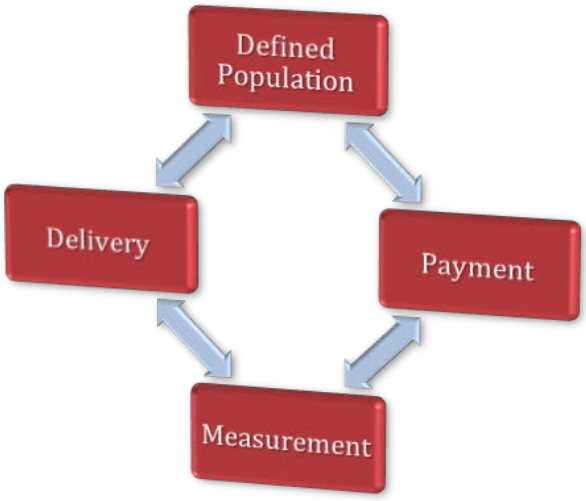

Figure 3. Conceptual Framework for Serious Illness Care

The components of the serious illness care conceptual framework outlined below include a definition of the population requiring serious illness care, an implementation and delivery structure, a payment and incentive structure, and performance measures. Each of

[9] http://www.thectac.org/wp-content/uploads/2015/06/ACP-Report-6-18-15-FINAL.pdf
[10] https://hcp-lan.org/workproducts/apm-whitepaper.pdf
[11] http://www.who.int/chp/knowledge/publications/iccc_ch3.pdf?ua=1
[12] http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx
[13] http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=82665

these components consists of a series of subcomponents, presented in Table 1, that together comprise the elements required to design effective care and payment models for the serious illness population. The framework reflects the need for care delivery, payment, and measurement to be linked and mutually reinforcing.

Definition of Population Requiring Serious Illness Care

A target population for serious illness care must be clearly defined to ensure that the program focuses its resources and services on the population it is intended to support. A defined target population allows for identification of appropriate patients to receive intervention and effective patient attribution to the model. It also allows for the accurate assessment of the quality of care provided to the target population and the ability to make improvements as needed.

The conceptual framework outlines additional characteristics for population definition. The definition should be based not only on number of conditions, but also on cognition, functional limitations, and recent utilization of services, including hospitalizations.[14] In addition, patient attribution methodologies should flow directly from the population definition and should include predictive modeling to prospectively identify the right patients and their potential needs.

Implementation and Delivery Structure

The implementation and delivery structure for serious illness care must be explicitly defined. Participating practices and providers must fully understand their eligibility, contractual, structural, cost, and delivery requirements to effectively support transformation and receive payment for services rendered. The delivery structure and payment model should reinforce each other to promote improved quality and lower resource use.

There are several necessary elements for establishing a strong implementation and delivery structure to effectively serve the serious illness population. Care delivery should be team-based, culturally competent, well-coordinated across multiple settings, and sensitive to the needs and preferences of the individual and his or her family. In addition, care should extend beyond the clinical setting to include partnerships with community organizations and services that address non-medical needs. Technology should be used to facilitate sharing of information and increased accessibility for patients.

Payment and Incentive Structure

An effective value-based payment model must be linked to accountability for quality and cost. The model should be as flexible and simple as possible while being designed to drive the necessary changes to the delivery system and provide the resources to achieve the desired outcomes. This includes the ability for providers to make investments to improve the care delivery model and incentives that promote collaboration across the care continuum.

Payment models that are multi-payer are most desirable, as they help streamline processes for the provider by ensuring the same incentives are in place across all patients. Population-level payments help promote patient-centered care by allowing for the necessary investments in infrastructure and care

[14] http://www.ncbi.nlm.nih.gov/pubmed/26990009

coordination activities. Additionally, incentives should be used to reward improvements in quality and cost and penalize poor performance. The model should also include disincentives for avoiding patients with intensive care needs that might affect provider performance scores and monitoring systems to identify and mitigate unintended consequences.

Performance Measures

Measurement is essential for assessing provider performance and monitoring and improving the quality of care delivered to patients with serious illness. Measures should include a blend of structure, process, and outcome measures that are related to the goals of the program. Given their importance to payment and delivery, steps should be taken to ensure that measures are fit-for-purpose and are positively correlated with improving the standards of care.

Measures should be National Quality Forum (NQF)-endorsed where possible and assess quality of care across multiple domains of care, including care planning and delivery, clinical outcomes, cost, and patient experience and satisfaction. They should be aligned within and across care settings, specified for the appropriate level of analysis, and suitable for electronic reporting. Moreover, measures should be risk-adjusted and benchmarked appropriately across patients, providers, and services.

Table 1. Serious Illness Care Conceptual Framework

Serious Illness Care Population Defined	Implementation and Delivery Structure	Payment and Incentive Structure	Accountability and Performance Measures

Serious Illness Care Population Characteristics
▪ People with life threatening, debilitating illness or injury, or living with persistent or recurring conditions that affect their cognition, daily function, or that will predictably reduce life expectancy
▪ People with palliative and/or end-of-life care needs
 	
Patient Attribution Methodology
▪ Predictive modeling
▪ Identifies patients with high probability of benefiting from the intervention
	Infrastructure Needs
	▪ Sustainable and scalable business model for care delivery
	▪ Partnerships with other practices and settings
	▪ Electronic health records
	▪ Telehealth capability
	▪ Electronic decision support tools
	▪ Interoperability of patient information
	▪ Workforce training
	▪ Continuous learning and improvement
	
	Care Coordination
	▪ Engage individual, family, caregivers, physicians and other clinicians, and other care managers
	▪ Coordination with community agencies
	  ▪ Social workers
	  ▪ Public health
	  ▪ Churches
	  ▪ Community navigators
		Payment Structure
		▪ Bridge from FFS to value-based reimbursement
		▪ Multi-payer structure
		▪ Population level payment that supports patient-centered care
		▪ Payment aligned with optimal delivery structures and processes for the population
		▪ Measures in place to assess provider performance
		▪ Monitoring and evaluation to identify and mitigate undesirable, unintended effects
		▪ Simple/streamlined payment structure
		
		Incentive Structure
		▪ Withholds for poor performance
		▪ Small, frequent incentives with shorter lag times
			Quality Measurement Domains
			▪ Serious illness care planning
			▪ Documentation of patient goals and preferences (physical, psychosocial, spiritual)
			▪ Clinical effectiveness
			▪ Patient safety
			▪ Management of pain and other symptoms
			▪ Efficiency and cost reduction
			▪ Patient and family experience and satisfaction
			▪ Care coordination (clinical, social)
			▪ Hospital admissions/ readmissions; ED visits
			▪ Length of stay (hospice, ICU)
			▪ Hospice utilization
			
			Measure Implementation
			▪ NQF-endorsed measures preferred

	▪ Not duplicative of existing or developing infrastructure. **Provision of Care** ▪ Community-based ▪ High-quality and affordable ▪ Interdisciplinary team ▪ Patient and family engagement and ▪ activation with decision support tools ▪ Goal and care-plan driven ▪ Health literacy and cultural competency ▪ Caregiver supports ▪ In addition to acute and specialty medical care, attention to palliation of symptoms, psychological, spiritual, ethical and legal needs ▪ Discharge planning and bereavement support	▪ Tiered absolute thresholds ▪ Decouple from baseline reimbursement ▪ Align incentives for providers, managers, and patients	▪ Measures are specified for electronic reporting ▪ Mix of outcome measures and measures of processes that are related to better outcomes ▪ Measures are specified for the appropriate level of analysis ▪ Measure set includes the minimum number of measures required to meet the goals of the program ▪ Measures are aligned with in and across programs **Risk Adjustment** ▪ Risk adjust for patients within individual conditions ▪ For each condition, risk adjust for patients with outlying conditions **Benchmarking** ▪ Across clinical services ▪ Across patients with similar conditions health outcomes ▪ Across provider performance scores ▪ Across efficiency and utilization of services

Research Methodology

Table 2. Payment Model Categories

Primary Care-Based Models (3)
Specialty Care-Based Models (4)
Hospital/Health System-Based Models (4)
Post-Acute Care-Based Models (7)
Health Plan-Based Models (4)
Accountable Care Organizations (5)
Global Payment Models (4)

Using the serious illness care conceptual framework above as a guide, Discern conducted an environmental scan of payment models. The scan was a convenience sample of models identified in a literature search and review of relevant websites. This sampling method allowed for rapid identification of accessible models relevant to serious illness care.

Discern researched CMMI initiatives, Medicare quality reporting and pay-for-performance programs, private sector health plan models, and health system efforts.

Each model was assigned to one of seven categories (see Table 2). To the extent that information was available, Discern compiled data on relevant program elements: title, implementer, setting, population, scale, payment type, incentive structure, performance measures, delivery type and requirements, objectives and outcomes, implementation strategy and timing, and implications for serious illness care.

The environmental scan yielded an in-depth review of 31 current payment models for serious illness care. The results of the environmental scan can be found in the Appendix, and an analysis of the findings is presented below.

Payment Model Analysis

Analysis of the payment models resulted in the identification of numerous advantages and limitations for each category of models, which is presented below. There is not one ideal payment model that fully meets all of the elements of the conceptual framework. Rather, different models may be appropriate for different contexts, and elements of various models may be combined to develop new models that build on earlier success. The discussion following this section synthesizes the key findings across the categories, which informs the recommendations for advancing serious illness care payment models.

Primary Care-Based Payment Models

Primary care includes services such as health promotion and maintenance, disease prevention and management, patient education and counseling, and diagnosis and treatment of acute and chronic illnesses in a variety of healthcare settings (e.g., office, long-term care, home care, day care). For the serious illness population, primary care should serve as an entry point into the health system and provide a pathway to more intensive care services as needed.

Advantages	*Limitations*
■ Establishes a bridge from FFS payments to a risk, performance, and value-based payment structure. ■ Medical home standards emphasize population health management and team-based care. ■ The emerging emphasis on multi-payer structures (e.g., CPC+) can help ease provider burden through aligned quality measures, payment incentives, and streamlines care for patients. ■ Movement toward up-front payments (e.g., CPC+) allows providers more flexibility to invest in necessary care infrastructure and provide early care planning to better manage health of patients with serious illness.	■ In primary care settings, the population in need of serious illness care may be ill defined given the broad scope of patients and, in some cases, limited tools available to providers. ■ Risk adjustment may not fully account for multifaceted risk in patients with serious illness, potentially making providers vulnerable under risk-based payment. ■ With a focus on primary care, additional steps are necessary to ensure coordination with specialty care services so that patients receive the appropriate levels of care from interdisciplinary care teams. ■ Accountability measures are typically broad and not focused specifically on patient preferences,

- Ongoing, flexible payment in primary care facilitates continuous, intensive care management, more team-based care structures, and integration with palliative care providers and other social and community-based resources.
- Home-based primary care models (i.e., Independence at Home) have shown significant cost-savings while increasing patient satisfaction and quality of life. These models allow providers to spend more time with patients and potentially better assess their psychosocial needs while patients are able to remain in the comfort of their home.

- pain management, quality of life, and other key serious illness care measures.
- Primary care providers may have less ability to impact cost of care compared to specialty, acute, and post-acute providers.

Specialty Care-Based Payment Models

Specialty care models are designed to focus on a patient population with a specific disease being treated by specialists across various care settings. Patients receive care from providers who specialize in their particular illness and counsel them on the care needed to manage their disease. Payment models in this setting are focused on reducing the use of expensive, highly intensive care and on reimbursement for care management.

Advantages

- Focus on improving the quality and efficiency of otherwise highly expensive and intensive specialty care for well-defined patient populations.
- Several models provide a flexible, ongoing payment that can be used for services not otherwise covered, including care coordination across providers, serious illness care planning and documentation of patient goals and preferences, and integrated palliative care.
- Use of up-front payment (e.g., PCOP and Radiation Oncology Palliative Care Model) gives the provider even more flexibility.
- Measures across the majority of models have significant focus on quality of life, patient and family engagement, and patient preferences.

Limitations

- Many specialty care models are still in the concept phase and have not been implemented.
- Several models exist for oncology care, but there are few models for other serious illness-related conditions.
- Several models simply provide an additional payment on top of existing FFS payment, with little payment at risk. To reduce the total cost of care, these models must result in significant savings in acute and post-acute settings.
- Specialists may have little ability to significantly reduce costs in certain specialties like oncology due to the high cost of therapies, making downside risk structures potentially overly burdensome and creating financial instability for practices.

- Robust risk-adjustment methodologies enable providers to accept high-needs patients with serious illness with minimal concerns about undue impact on performance measures and payment.

- Compared to primary care providers, specialists may be less attuned to non-medical and social needs and less aware of community-based resources to address these needs.

Hospital/Health System-Based Payment Models

Hospital and health system-based models are designed to provide acute care, coordinated with additional services for patients beyond the clinical setting. Such models enable providers to deliver high-quality person-centered care across the care continuum by collaborating with an interdisciplinary network of healthcare workers in clinical and community settings. In turn, patients are able to receive comprehensive and continuous care and services provided beyond the clinical setting.

Advantages

- Promotes a multidisciplinary approach to clinical services across care continuum, especially in larger health systems. This integration may make it easier for the patient and family to navigate their complex care and multiple providers.
- Often implemented for the purposes of improving health system organizational financial and quality goals.
- Primarily sustained through cost savings due to an effective implementation strategy and high performance on quality indicators.
- Success of these models relies heavily on the willingness to adopt a shift in culture among patients and providers to work together toward improving care.
- Incentives may include bonuses to providers for effectively providing care according to the patient's goals and preferences as well as high patient satisfaction scores.

Limitations

- These care models will not promote value unless already operating under value-based payment arrangements with payers. In fact, they may promote increased utilization under FFS arrangements because hospitals lose revenue.
- Without a value-based payment foundation, these models may not be tied to meaningful quality measurement and reporting, making it difficult to assess and track performance.
- A lack of robust, comprehensive patient data, such as data on functionality, can make it difficult for health systems to identify the seriously ill within their broader patient populations.
- Payment arrangements within one health system may not be easily replicable in other health systems or other settings of care.
- When a patient needs services outside the health system, there may be little coordination and sharing of information about the patient.

Post-Acute Care-Based Payment Models

Post-acute care-based models provide healthcare services in skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), hospice facilities, and home health agencies (HHAs). Post-acute care-based payment models connect a reimbursement or incentive structure to a wide range of healthcare services.

These services support patient transition from inpatient acute care to the community, with a focus on restoring functional capacity. Many patients, including people with serious illness, who receive care in any of these settings often require specialized follow-up.

Advantages	*Limitations*
▪ Enhanced quality reporting requirements are currently being implemented for Medicare post-acute programs, which will establish a higher level of accountability and potentially generate quality-based competition among providers. ▪ Post-acute care presents significant opportunity for cost savings. Spending has been rising in these care settings in recent years and there are currently few providers operating under value-based payment arrangements.[15] ▪ If properly designed, value-based payment models in post-acute care can leverage and align with primary care and health system strategies to create continuity of care for the patient. ▪ Measurement of non-medical needs may drive post-acute providers to engage in more community partnerships and help prepare patients for maintaining health at home and in the community.	▪ Payment remains FFS in most of these models. With the exception of the SNF program, the CMS programs in this area are strictly pay for reporting and have no accountability for quality, outcomes, and cost. ▪ Even when a patient recovers, stays in post-acute settings are typically short, making post-acute providers less able to impact overall quality of care, patient outcomes, and total cost of care compared to other providers. ▪ Many post-acute providers are for-profit and do not have significant interest in entering into payment arrangements beyond the pay-for-reporting programs.

Health Plan-Based Payment Models

Health plan-based models offer extended care services to their members with serious illness as part of their healthcare premium. Services include case management, care coordination, and serious illness care planning. Payment structures vary depending on the goals of the health plan and their contracts with providers.

Advantages	*Limitations*
▪ These models expand serious illness care services to the private sector and younger, privately insured populations. ▪ Development of private health plan models that align with Medicare models presents an opportunity to establish multi-payer programs	▪ These models rarely have a defined payment and incentive structure that can easily be replicated. In some cases, these structures are considered proprietary. ▪ Case management and care coordination by health plans may be duplicative of provider-

[15] http://www.modernhealthcare.com/article/20160121/NEWS/160129976

that align payment for providers and care for patients. • Health plans have the flexibility to adjust incentives for both providers and patients, which can drive use of high-quality, effective services. • Health plans have large amounts of patient data at their disposal, facilitating patient tracking and care planning.	based services. Even when they are not duplicative, they may not be integrated with patient care. • Telephonic case management is often utilized by health plan models but has shown less effectiveness than in-person models.[16] • Private health plan models alone will only capture a small portion of the serious illness population, as a large portion is covered by Medicare and Medicaid. • Health plans may not have the necessary clinical expertise in serious illness care to effectively build these models. Workforce changes are necessary and may pose challenges. • Plan-based models often lack the extra layer of accountability that provider-based models have from the payer. Quality reporting and cost savings should be independently validated.

Accountable Care Organizations

Accountable care organizations (ACOs) create incentives for a group of healthcare providers to work together to treat individual patients across settings, including offices, hospitals, and post-acute care. ACOs are rewarded if they are able to lower growth in healthcare costs while meeting performance standards for quality of care. ACO models may include downside risk, and some feature advanced payments. Provider participation in Medicare ACOs is purely voluntary, and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish.

Advantages	***Limitations***
• Establishes a large network of providers from across the care continuum to offer coordinated, high-quality, and affordable care. • Movement from shared savings only to two-sided risk (i.e., Next Generation ACO) creates strong incentives to effectively coordinate care, improve quality, and reduce unnecessary utilization. • Provides increased flexibility for providers to use resources to engage in care planning and meet	• One-sided risk ACOs have not shown significant cost savings; the effectiveness of two-sided risk ACOs is a bit more promising but not conclusive. • Retrospective attribution in the MSSP ACO program makes it very challenging for providers to identify and manage their attributed beneficiaries. However, relying strictly on prospective attribution, which is used in the Next Generation ACO model, may miss drastic

[16] http://jama.jamanetwork.com/article.aspx?articleid=2099528

the variable and complex needs of serious illness patients. • Provider participation is voluntary and beneficiaries continue to receive traditional Medicare benefits and maintain their freedom to see any Medicare provider. • Quality measures include focus on chronic disease management and patient experience, which are used to calculate savings/losses. • Studies have shown modest savings to the Medicare program, which were realized primarily through reductions in use of institutional settings by clinically vulnerable patients.	changes in care patterns, which is not uncommon in patients with serious illness. • Financial benchmarking has been a significant challenge for ACOs. Once shared savings are achieved, the benchmark is rebased and it is becomes challenging for providers to achieve additional savings. While CMS has implemented a number of strategies to address this issue, the problem is almost certain to remain. • Lack of a defined network provides flexibility for patients, but makes it significantly more difficult for providers to track and manage their attributed lives. However, newer ACO models are offering incentives to beneficiaries for staying in-network.

Global Payment Models

Global payment models feature a fixed payment for care that patients receive during a given period of time. They are typically paid on a per-patient basis and do not vary with the actual quantity of services delivered. Payments are bundled at the patient-level, rather than the service- or episode-level. Under such a model, patients receive coverage for all or most of their costs of care, including physician and hospital services, and prescription drugs. Providers are accountable for patient health outcomes and care management. Usually, benchmarks are estimated from past cost experience and adjusted for various risk factors and the expected progression of a current medical condition.[17]

Advantages	***Limitations***
• Significant opportunity for cost savings through community-based approaches to care and reduced utilization of acute and intuitional care. • If the model has a defined set of providers, the payment structure will drive close integration of services across the care continuum (e.g., PACE). • Gives providers a very high level of flexibility in determining the most appropriate services and treatments for the patient. • Enables investments in both clinical and non-clinical services to address a wider range of	• There are few models in operation; most are still in the concept phase. • Global payment models can have significant administrative complexity for providers, requiring technical infrastructure and personnel devoted to managing financial risk. • Highly robust risk adjustment must be used in setting payment amounts to avoid undue amount of risk on the provider(s). • There may be significant regulatory issues around monitoring financial solvency of providers due to significant risk transfer.

[17] http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=13406

health needs and optimize care for the chronically ill.

- Quality measures tend to have significant focus on needs of serious illness population, including documentation of care planning, patient experience, and quality of life.
- High degree of care integration across the continuum and focus on non-clinical needs is likely to result in care that is sensitive to patient preferences and high patient satisfaction.
- In Medicare Advantage and PACE, there is increased use of preventive services and less intensive end of life care services,[18,19] which is likely more responsive to patient preference.
- Due to being at full or nearly full-risk, robust monitoring and evaluation must be in place to ensure that patients are receiving needed care and that there are no adverse impacts on outcomes.
- In Medicare Advantage, carving out hospice negatively impacts care coordination and creates administrative difficulties for clinicians, patients, and their families.

Discussion

Innovative payment models for serious illness care are being implemented across the care continuum by a number of different entities, including CMS, private payers, and providers themselves. Each model presents its own unique set of distinct advantages and disadvantages. However, Discern identified several common threads that are important for the future development of serious illness care payment models that will most effectively drive improvements in the quality of serious illness care while reducing costs.

Our analysis found that almost all of the models have elements that address the components and subcomponents of the conceptual framework. A few of the most common subcomponents are a focus on care coordination, incentives to provide the right care, and relevant quality measurement. However, some key subcomponents within these categories are rare, such as multi-payer design, downside risk, and adequate risk adjustment, as well as care delivery components such as telehealth, coordination with community agencies, caregiver supports, and decision support tools. Below are findings for each of the four components of the conceptual framework.

Definition of Population Requiring Serious Illness Care. As highlighted in the conceptual framework, payment models vary in the extent to which they explicitly target the sub-population of people with serious illness. Models that focus specifically on this population tend to include more relevant care delivery elements, incentives, and measures, while models focused on a broader population may offer greater flexibility, scalability, and integration of services across the care continuum. We found that about two-thirds of the payment models focus explicitly on serious illness populations. Clearly defining

[18] https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PACE_Outcomes.pdf
[19] http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/

the target population in a model can be difficult due to lack of sufficient patient-level data and lack of general agreement on how serious illness should be defined.

Implementation and Delivery Structure. To best meet the needs of the serious illness population, payment models should provide serious illness programs with the necessary flexibility to provide care in any setting, including patients' homes, using a multi-disciplinary team-based approach that attends to medical and social needs of both patients and caregivers. To ensure that needs are met and care is sensitive to patient preferences, services should be driven by a care plan aligned with patient goals. It is important that the care model not duplicate existing infrastructure or add additional complexity to patient care.

These design elements are found across the assessed models, but are used inconsistently. More than one-third of the reviewed models include services provided in the patient's home. Primary care-based models tend to focus on care coordination and include care planning and interdisciplinary care teams, although they do not always include a significant focus on services delivered in other settings. Delivery models designed specifically for the serious illness population, such as those in the health system setting and several of the global payment models, are more likely to include a significant number of patient-centered elements, such as care plans that capture patient preferences, palliative care, and discharge planning. However, elements such as telehealth, caregiver support, decision support tools, and bereavement were less common. ACOs include some of these care elements as well, but their delivery models are less well-defined.

Payment and Incentive Structure. Payment models should be performance-based, as simple as possible, and give providers the necessary resources and flexibility to support transformation and delivery of desirable care elements. A multi-payer structure helps to streamline processes for the provider, and advanced payments provide the funds to build the necessary infrastructure and coordinate the full range of services needed by the patient. Given the significant and complex needs of the serious illness population, models that align incentives across the care continuum result in better care coordination. Payment should also be structured to include disincentives for avoiding complex patients.

A small but growing number of payment models are providing advanced payments and about half of those reviewed include some level of provider risk. On the other hand, multi-payer models and aligned incentives across the care continuum are still rare. Global payment models have significant downside risk while also providing relative simplicity and flexibility to support care transformation and the full range of services needed by the seriously ill. However, monitoring is required to ensure that all needed services are provided. Health system and ACO models that do not have downside risk may not provide a large enough incentive to drive major changes in care delivery and coordination with other providers in post-acute and other relevant settings. These models often have complex payment structures, leading to uncertainty for the provider. Additionally, post-acute care-based models may not include the incentives necessary to drive coordination with other care settings. Health plan-based models offer advantages in terms of payment flexibility and data on the serious illness population, but may not be easily replicable or scalable.

Accountability and Performance Measures. The use of robust quality measurement is a critical element for establishing accountability, monitoring for unintended effects, and promoting performance improvement within a payment model. An effective and simple reporting process should be used to

minimize provider burden. Measure sets should include meaningful measures of patient-reported quality of life, adherence to patient preferences, and utilization and cost. Risk-adjustment and appropriate benchmarks are necessary to ensure that providers are not unfairly penalized. Utilization and cost metrics should be included to help monitor and manage resource use and determine the overall value of care.

Desirable measures are more often found in models designed specifically for the serious illness population, regardless of the payment category. However, provider and private health plan-sponsored models tend not to include as wide a range of measures as public payer models. Even when a comprehensive set of measures is included, some models lack risk adjustment and appropriate benchmarking to account for the complexity of the serious illness population.

Linkages to Other Strategies

Outside of the four-part conceptual framework, payment models should be linked to other mutually reinforcing strategies. These include making quality information available so that patients and their families can make more informed care decisions, developing accreditation programs, and improving provider knowledge of new payment and delivery models through changes to medical education. In addition, evaluation and monitoring should be used on an ongoing basis to identify and mitigate unintended consequences of these new models within appropriate timeframes.

Accountability and Policy Issues

Quality measurement is an essential component to holding providers accountable for providing high-quality, patient-centered care. While the most effective payment models utilize performance measures to set payment, tying payment to quality measurement is not the only mechanism for accountability. Quality reporting and accreditation programs can help consumers and purchasers make more informed decisions about where they seek care and can generate quality-based competition among providers.

Quality reporting. Beyond use in assessing performance for payment, appropriate measures should be publicly reported. CMS has a number of reporting programs that address serious illness care, including 'Compare' websites for nursing homes, home health agencies, dialysis facilities, and hospitals. Moreover, some private payers and consumer advocacy organizations provide publicly available performance information. These reports are useful for supporting consumer decision-making and can drive market share.

As a result of the ACA, the IMPACT Act of 2014, and other acts of Congress, CMS is in the process of standardizing data elements and implementing pay-for-reporting programs for SNFs, home health, long-term care hospitals, and hospice. Most of these programs are still collecting data and have not yet yielded publicly available measures. While public reporting is essential for transparency, it is unclear how frequently publicly reported information is used by patients and their families to help make decisions about care.

Accreditation. Accreditation programs exist for hospitals and other providers, but are not yet in place for community-based serious illness programs. A national accreditation program for serious illness care would ensure a baseline level of quality across providers. Achieving accreditation could then be tied to payment, either by making it an eligibility criterion for participation in a payment program or making

adjustments to payment based on accreditation status. Additionally, accreditation status could be used by consumers making decisions about where to seek care.

Public Awareness

Increasing public awareness is another strategy for advancing serious illness care. This strategy may seem distinct from the implementation of new payment models, but there are important linkages that should be considered.

Provider payment for end-of-life discussions. When it comes to educating patients about end-of-life issues, doctors – and primary care physicians in particular – are an important and trusted source of information. Studies show that a large majority of patients want to have end-of-life discussion with their physicians, and most believe the physicians should initiative the conversation.[20] The ability to bill for or receive flexible up-front or ongoing payments for serious illness care would likely significantly increase discussions about treatment options, the development of care plans and advanced directives, and consideration of other end-of-life issues.

Availability of quality information. As mentioned above, quality reporting can assist patients and their families in making informed decisions about where to seek care. These types of reporting programs should drive patients to higher quality providers. However, studies show that positive quality reports for nursing homes has had minimal effect on increasing their market share.[21] Public awareness campaigns should highlight these reporting programs and encourage patients and their families to make informed decisions about where to seek care.

Workforce Development

For providers to be successful under new payment models and for patients with serious illness to receive the highest quality of care possible, efforts should be made to improve provider knowledge and understanding of goal- and team-based care, having end-of-life conversations, and other topics in serious illness care. This is critical for both practicing providers and those in training. Currently, less than one-third of practicing physicians have had training on having conversations on end-of-life care,[22] and fewer than 30 percent of medical schools have a required course on palliative care.[23] Payment models should recognize the value of this training and related certification.

Workforce development should address not only medical education, but also nursing, social work, pharmacy, and other health professional training programs. Coursework on end-of-life issues should be required in the curricula for these programs. Moreover, greater emphasis should be put on end-of-life issues in continuing medical education across the various medical specialties that deal with serious illness. Not fully preparing providers to succeed in these new payment models will hurt them financially, which in turn will only lead to less available resources and poorer quality of care for patients.

[20] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495357/
[21] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3393022/
[22] http://www.jhartfound.org/blog/talking-with-patients-about-end-of-life-care-new-poll-reveals-how-physicians-really-feel/
[23] http://www.ncbi.nlm.nih.gov/pubmed/19021481

Monitoring

A significant challenge in establishing and operating value-based payment systems is the need to integrate data from across providers and payers. A national surveillance system for quality and cost data, including serious illness care data, would facilitate the establishment of new payment programs and the operation of existing programs. With patient level data, this type of system could be used for attribution, risk adjustment, and other payment purposes.

In addition to payment functions, a robust monitoring system could also include patient registries and consumer surveys. This would facilitate sharing of patient utilization information like clinical outcomes, care plans, histories, advanced directives. In addition, consumer surveys on American's knowledge and experiences with serious illness and end-of-life care issues could be used for monitoring, quality improvement, and identification of unintended consequences. The monitoring system could in turn serve as a one-stop shop for report cards and other consumer-oriented quality reporting.

Reinvestment into Community-Based Approaches

As providers take on more risk under value-based payment models, it is increasingly in their best interest to not only improve the quality of care that they deliver but to also reduce acute care utilization and improve the health of patients. Many of these payment models are using utilization measures to establish accountability, and there is a movement to more outcomes-based measurement and inclusion of measures of psychosocial and other non-medical needs. In addition, in capitated systems and global budget arrangements, preventing unnecessary utilization has a direct impact on revenue.

Management of patients and preventive care in the community is the most effective approach to impacting these types of measures and generating savings in these types of models. These community-based approaches typically involve organizations outside the healthcare delivery system providing services that have not traditionally been reimbursed. Providers should consider the return on investment they receive from these services and make the investments necessary for them to proliferate. In addition, payment model sponsors – whether public or private – should directly invest a portion of the savings in community-based programs.

Next Steps

Building on the findings from our payment model analysis, Discern identified a series of next steps to support progression toward high-quality payment models for serious illness care. These next steps reflect the importance of engaging various stakeholders in future development, addressing specific barriers to further model development, and establishing milestones and tracking progress over time.

1 ***Engage stakeholders to further model development***

Rationale. The conceptual framework and findings outlined should be shared with payers working on model development, providers considering model development and participation, patients and consumers, other stakeholders, and subject matter experts. These stakeholders should be engaged to provide feedback on this analysis, discuss barriers to further

implementation of promising models, and identify policy changes and other actions that may facilitate further development.

Proposed process. A multi-stakeholder advisory group of payers and purchasers; professional and facility providers; patients and consumers; and subject matter experts in payment, measurement, and data should be convened. Payers representing public and private health plans and large employers should be identified to participate in the group, as well as large health systems, ACOs, primary care providers, specialists, and post-acute providers. To establish and sustain momentum, this group should be meet two-three times per year, alternating in-person and web meetings. The advisory group should guide the development of Next Steps 2-4 below, among other initiatives related to advancing serious illness care. Workgroups with additional members may be formed as needed. The group should publish reports that include guidance on aspects of model development and operation.

2 *Enhance data availability and alignment*

Rationale. Existing data resources are not being used to their full potential to support payment models and high quality care delivery. Data should be aligned across various sources such as federal data sets, clinical registries, and electronic health records. In addition, patient-reported outcomes should be utilized more effectively to make care more sensitive to patient preferences and quality of life. Other gaps in data need to be better understood and addressed.

Proposed process. A framework should be developed that maps various existing data resources, including federal data sets, clinical registries, electronic health records, and repositories of patient-reported outcomes, onto current and future needs in value-based payment, quality measurement and reporting, and monitoring and evaluation. As part of this process, these data resources should then be assessed to better understand their current state, pinpoint critical issues, and identify future opportunities. This process will help determine gaps in data availability and lay the foundation for evolving existing data resources and developing new resources. The advisory group should provide input and feedback throughout this assessment process.

3 *Define milestones*

Rationale. Setting milestones is critical to assessing progress and developing highly defined goals and strategies for improvement. Milestones should be set for adoption and spread of select components and subcomponents of the conceptual framework. In addition, milestones should be set of adoption of promising individual payment models.

Proposed process. A selection of components and subcomponents should be developed into clear, quantitative milestones within a defined timeframe. The milestones should be developed through a multi-stakeholder consensus process that includes a balance of perspectives from across the health care system, such as through the advisory group. The choice of which components and subcomponents to use should necessarily be guided by what is measurable

through available data, including registries, surveys, or new surveys of providers, payers, and patients (see Next Step 4). In addition, milestones should be set for adoption of individual payment models that the advisory group deems to be high priority.

4 *Establish monitoring mechanisms*

Rationale. Monitoring will be necessary to assess the extent to which milestones are being met and to further spread of payment models. Monitoring should also focus on the effects of model implementation, including unintended consequences such as negative impacts on benefit coverage and patient cost sharing.

Proposed process. The advisory group should develop a monitoring plan to guide this process. A range of data resources, including those listed in Step 2, should be leveraged for monitoring purposes. However, these existing resources are necessary but not sufficient to engage in a complete monitoring system. Regular surveys of providers, payers, and patients should be used to fill data gaps and provide more nuanced information, including unintended consequences, that would not be available in traditional data sources. The results of this ongoing monitoring should be used as part of a quality improvement cycle and help guide evolution of payment models for serious illness care.

Appendix: Serious Illness Care Payment Models Environmental Scan

This appendix summarizes the findings from Discern Health's analysis of select payment and delivery system models related to serious illness. The models have been assigned to seven categories listed in the table of contents below. To the extent that information was available, Discern compiled data on relevant elements: setting, population, and scale; payment type and incentive structure; performance measures; delivery type and requirements; objectives and outcomes; implementation strategy and timing; and implications for serious illness care.

List of Models:

- **Primary Care Home-Based Models**
  1. Comprehensive Primary Care Plus (CPC+)
  2. Cambia Palliative Care Medical Home Pilot
  3. Independence at Home
  4. Geriatric Resources for Assessment and Care of Elders (GRACE)
- **Specialty Care Models**
  1. Oncology Care Model (OCM)
  2. Patient Centered Oncology Payment (PCOP)
  3. Radiation Oncology Palliative Care Alternative Payment Model
  4. Comprehensive ESRD Care Model
- **Hospital/Health System-Based Models**
  1. Gundersen Respecting Choices Advance Care Planning (ACP) System
  2. Kaiser Palliative Care Model
  3. Sutter Advanced Illness Management Program
  4. Hospital at Home
- **Post-Acute Care-Based Models**
  1. IMPACT ACT of 2014
  2. Home Health Quality Reporting Program
  3. Hospice Quality Reporting Program
  4. Long-Term Care Hospital (LTCH) Quality Reporting Program
  5. Skilled Nursing Facility (SNF) Quality Reporting Program
  6. Skilled Nursing Facility (SNF) Value-Based Purchasing
  7. Medicare Care Choices Model (MCCM)
- **Health Plan-Based Models**
  1. Aetna Compassionate Care Program
  2. Regence Personalized Care Support Program
  3. Sharp Transitions Program
  4. United Advanced Illness Care Management Program
- **Accountable Care Organizations**
  1. Medicare Shared Savings Program (MSSP)
  2. Pioneer ACO Model
  3. Next Generation ACO Model
  4. MACRA, MIPS, and APMs
  5. Removing Barriers to Person-Centered Care Act
- **Global Payment Models**
  1. PACE Program
  2. Medicare Advantage
  3. MediCaring Accountable Care Community Model
  4. Personalize Your Care Act 2.0

Setting, Population, and Scale	Payment Type and Incentive Structure	Performance Measures	Delivery Type and Requirements	Model Objectives and Outcomes	Implementation Strategy and Timing	Implications for Serious Illness Care
Primary Care Home Models						
Comprehensive Primary Care Plus (CPC+) (CMS/CMMI): CPC+ is a national payment model designed to improve care delivered by primary care practices to Medicare, Medicaid, and dual eligible beneficiaries and private plan members through a regionally based multi-payer payment reform and provider transformation. The purpose of this model is to establish multi-payer partnerships to financially support practices making significant changes in care delivery. The model will accommodate 2,500 practices per track for a total of 5,000 practices across 14 selected regions. Practices will enter into a shared commitment to align on payment, data sharing, and quality metrics throughout the five-year initiative effective January 2017.						
Setting: Primary care practices Population: Medicare, Medicaid, and dual eligible beneficiaries, commercially insured Scale: • 14 regions (11 statewide and 3 metro areas) • Track 1: Up to 2,500 practices • Track 2: Up to 2,500 practices	Type: • Fee for service (FFS) with additional per beneficiary per month (PBPM) and performance adjustment • Regional multi-payer model, including Medicare, commercial plans, Medicare Advantage, Medicaid/CHIP, Medicaid MCOs HCP-LAN Category: 3A Payment/Incentive Structure: • Track 1: o Medicare FFS payments o Care Management Fee tiered by risk (average of $15 PBPM) o Prepaid performance fee ($2.50 PBPM); may only keep if performance targets are met • Track 2: o Hybrid of Medicare FFS payment and up front percentage of expected Medicare E&M payments o Care Management Fee tiered by risk (average of $28 PMPB) o Prepaid performance fee ($4 PBPM); may only keep if performance targets are met • Both tracks count as an Advanced APM under MACRA	• Measure set (see Appendix D) • Measure domains include: o Clinical process/ effectiveness (9): depression and substance abuse; blood pressure; diabetes; dementia; pneumonia vaccination; breast, cervical, and colon cancer screening o Patient safety (3): medications, falls o Population /public health (4): depression screening, HbA1c, tobacco cessation, flu immunization o Efficient use of healthcare resources (1): imaging o Care coordination (1): referrals o Patient and family engagement (2): CAHPS, PROs o Utilization (2): ambulatory and inpatient	• Medical home model • The model will offer two tracks with different care delivery requirements. The tracks will have progressively more advanced requirements, with commensurate payment o Track 1: provides a pathway for practices ready to build the capabilities to deliver comprehensive primary care. o Track 2: provides a pathway for practices prepared to increase the comprehensiveness of care through enhanced HIT, improve care of patients with complex needs, and inventory of resources and supports to meet patients' psychosocial needs. • All practices must use certified EHRs Track 2 practices must have a Health IT vendor partner • Interested payers must submit a proposal to participate in the model • Limited number of ACO practices may participate • Can participate in Model 2 and Model 3 of the bundled payments for Primary Care Initiative as well as engage in shared savings with participant hospitals in the CCJRI • Required to carefully track services	Objectives: • Access and continuity • Care management • Comprehensiveness and coordination • Patient and caregiver engagement • Planned care and population health	• Five-year test • Will bring together CMS, commercial insurance plans, and State Medicaid agencies • Payers will financially support Track 1 practices to build the capabilities to deliver comprehensive care and Track 2 practices to increase the comprehensiveness of care through HIT • Maturity: Not active; will begin January 2017	• Multi-payer structure has potential to reduce provider burden and streamline workflow through aligned quality measures and payments across payers • Up-front payments offer greater cash flow and flexibility for primary care practices to invest in practice transformation and deliver high quality care to patients with serious illness • HIT objectives address care planning, including advanced directives and patient preferences Risk adjusted care management fee allows practices to devote more time and resources to patients with serious illness • Will provide practices with a learning system, and actionable patient-level cost and utilization data

	o 5% bonus under Medicare Part B incentive • Cannot bill Medicare for chronic care management fees[24]					
Cambia Palliative Care Medical Home Pilot (Cambia Health Foundation): This care delivery model is designed to provide expanded health benefits to Cambia Health members with serious illness through a dual payment structure for Cambia Health providers and grantees of the Cambia Health Foundation's Sojourns program. Providers are reimbursed through risk-adjusted payments. Payments are tied to performance of cost and resource use measures for services such as counseling, advanced care planning, care coordination, and medical team conferences among health providers of seriously ill patients. The model's objectives are to support providers in initiating dialogue and increasing access to palliative care.						
Setting: Integrated delivery network Population: Grants awarded to participating organizations and their patient populations with serious illness and palliative care needs Scale: Over 2 million members covered within 6 health plans operating in 4 states	Type: Care delivery model HCP-LAN Category: n/a Payment/Incentive Structure: • Dual payment structure o Cambia Health commercial insurance based payments (risk-adjusted) o Grant awards to Cambia Health Foundations Sojourns Program • Adjusting provider reimbursement structure to include palliative care services • Pay for value incentive structure • Cost savings through decreased utilization of costly acute care services • Reimbursement for services including counseling, advanced care planning, care coordination and medical team conferences among health providers of seriously ill patients • Reimbursements for office counseling, advanced care planning, care coordination, interdisciplinary team conferences, home health	• Cost and Resource Use Measures: o ED visits and hospitalizations o Cost savings from reduced LOS o High potential DRG claims o Number of ICU stays o Hospice uptake and LOS o Patient satisfaction rates	• Medical home model • Provides expanded benefits for members o Curative treatment in conjunction with palliative treatment o Care coordination through a dedicated case manager o Removal of the homebound requirement for home health services o Behavioral health services for the individual and family • Provides grants to organizations committed to implementing palliative care programs [25] • Eligibility requirements o Applicant organizations must be a nonprofit (501c3) or public entity and located in the four state region (Idaho, Utah, Washington or Oregon) o National organizations are eligible to apply for regional grant opportunities, but the project intent must be focused on one or more of the four states within the foundation's region • Non-profit hospitals and other community-based healthcare organizations are eligible	Objectives: • Provides access to palliative care to over 2 million members covered within six health plans operating across OR, WA, ID, UT. • Financially support providers to encourage conversation with patients earlier in their illness process • Change perception of palliative care	• Cambia Health Foundation has invested $10 million over 7 years on research and design of a palliative care program • Cambia has created new health care services, benefits, training and education to ensure that patients and providers (doctors, nurses, home health aides, and others) are equipped to put the patients physical, social, and spiritual needs at the core of the care delivery plan • Access to palliative services effective July 2014, Medicare Advantage customers effective January 2015 • Maturity: Effective July 2014	• Promotes patient and family centered care for serious illness • Reimburses for time spent counseling and for the interdisciplinary team • Encourages earlier conversations about treatment options that enhance quality of life for patients with serious illness • Allows people with serious illness to live with dignity and a sense of control

[24] https://regpulseblog.com/2016/04/20/cms-unveils-new-multi-payer-primary-care-initiative-to-reinforce-move-away-from-fee-for-service-reimbursement-model/
[25] https://www.capc.org/about/press-media/press-releases/2013-4-18/cambia-health-foundation-center-advance-palliative-care-partner-help-americans-understand-palliative-care/

	aides and other home services, in home counseling, and training to providers on developing their ability to better engage patients and their families					
Independence at Home (CMS/CMMI): IAH is designed to collaborate across medical practices to assess the effectiveness of delivering comprehensive primary care services at home and its effect on health outcomes for Medicare beneficiaries with multiple chronic conditions. This is a risk-adjusted shared savings payment model that incentivizes providers to deliver high quality care while also reducing costs. This model has proven to substantially increase savings for the beneficiary, participating practices, and for CMS. The success of this model has resulted in a legislative proposal to implement this model nationwide.						
Setting: Home Population: Medicare beneficiaries with multiple chronic conditions Scale: Across 16 participating organizations	Type: Medicare FFS with risk adjustment and shared savings HCP-LAN Category: 3A Payment/Incentive Structure: • Shared savings if under annual practice-specific spending target • Spending target derived from risk-adjusted Medicare FFS claims that also includes frailty and trend adjusted factors. • Practice must meet minimum savings requirement to be eligible for shared savings • CMS retains first 5% of savings; practice receives the remainder • Not considered an Advanced APM under MACRA	• Measures include: o Number of inpatient admissions for ambulatory-care sensitive conditions per 100 patient enrollment months o Number of readmissions within 30 days per 100 inpatient discharges o Number of ED visits for ambulatory-care sensitive conditions per 100 patient enrollment months o Contact with beneficiaries within 48 hours upon admission to the hospital and o discharge from the hospital and/or ED o Medication reconciliation in the home o Patient preferences documented o Beneficiary/caregiver goals o Screenings/assessments o Symptom management o Medication management o Caregiver stress o Voluntary disenrollment rate o Referrals o Patient satisfaction	• Participating practices were required to demonstrate experience providing home-based primary care to high-cost chronically ill beneficiaries. Participating practices include primary care practices and other multidisciplinary teams that are: o led by physicians or NPs ▪ teams also include physician assistants, pharmacists, social workers, and other staff o organized for the purpose of providing physician services o have experience providing home-based primary care to patients with multiple chronic conditions o serve at least 200 eligible beneficiaries • Participating practices will make in-home visits tailored to an individual patient's needs and preferences • Eligible Beneficiaries: o Have two or more chronic conditions o Have coverage from original Medicare-FFS o Need assistance with two or more functional dependencies o Have had a non-elective hospital admission within the last 12 months	Objectives: • Provide chronically ill patients with a complete range of primary care services in the home setting. • Determine whether home-based care can: o Reduce the need for hospitalization o Improve patient and caregiver satisfaction o Improve health outcomes o Lower costs to Medicare Outcomes: • Cost savings per beneficiary $3070 • Cost savings for practices $25 million • Cost savings to CMS $13 million	• Established by ACA • CMS will work with medical practices to test the effectiveness of delivering comprehensive primary care services at home • Maturity: Active; currently being proposed for legislation	• Home-based primary care allows health care providers to spend more time with their patients in a setting comfortable to the patient • May allow care team to identify additional psycho-social needs that would have gone undetected in an office visit • Addresses the significant access to care barrier of transportation • If patient needs are addressed, has potential to forestall institutional care by keeping patient healthy at home

			o Have received acute or subacute rehabilitation services in the last 12 months			
Geriatric Resources for Assessment and Care of Elders (GRACE) (Indianapolis-based Wishard Health Services): GRACE is a primary care delivery model that provides comprehensive, team-based, and coordinated care to low income seniors with multiple chronic conditions. The purpose of this model is to improve the quality of geriatric care as well as reduce costs. This model does not include a defined payment structure.						
Setting: Across the care continuum and in patient homes Population: Low income seniors 65 years and older Scale: 4 integrated health systems	Payment Type: Capitated payments/Medicare-FFS (10%) HCP-LAN Category: 3A Payment/Incentive Structure: • Reimbursements through Medicare-FFS (10% of payments) • Cost savings	• Measures include: o Serious illness care planning o Health maintenance o Medication management o Difficulty walking/falls o Chronic pain o Urinary incontinence o Depression o Malnutrition/weight loss o Visual impairment o Hearing loss o Dementia o Caregiver burden	• Certified NPs and LCSW provide in-home assessments o Periodic assessments (3 & 6 weeks; and 3, 6, 9 & 12 months) • Use of interdisciplinary care team to coordinate care across providers and settings • Integration of the program in primary care through EHRs • Special attention to orthostatic vital signs, vision, hearing, gait and balance, affect, and mental status • Home safety evaluation required • Patient eligibility: o 65 years and older o Annual income below 200% federal poverty level o One of more primary care visit in the last 12 months o Resided in the community implementing the GRACE Model o Access to a telephone	Objectives: • Improving access to care • Coordination of care for patient's total needs of care • Increasing patient education to improve patient self-management Outcomes (from pilot study[26,27]): • Better performance on ACOVE quality indicators • Enhanced quality of life by SF-36 Scale • Lower resource use and costs in high risk patients • Decreased hospitalizations and costs for high risk patients • Satisfaction survey found that physicians were more satisfied with the resources available to treat patients in the program • GRACE Program rated very helpful in providing care for older adults • 2-year GRACE intervention saved $1500 per enrolled high-risk patient in the second year	• GRACE Support Team[28] o Team completes special training in implementing the GRACE protocols and working as an interdisciplinary team during 12 weekly small group seminars • Maturity: Active	• Low income seniors with multiple chronic conditions receive coordinated care across multiple settings • Patients and their interdisciplinary care teams develop an individualized care plan according to person-and-family centered preferences • Teams encourage goal setting, self-care, problem solving skills, provide education using health literacy materials according to patients understanding
Specialty Care Models						
Comprehensive ESRD Care (CEC) Model (CMS/CMMI): CEC is an accountable care organization-like model that includes fee-for-service payment with potential shared savings and losses. This model requires collaboration across ESRD Seamless Care Organizations (ESCOs) that are held accountable for clinical quality and financial outcomes measured by Medicare Parts A & B spending, including all spending on dialysis services for their ESRD beneficiaries. Participating facilities receive shared savings or incur shared losses based on their collective performance on specified outcome measures.						
Setting: Dialysis facilities and their partners	Type: FFS with shared savings/losses HCP-LAN Category: 3B	• Proposed measure set • Measure domains include: o Patient quality of life	• Dialysis clinics, nephrologists and other providers join together to create an ESRD Seamless Care	Objectives: • Putting beneficiary first • Beneficiary choice • Active monitoring	• Test the effectiveness of a new payment and service delivery model in providing	• Includes specific attention to advanced care planning • Quality adjustments to shared savings (or losses)

[26] http://content.healthaffairs.org/content/30/3/431.full.pdf+html
[27] http://www.in.gov/fssa/files/ABD_GRACEIndianaAug2013.pdf
[28] http://www.medscape.com/viewarticle/541536_3

Population: ESRD Beneficiaries enrolled in FFS Medicare Parts A&B. Additional patient exclusions apply Scale: 13 sites nationwide	Payment/Incentive Structure: • Expenditure benchmarks in Medicare Part A and B are trended and adjusted for risk. Providers eligible to retain savings • Participants classified as Large Dialysis Organizations (LDOs; those with 200+ facilities) must share in losses if expenditures exceed benchmark • Percentage of shared savings or losses accruing to provider dependent on quality scores • Low quality scores may also result in ineligibility to receive shared savings and/or removal from the program • LDOs qualify under MACRA as an Advanced APM for a 5% Part B incentive payment	o Chronic disease management o Patient safety o Preventive health o Care coordination o Patient and family engagement • Required to report on a variety of care delivery and health outcome measures across the continuum of care, not just ESRD services	Organization (ESCO) to coordinate care for matched beneficiaries • Medicare enrolled providers of services and suppliers are eligible to participate: o Physicians, non-physician practitioners, and other healthcare suppliers that are not: ▪ Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers ▪ Ambulance suppliers ▪ Drug and/or device manufacturers ▪ Excluded or otherwise prohibited from participation in Medicare or Medicaid o Medicare-enrolled providers of services that are also DMEPOS suppliers, but whose primary taxonomy is as a non-DMEPOS provider, are eligible to participate		beneficiaries with patient-centered, high-quality care • Separate financial arrangements for larger and smaller dialysis organizations o Large Dialysis Organizations have downside risk • Maturity: Round 1 implemented in 2014; Round 2 begins in 2017	provide strong incentive for patient-centered care • Downside risk for LDOs (12 of the 13 sites) establishes significant accountability
Oncology Care Model (CMS/CMMI): The OCM is a payment and delivery care model designed to improve the effectiveness and efficiency of specialty care for oncology patients and providers. It is a multi-payer shared savings model that includes Medicare and other payers such as commercial insurance plans or state Medicaid programs. This new model launched in spring 2016 for physician practices administering chemotherapy to cancer patients and holds them accountable for the financial and performance outcomes of episodes of care. The purpose of this model is to improve health outcomes for patients with cancer through high quality services and effective care coordination while reducing spending for cancer treatment.						
Setting: Oncology practices that offer chemotherapy services Population: Cancer patients Scale: 195 practices nationwide	Type: • FFS with additional capitated payment during episode of treatment • Potential shared savings based on performance during episode • Multi-payer model including Medicare FFS (Part A, B, and certain D benefits) and 17 private payers HCP-LAN Category: 3A Payment/Incentive Structure:	• Measure domains (page 24): o Communication and care coordination o Person- and caregiver-centered experience and outcomes o Clinical quality of care o Population health o Efficiency and cost reduction	• Specialty medical home/medical neighborhood model • To participate in OCM, practices must: o Provide the core functions of patient navigation o Document a care plan that contains the 13 components in the Care Management Plan outlined in the IOM report o Provide 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice's medical records	Objectives: • Appropriate selection of chemotherapy • Provide higher quality, more coordinated care at a lower cost	• OCM encourages other payers to participate in alignment with Medicare to create broader incentives for care transformation at the physician practice level, across a broader population • Other payers would also benefit from savings, better outcomes for their members, and information gathered about care quality • Payers who participate will have the flexibility to design their own payment incentives while aligning with the	• Payment structure encourages coordinated care during episode while incentivizing cost reduction • Includes quality measures for patient and caregiver experience and palliative and end-of-life care • Potential to align incentives across payers • Cost savings dependent on reductions in acute care utilization. Without significant reductions, model will result in increased costs overall

	• $160 PBPM for 6 months of treatment episode • Semi-annual performance payments based on:[29] o Difference between target and actual spend per episode o Trend factor o Adjustments for novel therapies • Payment to physician group practices and solo practitioners that provide oncology care		o Treat patients with therapies consistent with nationally recognized clinical guidelines o Use data to drive continuous quality improvement o Use an ONC-certified electronic health record and attest meaningful use by the end of the third model performance year		Innovation Center's goals for care improvement and cost reduction • Maturity: Five-year model. Expected implementation in 2016	
Patient Centered Oncology Payment (PCOP) (ASCO): The PCOP is a payment and delivery model that offers flexible payments to providers to support patient care and tailored services. Providers are accountable for delivering high-quality, appropriate, evidence-based care at reduced costs. This model includes a flexible FFS payment structure with an additional set of capitated payments through four different billing options. These payments are in addition to the oncology practices' current payment structure which increases care delivery options for cancer patients. The purpose of this model is to improve the quality and effectiveness of care, reduce costs, and increase savings for payers and providers.						
Setting: Oncology practices Population: Cancer patients Scale: Not currently implemented	Type: FFS with additional capitated payments HCP-LAN Category: 2A Payment/Incentive Structure: Four PBPM payments: • New patient treatment planning: $750/patient • Care management during treatment: $200 PBPM • Care management during active monitoring: $50 PBPM during treatment, up to 6 months following end of treatment • Participation in clinical trials: $100 PBPM during treatment, up to 6 months following end of treatment for trials in which practice support is not available • For greater flexibility, advanced oncology practices	• Measure set (see Table 2) • Measure domains include: o Quality of treatment planning for a new patient (pathology, care plan, emotional well-being assessment, experience of care) o Quality of care during treatment (all patients, breast, colon and rectum, lung) o Quality of care following completion of treatment (avoiding chemo in last 14 days, hospice, pain, experience of care)	Oncology practices take accountability for: • Avoiding emergency department visits and hospital admissions for complications of cancer treatment • Following evidence-based guidelines for the appropriate use of treatment • Following evidence based guidelines for high quality care near end of life • Providing care consistent with standards of quality defined by ASCO	Objectives: • Increase quality and effectiveness of care and reduce costs • 50% increase in revenue • Increase savings for payers by a 4% net reduction in total spending from avoidable hospitalizations Outcomes (from pilot study[4]): • Referral coordination and care management were the most demonstrated functions • Least demonstrated functions included tracking and coordination of tests, quality measurement, and improvement • Needs to improve streamlining HIT, care coordination, quality improvement, telephone triage, symptom management, patient education, financial counseling, and care team communication	• The basic PCOP system provides non-visit based payments • Maturity: Not active; Piloted in 5 oncology practices[30]	• Up-front payment during diagnosis and treatment initiation would provide resources for care planning • Support for care management, oral therapy management, and end-of-life care • Support for oncology practice participation in clinical trials addresses significant barrier • Specific attention to end of life issues • Without significant reductions, model will result in increased costs overall due to add-on payments

[29] https://innovation.cms.gov/Files/x/ocm-methodology.pdf
[30] http://eresources.library.mssm.edu:2132/pubmed/26420891

	and payers can also choose between o Option A: Consolidated payments services o Option B: Virtual budgets for services, with a stop loss					
Radiation Oncology Palliative Care Alternative Payment Model (ASTRO): This is a payment and delivery model focused on the population of cancer patients with bone metastases. This particular disease site was selected because of the growing evidence demonstrating the value of radiation therapy for the palliation of bone metastases when used appropriately. The purpose of this model is to increase participation of radiation oncologists in quality incentives, increase access to care for patients, and ensure appropriate treatment for patients that yield the best possible outcomes. This model has not yet been implemented by ASTRO. This model includes a value-based payment methodology that features two diagnostic categories and bundled payments for care management, treatment, and follow up care as well as incentives for adherence to quality measures.						
Setting: Specialty oncology practices providing radiation therapy Population: Cancer patients with metastatic bone cancer Scale: Not currently implemented	Type: Bundled payment HCP-LAN Category: 3B Payment/Incentive Structure: • Episode begins after treatment decision is made • Bundle total amount is based on weighted average of FFS Medicare payments for that treatment • 60% paid up front • 35% paid on completion • 5% at risk based on quality measures • Potential additional 5% bonus based on 42 days of follow up and coordination • Stop loss for outliers, reverting to FFS payment	• Measure set (see page 4)	• Specialty care model • Patient must have metastatic bone cancer • Two treatment categories: simple and complex • Episode of care begins after the initial evaluation and management visit, when a treatment plan is agreed on • Episode includes any retreatment and treatment of new metastatic bone sites within 28 days of completion of the initial treatment	Objectives: • Support care planning • Relieve pain • Improve quality • Reduce costs Outcomes (projected): • Cost savings represent a 50% increase in revenue compared to current payments • Net reduction of 4% in total spending	Maturity: Not implemented; in public comment	• Up-front payment during diagnosis and treatment initiation would provide resources for care planning and management • Incentive for follow up/monitoring after treatment episode • However, bonus payment based solely on process measures rather than outcomes; does not include patient reported outcomes measures
Hospital/Health System-Based Models						
Gundersen Respecting Choices Advance Care Planning (ACP) System (Gundersen Health System): This program is an internationally recognized evidence-based care delivery model with a reliable systematic approach to transforming care for patients with serious illness. This model has also proven a major return on investment in diverse communities and cultures worldwide. The purpose of this program is to guide organizations and communities worldwide to effectively implement and sustain evidence based care planning systems and to transform health care culture by integrating and disseminating best practices in advanced care planning. This model does not include a payment methodology.						
Setting: Integrated Delivery System Population: La Crosse, WI Health Region (southwest WI, southeast MN, and northeast IA);	Type: Health system based model HCP-LAN Category: n/a Payment/Incentive Structure: No defined payment system. • Relies on cultural adoption of serious illness care	• Measures not available	• Standardized advanced care planning system • First Steps ACP: All adult patients to encourage advanced planning • Last Steps ACP: Physician Orders for Life-Sustaining Treatment (POLST)	Outcomes: • 96% of La Crosse County population had written care plan • 99% had care plan in medical file • 99% had treatment consistent with medical plan	• Develop an organized system for ACP so that the patients in the target populations are always approached, the quality of care planning was facilitated by trained staff and community volunteers, systems were designed and	• Lack of defined payment model limits significance • Significant improvements in care plan use while significantly reducing costs • Patients receive treatment aligned with preferences

seriously ill patients and healthy adults open to the ACP discussion Scale: Internationally implemented model	planning that translates to savings utilizations costs • Promotes shared savings and ACO models[31]		• Next Steps: focused on advanced illness • Documentation systems for care plan storage and easy updating and retrieval	• Decreased total number of days in hospital and ICU in the last 2 years of life • Decreased hospital days in the last two years of life (10 vs. 16.7) • Decreased ICU days in the last two years of life compared to the national average (2.2 vs. 5.9) • Decreased total cost of care in the last two years of life compared to national average ($49,000 vs. $79,000) • Lower LOS in hospice compared to national average (15.5 vs 21)	implemented so that documented care plans could be stored and retrieved when patients transition • Care plans were updated over time as illness or health conditions changed • Planned community engagement to make ACP part of the community and health care culture • Maturity: Active	• Improved patient satisfaction, communication across care continuum, and caregiver burden
Kaiser Palliative Care Model (Kaiser Permanente Health System): This model is based on Gundersen's Respecting Choices ACP System. Kaiser is expanding palliative care services across the care continuum in hospital, ambulatory, and home-based settings. The implementation of this model is sustained through a commercially-based payment structure that provides enhanced benefits to members with serious illness. The purpose of this model is to ensure that the advance care planning wishes of palliative care and other patients are met.						
Setting: Integrated delivery system Population: Kaiser health plan members with palliative care needs Scale: Kaiser facilities nationwide	Type: Fully capitated as an integrated delivery system HCP-LAN Category: 4B Payment/Incentive Structure: • Health system and payer • Commercially-based payment structure for enhanced palliative care services to members	• Aligning patient preferences with actual care experiences • KP continues to develop new quality measures as it works to fully integrate palliative care processes into usual care	• Gundersen's Respecting Choices Advanced Care Planning System's Requirements: o Standardized advanced care planning system o First Steps ACP: All adult patients to encourage advanced planning o Last Steps ACP: Physician Orders for Life-Sustaining Treatment (POLST) o Next Steps: focused on advanced illness • Documentation systems for care plan storage and easy updating and retrieval	Outcomes: Three RCTs of patients in hospital, home, and clinical settings found: • Improved quality of care • Higher patient satisfaction • Improved communication and advanced planning • Fewer hospital admissions • Decreased ED visits • Decreased costs • Improvements in the percent of decedents enrolled in hospice or palliative care 31 or more days before their death, increasing from 44% in 2008, to 65% in 2015	• Implementing Gundersen's Respecting Choices ACP System's Model • Establishing a team of specialized, team-based support across hospital, home, clinic, and other settings • Maturity: Active	• Payment structure may not be feasible outside integrated system like Kaiser • Patients with advanced illness have documented care plans • Significant focus on end of life preferences and aligned treatment • Results demonstrate clear improvement in patient satisfaction, communication across care continuum, and caregiver burden while reducing costs

[31] http://www.gundersenhealth.org/upload/docs/respecting-choices/Respecting-Choices-return-on-investment.pdf

Sutter Advanced Illness Management Program (Sutter Health System): This is a delivery care model that provides home-based services. It is sustained through an effective implementation strategy resulting in substantial savings due to decreased costs in acute care utilization. This model increases access to existing services, wherever available, and fills gaps in care where no support is available. Multidisciplinary care teams partner closely the patient's physicians and other providers to drive serious illness care until patient deceases or transitions to hospice. This model does not define a payment model, although Sutter has indicated interest in collaborating with payers to develop and implement a nationwide payment model.						
Setting: Integrated delivery system Population: Persons with serious illness Scale: IDN serves over 100 communities, 5,000 physicians, 24 acute care hospitals, over 24 surgery centers, a center for Integrated Care, and approximately 48,000 employees	Type: Care delivery model HCP-LAN Category: n/a Payment/Incentive Structure: Sutter received $13 million Innovation Award from CMS to fund the ongoing implementation and evaluation of the AIM program • Sutter provided $21.4 million to fund the program • No specified incentive structure • Payment model not defined, but partnering with payers to develop and implement payment models • Relies on cultural adoption of serious illness care planning that translates to savings utilizations costs	Measure set (page 30): • Care at the end of life o % transferred to hospice o % died in hospital o Hospital days in last 6 months of life o ED use in last 30 days of life o ICU use in last 30 days of life o LOS of hospice stay • Outcomes, resources, costs o Inpatient and ED visit rates per 100 patients o 30, 90 and 180 day pre/post enrollment utilization for hospital, ED, and ICU o LOS in hospice o 90-day payer impact, hospital cost impact, total cost of care	• Recipients of this program include individuals with advanced illness (chronic or other) in the last 12-18 months of life, with any of the following indicators of active decline: o Significant function decline (loss of 1 ADL in the last 3 months) o Significant nutritional decline (5% of baseline weight or albumin <3.0) o Recurrent and unplanned hospitalizations (2 or more hospitalizations in the last 6 months or 2 or more ED visits in the last 3 months), hospice eligibility but not ready, provider not surprised if patient died in the next 12 months	Outcomes: • 60% reduction in hospitalizations • 67% reduction in ICU days • 33% reduction in ED visits • Over 95% physician and patient satisfaction • $9,985 payer savings per enrollee • $8,289 (52%) reduction in total cost of care	• Collaborates with hospitals, physicians, home health, and hospice providers to ensure a multidisciplinary treatment plan • Partnering with ACP to promote adoption of similar interventions • AIM services are provided until patient deceases or transitions to hospice • Maturity: Active	• Lack of defined payment model, although highly promising results suggest it is highly appropriate for several different payment structures • Provides convenience and access to services for patients and caregivers • Ensures a multidisciplinary approach to drive advanced illness care, focus on advanced care planning, symptom management, care coordination, patient engagement, self-management and supportive services
Hospital at Home (HAH) (Johns Hopkins Schools of Medicine and Public Health): HAH is a delivery care model tied to the payment structure of the adopting organization. However, CMS is currently testing this model with the Icahn School of Medicine at Mount Sinai, New York to inform a possible 30-day bundled FFS payment structure. This model does not have a defined payment or incentive structure that will support implementation across health care organizations. Hospitals that are interested in adopting this model will need to determine how best to develop new systems and roles, while overcoming resistance to change, that ties into their current financial and organizational goals.						
Setting: Across the care continuum; home Population: Acutely ill older adults Scale: Tested at various medical centers across the country	Type: Varies HCP-LAN Category: Varies Payment/Incentive Structure: • Depending on organization model (FFS, managed care, or Veterans Administration) and on the organization's motivation for implementing this care model	• Measure domains: o Clinical process o Standards of care o Clinical complications o Satisfaction with care o Functional status o Costs of care	• Eligible beneficiaries o Patients who require hospital admission for certain diseases, such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis o Organizations must take a readiness assessment to ensure that conditions are right and that needed resources are readily available • Eligible patients can receive hospital-level care–including diagnostic tests and treatment	Outcomes: • Reduced complications such as delirium • Reduced sedative medications or chemical restraints • Reduced stress for patient/ family/caregivers • Satisfaction survey judged quality of care to be better than that provided in acute hospital • Modest improvement in activities of daily living (ADL) and instrumental activities of daily living (IADLs)	• Patient is identified and assessed in the ED/ambulatory site for the program using validated criteria • Eligible and consensual patients are then transported home, usually by ambulance • At home, the patient receives extended nursing and physician care for the initial portion of their admission, and then at least daily visits according to clinical need • The clinicians use care pathways, including illness-	• Model is highly suitable bundled payment arrangements, capitation, shared savings, and other payment arrangements due to significant cost savings • Much larger range of acute care services than other home-based care models • Measures include patient satisfaction and other patient-centered measures • Patients may be more comfortable in this setting,

			therapies from doctors and nurses–in their own home • Services include respiratory therapy, pharmacy services, and skilled nursing services • Patients receive 24/7 care for all services requiring urgent attention • Diagnostic studies and therapeutics that cannot be provided at home, such as computerized tomography, magnetic resonance imaging, or endoscopy, are available via brief visits to the acute hospital	• Improved patient and family satisfaction with physicians • Patients were just as likely to meet illness specific quality indicators as those treated in hospitals • 19% reduction in costs ($5081 vs. $7480 hospital expenses per patient)	specific care maps, clinical outcome evaluations, and specific discharge criteria • The patient is treated until stable for discharge. When the patient is discharged by the Hospital at Home physician, care reverts to the patient's primary care physician • Participating organizations are provided with a toolkit • Maturity: Active	as indicated by increased patient satisfaction and reduced stress levels
Post-Acute Care-Based Models						
IMPACT ACT of 2014 (CMS): The IMPACT Act is a pay-for-reporting program that requires PAC providers to submit standardized patient assessment, quality, and resource use data as well as other specified measures.. The Act is a major step toward measurement alignment and shared accountability that ensures benchmarking across settings and patient-centered cared by capturing patient preferences and goals in medical records. In addition, the Act addresses all of the priorities in the CMS Quality Strategy including better care, healthy people and communities, and affordable care. Failure to submit quality data results in a reduction in the annual market basket increase by two percentage points.						
Setting: Post-acute care settings Population: Medicare and Medicaid beneficiaries with post-acute care needs Scale: PAC facilities nationwide	Type: Pay-for-reporting programs for post-acute care HCP-LAN Category: 2B Payment/Incentive Structure: • Payment to post-acute care providers • Reduction in market basket increase by 2 percentage points for failure to report quality data • CMS will publicly report the quality information on its website	• Quality measure domains o Skin integrity and changes in skin integrity o Functional status, cognitive function, and changes in function and cognitive function o Medication reconciliation o Incidence of major falls o Transfer of health information and care preferences when an individual transitions • Resource use and other measure domains o Resource use measures, including total estimated Medicare spending per beneficiary o Discharge to community o All-condition risk-adjusted potentially preventable hospital readmissions rates • Assessment categories o Functional status	• PAC providers are required to report standardized patient assessment data as well as data on quality, resource use, and other measures. PAC programs affected by the IMPACT Act include HH QRP, SNF QRP, IRF QRP, and LTCH QRP	Objective: • Increase standardization and interoperability of data across the post-acute care settings	• CMS is in the process of developing a Data Element Library that will manage the standardization of PAC assessment data elements and the identification of HIT standards for these data elements; support interoperable health information exchange and the adoption of HIT products; and allow HIT vendors to access content from the library database to support the development of interoperable HIT and health information exchange solutions for PAC/other providers • Maturity: In implementation	• Provides standardized data important to advanced illness care • Wide range of patient centered measures • However, payment tied only to reporting, not performance on the measures

		o Cognitive function and mental status o Special services, treatments, and interventions o Medical conditions and co-morbidities o Impairments o Other categories required by the Secretary				
Home Health Quality Reporting Program (CMS): The HHQRP is a pay-for-reporting and public-reporting program established in accordance with Section 1885 of the Social Security Act and aims to improve the quality of care provided to home health patients. The incentive structure is designed to require all HHAs to submit quality data from the Outcome and Assessment Information Set (OASIS) and Medicare-FFS claims. HHAs that do not comply with the incentive structure are subject to a two percent reduction in the annual PPS increase factor. This program specifically applies to home health agencies (HHAs) under the Medicare program. In addition, HHAs must also meet the requirements under the IMPACT Act described above.						
Settings: Home health agencies Population: Medicare and Medicaid beneficiaries with home health needs Scale: Home health agencies nationwide	Type: Pay-for-reporting HCP-LAN Category: 2B Payment/Incentive Structure: • Payment to HHAs • HHAs must submit data or receive a 2% reduction in their annual HH market basket increase o OASIS assessments o Home Health Care CAHPS data	• Measure set (zip file) • High priority measure domains: o Patient and family engagement, care preferences, functional status/decline o Making care safer, major injury due to falls, new or worsened pressure ulcers o Making care affordable (efficiency based measures) o Communication and care coordination, transitions and re-hospitalizations, medication reconciliation	• Must meet IMPACT Act data requirements • Under the HH Conditions of Participation data must be submitted no less frequently than: o The last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the 60-day episode o Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests o At discharge	Objectives: • Effectiveness, efficiency, equity, patient centeredness, safety, and timeliness	• Procedures for making data submitted available to the public • Maturity: In implementation	• Provides standardized data important to advanced illness care • Wide range of patient centered measures • However, payment tied only to reporting, not performance on the measures
Hospice Quality Reporting Program (CMS): The HQRP is a pay-for-reporting and public-reporting program that applies to all hospices, regardless of setting. The program ensures that hospice patients are made as physically and emotionally comfortable as possible, with minimal disruption to normal activities, while remaining primarily in the home environment. Under the program, hospice providers are required to submit quality data from proposed sources such as the Hospice Item Set (HIS) and the Hospice Consumer Assessment of Health Care Providers and Systems (HCAHPS) questionnaire through which future measures can be developed. Failure to submit quality data will result in a 2% reduction to hospices' annual payment update.						
Setting: Hospice facilities Population: Medicare and	Type: Pay-for-reporting HCP-LAN Category: 2B Payment/Incentive Structure:	• Measure set • CAHPS Hospice survey • High priority measure domains:	• Medicare Hospice Benefit Requirements: o Medicare beneficiary is eligible for Part A	Objectives: • Ensure patient is physically and emotionally comfortable, minimal disruption to normal activities, while remaining	• Maturity: In implementation	• Provides standardized data important to advanced illness care • Wide range of patient centered measures

Medicaid beneficiaries with terminal illness Scale: Hospice facilities nationwide	• Payment to hospice facilities and providers • Beginning FY 2014, Hospices must submit quality data or receive a 2% reduction in their annual payment update	o Symptom management outcome measures o Patient and family engagement (goal attainment) o Making care safer, timeliness/ responsiveness to care o Communication and care coordination, alignment of care coordination measures	o Certified terminal illness with medical prognosis of ≤6 months to live o Receives care from a Medicare approved hospice program and waives rights to other Medicare payments for treatment of terminal prognosis o 2 periods of 90 days hospice coverage and unlimited subsequent 60 day periods	primarily in the home environment		• However, payment tied only to reporting, not performance on the measures
Long-Term Care Hospital Quality Reporting Program (CMS): The LTCH QRP is a pay-for-reporting and public-reporting program established under the Affordable Care Act and aims to provide comprehensive medical care to individuals with clinically complex conditions including multiple, acute, or chronic conditions requiring hospital level care for more than 25 days. This program specifically applies to LTCH facilities under the Medicare program. In addition, LTCHs must also meet the requirements under the IMPACT Act described above.						
Setting: Long-term care hospitals Population: Medicare and Medicaid beneficiaries with LTCH needs Scale: LTCH facilities nationwide	Type: Pay-for-reporting HCP-LAN Category: 2B Payment/Incentive Structure: • Payment to LTCHs • Beginning 2014, LTCHs must submit quality data or receive a 2% reduction in PPS increase factor • LTCH PPS updates o Dual payment system with certain qualifying cases will be paid the traditional LTCH PPS rate while others will be paid a lower site neutral rate based on the inpatient PPS rate o PY 2016-2017 site neutral cases will be paid a 50-50 blend of the standard LTCH PPS rate and the applicable site neutral rate	• Measure set • High priority domains for future measure consideration: o Patient and family engagement, functional outcomes o Effective prevention and treatment, ventilator use, ventilator-associated event and ventilator weaning rate, and mental health status o Making care affordable (efficiency based measures) o Communication/care coordination, transitions and re-hospitalizations, medication reconciliation • In order to satisfy the requirements of the IMPACT Act, CMS is finalizing one new assessment-based quality measure, and three claims-based measures for inclusion in the LTCH QRP:	• Must meet IMPACT Act data requirements • CMS strongly encourages all LTCHs to submit quality measure data several days prior to the deadline to provide an opportunity to review data submissions for completeness and accuracy, and address any submission issues	Objectives: • Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days) Outcomes: • The combined impact of the LTCH PPS payment update of 1.5% increase with the site-neutral payment component of 14.8% decrease, LTCHs will face a net decrease of 4.6% translating to a $250 million reduction in costs from FY2015	• Mandated under Section 3004(a) of the PPACA of 2010 • CMS must make quality data available to the public. However, before it is made public, LTCH providers will have the opportunity to review it • Maturity: In implementation	• Provides standardized data important to advanced illness care • Wide range of measures, including process, outcomes, and utilization • However, payment tied only to reporting, not performance on the measures

		o Discharge to Community – Post Acute Care (PAC) LTCH QRP (claims-based); o Medicare Spending Per Beneficiary (MSPB) – PAC LTCH QRP (claims-based); o Potentially Preventable 30 Day Post-Discharge Readmission Measure for LTCHs (claims-based); and o Drug Regimen Review Conducted with Follow-Up for Identified Issues (assessment-based).				
SNF Quality Reporting Program (CMS): The SNF QRP is a pay-for-reporting and public-reporting program established under the IMPACT Act and includes Medicare and Medicaid beneficiaries with nursing home care needs. This program requires that all participating facilities to submit data under the SNF PPS except those units affiliated with critical access hospitals. SNFs are required to submit quality data through Medicare-FFS claims and the Minimum Data Set (MDS) assessment data. As of fiscal year 2018, SNFs that fail to report quality data will receive a two percent reduction in their annual payment updates. In addition, SNFs must also meet the requirements under the IMPACT Act described above.						
Setting: Skilled nursing facilities Population: Medicare and Medicaid beneficiaries with nursing home care needs Scale: SNFs nationwide	Type: Pay-for-reporting HCP-LAN Category: 2B Payment/Incentive Structure: • Payment to SNFs • Beginning FY 2018, SNF providers must submit required quality reporting data to CMS or receive a 2% reduction in their annual update • FY 2017 SNF proposed rule updates shift Medicare payments from volume to value	• Measure set • The quality measures finalized for the FY 2018 payment determination and subsequent years to meet the resource use and other measure domain are: o Medicare Spending Per Beneficiary - Post-Acute Care (PAC) SNF QRP o Discharge to Community – PAC SNF QRP o Potentially Preventable 30-Day Post-Discharge Readmission – SNF QRP. o Drug Regimen Review Conducted with Follow-Up for Identified Issues.	• Must meet IMPACT Act data requirements • Data must be available to the public by posting to Nursing Home Compare website • SNFs must meet performance standards and quality measurement requirements identified by the Secretary	Objectives: • Tying 30% of Medicare payments to care provided in APMs • Reach 50% of payments to care provided in APMs by 2018 Outcomes: • CMS projects that aggregate payments to SNFs will increase in FY 2017 by $920 million, or 2.4%, from payments in FY 2016. This estimated increase is attributable to a 2.7% market basket increase reduced by 0.3 percentage points, in accordance with the multifactor productivity adjustment required by law.[32]	• The IMPACT Act established the SNF QRP under section 1899(B) of the Social Security Act • Maturity: In implementation	• Provides standardized data important to advanced illness care • Wide range of patient centered measures • However, payment tied only to reporting, not performance on the measures
SNF Value-Based Purchasing (CMS): The SNF VBP was established under Section 215 of the Patient Access to Medicare Act (PAMA) of 2014. The SNF VBP will be effective in fiscal year 2019 under which value-based incentive payments are made to SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospital swing bed rural hospitals based on performance. Under PAMA, the SNF VBP per diem rate will be reduced by two percent or incentive payments will be applied to facilities based on the readmission measure performance.						
Setting: Skilled nursing facilities	Type: Pay-for-performance HCP-LAN Category: 2C or 2D	• SNF 30-day all cause readmissions • SNF 30-day potentially preventable readmissions	• Must meet IMPACT Act data requirements	Objectives: • Promotes better clinical outcomes for SNF patients and	• Established under PAMA to begin in FY 2019 • CMS will pay participating SNFs for their services based	• Impact will depend on magnitude of performance adjustments

[32] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-29.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Population: Medicare and Medicaid beneficiaries with nursing home care needs Scale: SNFs nationwide	Payment/Incentive Structure: • Performance based payments or adjustments • Beginning FY 2019 • Additional detail unknown at this time		• Data must be available to the public by posting to Nursing Home Compare website • SNFs must meet performance standards and quality measurement requirements identified by the Secretary	makes their care experience better during stays	on the quality of care, not just quantity of services provided in a given performance period • Beginning 2016, CMS will send SNFs confidential quality feedback on their measure performance • Maturity: Effective 2019	• Currently no plans for additional quality measures that would assess patient/family experience, satisfaction, outcomes, or other important indicators of high quality care
Medicare Care Choices Model (MCCM) (CMS/CMMI): The MCCM is a bundled payment model that provides comprehensive care to serious illness patients in the hospice setting. The purpose of this model is to determine whether providing supportive services will improve quality of life and care received by Medicare beneficiaries, increase patient satisfaction, reduce Medicare expenditures, and inform new payment systems for the Medicare and Medicaid programs. The model will be phased in over 2 years and participating hospices will be randomly assigned to two cohorts. The first cohort began providing services to beneficiaries in January 2016, and the second cohort will begin providing services in January 2018. Participating hospices will receive a bundled payment under the model through the standard Medicare FFS claims process.						
Setting: Hospice facilities Population: Medicare beneficiaries (including dually eligible) eligible for the Medicare hospice benefit Scale: Currently 141 hospices nationwide participating	Type: Bundled payment HCP-LAN Category: 2A Payment/Incentive Structure: • Participating hospices paid on a PBPM basis for certain hospice services that cannot currently be billed for separately • PBPM ranges from $200-$400 • Payments received through standard Medicare claims process • Claims data will be compared to non-model Medicare and dual eligible beneficiaries with similar disease characteristics to determine the financial implications and effectiveness of this model	• Measures included in the Hospice Quality Reporting Program • Additional measures: o Pain management o Care coordination/case management o Care transitions o Communication o Patient-centered goals o Patient and family satisfaction	• Participation is limited to beneficiaries with advanced cancers, COPD, CHF, and HIV/AIDS • Payment may be used to cover these services: o Counseling services to beneficiary and family o Bereavement o Spiritual o Dietary o Family support o Psycho-social assessment o Nursing services o Medical social services o Hospice aide and homemaker services o Volunteer services o Comprehensive assessment o Plan of care o Interdisciplinary Group (IDG) o Care coordination/case management services o In-home respite care	Objectives: • Allow patient in hospice to continue curative care • Increase access to supportive care services provided by hospice • Improve quality of life and patient/family satisfaction • Inform new payment systems for the Medicare and Medicaid programs	• Participating hospices will provide services under the model that are currently available under the Medicare Hospice Benefit for routine home care and respite levels or care • Model will be phased over 2 years: o Cohort 1: Began January 2016 o Cohort 2: Beginning January 2018 • 24/7 hospice services • Maturity: Demonstration	• Allows patients to receive palliative and supportive care services from a hospice while continuing to receive curative care from their normal providers • Services have potential to significantly impact quality of life and satisfaction • With no downside risk and a significant PBPM, risk for increases in total cost of care
Health Plan-Based Models						
Aetna Compassionate Care Program (Aetna): This model is a care delivery model providing serious illness care services through commercial-based payments for case management services and enhanced benefits. There is no defined payment and incentive structure tied to the quality measures in the program. Reimbursements are through commercial-based FFS claims and not population, risk, and value-based payments. The model has proven success for significantly increasing hospice use, decreasing hospital utilization, and increasing earlier use of palliative and pain medication.						
Setting: Across the care continuum	Type: Care delivery system model through nurse case managers HCP-LAN Category: n/a	• Quality Improvement Opportunities (page 10) • Malnutrition • Pressure ulcers • Dementia	• Recipient must be member of an Aetna Health plan • Must meet the following criteria: o Persons who have one or more conditions that progress	Outcomes: • 82% of engaged decedents choose hospice • 82% reduction in acute inpatient days	• Pilot launched in 2005 and due to its success, it has now expanded nationwide	• Eliminates the need to decide between hospice or curative treatments by allowing members to enroll in hospice services while

Population: Aetna members with terminal illnesses Scale: Aetna health plan members	Payment/Incentive Structure: • Commercial payer-sponsored case management • Program expenses estimated at $400 per member enrolled in case management[33] o Includes hospice, respite, inpatient, and emergency department care and pain medications	• Falls and mobility disorders • Urinary incontinences • End of life care	enough that general health and functioning decline, and treatments begin to lose their impact o Defined by algorithm, care management process, physician referral, and/or care manager clinical judgement • Health plan RN case managers have telephone encounters • Team focuses on advance care planning and decision support, psychosocial support, symptom management and care coordination • Compassionate services are provided until patient is deceased	• 77% reduction in ED visits • 86% reduction in intensive care unit days • $12,000 cost savings per member	• Also part of Medicare Advantage program (as of 2014 has 1 million members)[34] • Program consists of two components o Case management services through trained nurses o Enhanced benefits • Maturity: Active	still receiving treatment for their disease • Earlier access to hospice services (12 months vs 6 months life expectancy) • Payment model is ill-defined and may not be easily replicated
Regence Personalized Care Support Program (Regence Health Plan): This model is a care delivery model providing serious illness care services through commercial-based payments. It includes benefits expansion for both commercial and Medicare Advantage members expanding home health service offering and reimbursing for care coordination, care management, and medical team conferences. Regence also offers specialized care management for members with serious illness beginning at the point of diagnosis or decline. Currently there is no defined payment and incentive structure tied to the quality measures in the program, although one is being developed. Reimbursements are through commercial-based FFS claims and not population, risk, and value-based payments.						
Setting: Across the care continuum Population: Regence health plan members and their families with palliative care needs; Medicare Advantage members Scale: Regence Health Plan Members	Type: FFS HCP-LAN Category: 1 Payment/Incentive Structure: • FFS payments to Regence BCBS in-network providers for enhanced member benefits • Value-based payment model currently in development	• Measures include: o Documentation of advance directive o Documentation of medical proxy o ER and inpatient utilization o Hospice acceptance rate o Hospice LOS o Patient and caregiver satisfaction o Cost savings to patient, payer, and provider	• Care delivery system through case managers • Provides enhanced benefit structure to include concurrent hospice model, separate palliative care benefits, and the addition of reimbursement for palliative care consultations, care plan oversight, and medical team conferences • Health plan administered case management services to members/caregivers in close partnership with physicians and social services • Specialized customer service team for members and love ones with serious illness in close partnership with case management • Partnerships with specialty providers, home health, hospice, and SNFs	Outcomes: • 72% of members who are contacted engage in palliative care case management • Over 700 families engaged in case management to date Objectives: • 360 approach to care that focuses on the patient/family, expands access and engages stakeholders at all levels o Expanded benefits o Dedicated member services team o Caregiver support o Provider partnerships	• Implemented through telephonic case management team focused on advanced care planning and decision and other supports • Directed case management outreach to individuals with any serious illness or advanced age, at high risk • Enrollee's eligible for palliative care customer service assistance • Partnerships focus on individuals with palliative care need, based on condition category and disease progression, dependent on provider location/specialty • Benefits extended to commercial, self-funding, and MA members	• Does not currently have a value-based payment model • Promotes coordination of care with specialty provider partnerships • While telephonic case management can be effective in some patients, it may not be intensive enough for patients with serious illness unless integrated with providers

[33] http://content.healthaffairs.org/content/28/5/1357
[34] http://www.thectac.org/wp-content/uploads/2014/12/Krakauer_5_21_14.pdf

			• For individual and employer group members, this benefit includes home health aide visits and in-home counseling sessions with a maximum of 30 visits per year		• Further development: Creation of palliative care-based oncology medical home with 3 community based oncology practices and Home Based Primary Palliative Care pilot for individuals with cancer, heart, and lung failure • Maturity: Active	
Sharp Transitions Program (Sharp Health Care): This model is a care delivery model providing serious illness care services through contractual arrangements with Medicare Advantage, ACOs, and other entities. The delivery model is based in part on Medicare's Community Care Transitions program. There is no defined payment and incentive structure tied to the quality measures in the program. This model has proven success in increasing discharges to hospice, reducing hospitalizations, and increasing savings.						
Setting: Varies Population: Persons with late stage illness such as advanced CHF, COPD, Dementia, Stage IV cancer, and end-stage liver disease Scale: Sharp Health Plan Members; San Diego, CA	Type: Varies. Contracts with Medicare Advantage, ACOs, and managed care contracts HCP-LAN Category: Varies Payment/Incentive Structure: • Varies	• Measures not available	• Modeled after Medicare's Community Care Transitions Program • Care is expanded from the clinical setting to the home setting and focuses on high risk, late stage chronic illnesses and delivered through skilled clinicians • Provides proactive in home consultation, evidence based prognostication, advanced care planning, and caregiver support • Eligibility: o San Diego, CA County patients with terminal illness	Outcomes: • 75% of discharges to hospice • 94% reduction in all cause ER/hospitalizations • $26,000 cost savings per enrollee • Improved patient quality of life • 100% completion of advance care planning, POLST	• community needs within their mission/financial capacity • Implemented through home and telephone visits • Interdisciplinary team of nurses, social workers and palliative care physicians • Maturity: Active since 2007	• No defined payment model, although is an example of ACO and palliative care integration that may be replicable • Promotes patient independence • Interdisciplinary team focuses on advanced care planning, symptom management, caregiver support, and care coordination
United Advanced Illness Care Management Program (United Health Group): This model is a care delivery model providing serious illness care services through commercial-based FFS payments. It utilizes a predictive modeling program that analyzes member utilization history, functional status, and clinical and disease specific data. UHG also uses the Karnofsky Score Performance Status scale to determine whether a patient is an appropriate candidate for hospice care.[35] This model has proven benefits for members by increasing the use of serious illness care plans, enhanced system management of patient information, improved hospice enrollment, and reduced utilization of unnecessary medical interventions.						
Setting: Integrated delivery system Population: UHG members with terminal illness in the last 12-18 months of life and significant functional decline	Type: Health plan based model HCP-LAN Category: n/a Payment/Incentive Structure: • Payments not defined	• Uses NQF Palliative Care Measures	• Recipients include UHG members facing life-limiting illness o Last 12-18 months of life o Significant function decline • Eligible patients are identified based on predictive modeling, which accounts for utilization history, functional status, and clinical and disease specific data • The Treatment Decision Support program (optional) is only available	• Increased formulation of advanced care plans • Enhanced system management • Improved hospice enrollment • 95% member and caregiver satisfaction • 95% of members identified their preferred site of death and goals of care	• Interventions include advanced illness care management, palliative care services or EOL support, behavioral health management program, and treatment decision support program • Optional: Treatment decision support program, respiratory care management, cancer	• Comprehensive treatment options for serious illness care • Uses predictive modeling that considers patients utilization history, functional status, and clinical/ disease specific data in order to develop a comprehensive care plan that includes care

[35] https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Clinician%20Resources/Geriatric%20Resources/Advanced%20Illness%20and%20Planning/Karnofsky_Performance_Scale_End_of_Life_Palliative_Care.pdf

Scale: UHG Health Plan Members			to Group Senior Supplement members (these plans are not available in FL, LA, MN, NH, VT, WA)	• Over 75% of members have advanced directives within 120 days of enrollment • Reduction in utilization of medical intervention that the member does not want[36]	support program, and ER decision support • Senior supplement plans include a single premium rate and plan design regardless of retiree's place of residence or health conditions, freedom to choose providers and hospitals that accept Medicare, portability options, virtually no claim forms, and 24/7 NurseLine • Maturity: Active	coordination, ACP, education, and symptom management according to patient preferences/goals
Accountable Care Organizations						
Medicare Shared Savings Program (CMS): MSSP payment methodology enables Medicare-FFS providers to voluntarily contract with CMS under an ACO reimbursement and delivery structure. The purpose is to transition payments from Medicare-FFS to value-based alternative payments by 2018. Under this program, participating practices are rewarded for decreasing spending in Medicare Parts A and B FFS while also meeting performance standards on quality of care. ACOs have the choice to participate under a Track 1 shared savings only model (one-sided risk), or under Track 2 or Track 3 shared savings and shared losses models (two-sided risk). ACOs that choose to become accountable for shared losses under Track 2 or Track 3 will have the opportunity to get a greater portion of shared savings.						
Setting: Integrated delivery networks that are organized as ACOs Population: Medicare beneficiaries Scale: More than 400 nationwide. Approximately 95% are Track 1	Type: Shared savings and losses (Tracks 2 and 3 only) HCP-LAN Category: 3B Payment/Incentive Structure: • ACOs are rewarded for reducing costs and improving quality of care • Costs are compared to benchmark to determine shared savings or losses • Shared savings of up to 50% based for Track 1 and up to 60% in Tracks 2 and 3 • Shared losses of up to 60 percent in Tracks 2 and 3 • Exact amount of savings and losses determined by quality scores	• Measure set with 2016-17 benchmarks (see Appendix A) • Quality reporting requirements align with PQRS • Measure Domains: o Patient/caregiver experience o Care coordination/patient safety o Preventive health o Clinical care for at-risk populations	• Must establish a governing body representing ACO participants and Medicare beneficiaries • Voluntary participation in ACO • Responsible for routine self-assessment, monitoring, and reporting of care delivery to Provider must notify beneficiary that their claims data will be shared in the ACO • Must follow ACO requirements for eligibility: o ACO professionals in group practices o Networks of individual practices of ACO professionals o Partnership or joint venture arrangements between hospitals and ACO professionals o Hospitals employing ACO professionals or o Other Medicare providers and suppliers, as determined by the Secretary	Objectives: • Better care for individuals • Better health for populations • Lowering growth in FFS expenditures through improvements in the health care system Outcomes: • One study determined that Medicare ACO programs are associated with modest reductions in spending and use of hospitals and emergency departments • Savings were realized through reductions in use of institutional settings in clinically vulnerable patients. o Total spending decreased by $34 per beneficiary-quarter after ACO contract implementation across Medicare population and decreased $114 in clinically vulnerable patients	• Designed to facilitate coordination and cooperation among providers of Medicare FFS patients • CMS will assess ACO's quality/ financial performance based on population outcomes • Maturity: Active	• Potential for higher quality and better coordinated care • Beneficiary autonomy of choice in providers is positive, but can create difficulties in effectively coordinating and managing care • Quality reporting emphasized prevention and management of chronic diseases that have a high impact on Medicare FFS beneficiaries such as heart disease, diabetes, and COPD • Patient experience included as quality measure

[36] http://www.aging.senate.gov/imo/media/doc/Bocchino_5_21_14.pdf

				- Hospitalizations and ED visits decreased by 1.3 and 3.0 events per 1000 beneficiaries per quarter, respectively - Hospitalizations and ED visits in the clinically vulnerable cohort decreased by 2.9 and 4.1 events per 1000 beneficiaries per quarter - Changes in total spending associated with ACOs did not vary by clinical condition of beneficiaries		
Pioneer ACO Model (CMS/CMMI): This model employs a shared savings and shared losses payment structure with higher levels of reward and risk than the MSSP. For the first two performance years, payments or penalties are determined through comparisons against an ACO's benchmark based on previous expenditures for the group of patients aligned to the Pioneer ACO as well as the trend in expenditures for the national Medicare population. In the third performance year, those Pioneer ACOs that demonstrate savings over the first two years are eligible to move to a population-based payment model. Population-based payment is a PBPM payment amount intended to replace some or all of the ACO's FFS payments through a prospective monthly payment.						
Setting: Integrated delivery networks that are organized as ACOs Population: Medicare beneficiaries Scale: 9 participants nationwide	Type: Shared savings and losses with potential population based payment HCP-LAN Category: 3B Payment/Incentive Structure: - Shared savings & losses - To receive savings or owe losses in a given year, ACO expenditures must be outside a minimum corridor set by the ACO's minimum savings rate and minimum loss rate - If savings/loss is within this corridor, no payment is made to the ACO or owed to CMS. If the Gross Savings/Losses percentage is outside this corridor, then the ACO splits the overall savings/loss with CMS - Alternative full risk, population based payment of up to full amount expected in	Measure set with 2016-17 benchmarks (see Appendix A)	- Providers must have experience coordinating care across settings - Tested for 2 years under the shared savings payment policies with higher savings and risks - Third year, providers that showed savings over the first two years were eligible to move to a population-based payment model - PBPM payment amount intended to replace some or all of the ACO's FFS payments with a prospective monthly payment - Responsible for the care of at least 15,000 aligned beneficiaries (5,000 for rural ACOs)	Objectives: - Reduce patient burden - Improve patient-provider partnership in shared decision-making - Medicare beneficiaries will have better control over their health care, and their doctors can provide better care because they will have better information about their patients' medical history and can communicate more readily with a patient's other doctors Outcomes: - Generated over $384 million in savings to Medicare in 2 years - PY1 $280 million - PY2 $104 million	- Model designed to complement MSSP - Incentives to perform beneficiary alignment and expenditure calculations - Tests whether certain design elements could be implemented before being considered for inclusion in CMS payment programs - Transition to greater insurance risk - Integrating accountability for Medicare Part D expenditures - Integrating accountability for Medicare care outcomes - Maturity: Active	- Potential for higher quality and better coordinated care - Beneficiary autonomy of choice in providers is positive, but can create difficulties in effectively coordinating and managing care - Greater financial risk than MSSP and potential for population based payment creates greater accountability - Prospective payment permits more flexibility in addressing needs of patients with serious illness

	Parts A and B available in Year 3 • Participants encouraged to negotiate outcomes based payment arrangements with other payers by end of 2nd year					
Next Generation ACO Model (CMS/CMMI): This is an accountable care organization payment model that sets predictable financial targets, enables providers and beneficiaries with greater opportunities to coordinate care and promotes high quality standards of care. The payment methodology is determined through a prospective benchmark based on a single performance year, with an annual adjustment that reflects relative regional and national efficiency plus the ACOs quality performance requirements. In addition, the model incorporates a better attribution approach than that of MSSP, using the Pioneer model's prospective, claims-based approach. The model also includes an increase in minimum lives to 10,000 and two-sided risk.						
Setting: Integrated delivery networks that are organized as ACOs Population: Medicare beneficiaries Scale: 18 participants nationwide	Type: Shared savings/losses HCP-LAN Category: 3B Payment/Incentive Structure: • Two-sided risk • 80-100% shared savings/shard loss, depending on ACO choice • 15% cap on total savings and losses plus outlier protection providing ACOs a greater level of accountability than past models, without going to full risk • Incentives based on cost savings and performance measures • CMS will publicly report the performance of the Next Generation ACOs on quality metrics, including patient experience ratings, on its website • Beneficiaries receive $50 bonus for staying in network	• Measure set with 2016-17 benchmarks (see Appendix A)	• Participants may be structured as: o Physicians/other practitioners in group practice arrangements o Networks of individual practices of physicians/other practitioners o Hospitals employing physicians/other practitioners o Partnerships or joint venture arrangements between hospitals and physicians/other practitioners o Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) • Must have an identifiable governing body with sole and exclusive authority to execute the functions and make financial decision on behalf of the ACO • Must have a leadership and management structure that meets certain criteria	• Like other Medicare ACO initiatives, this Model will be evaluated on its ability to deliver better care for individuals, better health for populations, and lower growth in expenditures	• Three initial performance years and two optional one-year extensions • Maturity: Active	• Use of two-sided risk provides strong financial incentives for care coordination, effective use of resources, and patient engagement • Payment model provides increased flexibility for providers to use resources to meet the variable and complex needs of patient with advanced illnesses • Beneficiary payment to stay in network helps to promote better care coordination and continuity.

MACRA, MIPS, and APMs (CMS): MACRA replaces the Sustainable Growth Rate (SGR) formula for Medicare physician payments with a new approach to improve the value of care. This includes a dual pathway called the Quality Payment Program which includes two tracks: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Under MIPS, the Physician Quality Reporting System (PQRS), the Value Modifier Program (VMP), and the Medicare Electronic Health Record Incentive Program are consolidated for the purposes of measuring and improving quality more effectively. Payments to clinicians in the program, including those participating in APMs, will be adjusted based on a composite performance score reliant on quality, resource use, clinical practice improvement, and the use of HIT. The rule improves the relevance and depth of Medicare's value and quality-based payments as well as increases clinician flexibility in choosing measures and improvement activities that are appropriate and align with the type of care they provide. Positive and negative adjustments to payment increase over time ranging from 4% in 2019 to as high as 9% by 2022 and beyond depending on performance. Under Advanced APMs, clinicians that take on a financial risk for monetary losses and meet program criteria qualify for a 5% bonus incentive through Medicare Part B.						
Setting: Across the care continuum Population: Medicare and Medicaid beneficiaries Scale: Nationwide	Type: Quality payment adjustment HCP-LAN Category: 2D Payment/Incentive Structure: • 2015-2019 Medicare physicians paid through physician fee schedule receive 0.5% annual update (2020-2025 0% update) • In 2016, APMs will receive 0.75% update • Non-APM's receive 0.25% • Develops a flexible system that links quality payments to 2 paths: o MIPS ▪ Combines PQRS, VBPM, and MU-EPs ▪ Applies payment adjustment, beginning with +/- 4%, increasing to +/- 9% o Advanced APMs ▪ From 2019-2024, some participating providers receive a 5% lump sum incentive payment ▪ Increased transparency of physician focused payment models ▪ Starting 2016, offer some participating providers higher annual payments	• Exact measures are still to be determined • CMS Quality Measure Development Plan includes six quality domains for MIPS and APMs: o Clinical care o Safety o Care coordination o Patient and caregiver experience o Population health and prevention o Affordable care • MIPS will also include measures of: o Quality o Resource Use o Clinical practice improvement o Meaningful use of certified EHR technology • APMs will include quality measures comparable to those in the MIPS quality performance category	• MIPS o Not eligible: 1st year Medicare Part B participation; low patient volume; certain advanced APM participants • Advanced APMs o Certified EHR technology o Bases payment on performance measures o Either bear more than nominal financial risk for monetary losses or is a Medical Home model expanded under CMMI authority o APM eligibility: ▪ Certain percentage of patients/payments through advanced APMs ▪ Excluded from MIPS	Objectives: • 30% of Medicare payments tied to quality/value through APMs by the end of 2016, and 50% by the end of 2018 • 85% of Medicare FFS payments are tied to quality/value by the end of 2016, and 90% by the end of 2018 • Set internal goals for HHS • Invite private sector payers to match or exceed HHS goals	• Repeals SGR formula • Streamlines multiple QRPs into the MIPS • Provides incentive payments for participation in APMs • Maturity: In implementation o MIPS and APMs will begin tracking performance in 2017 for payment adjustment in 2019	• Model is designed to align patients with primary care/ multispecialty practices, increase care coordination, access, and continuity of care, provide risk stratified care management, patient/caregiver engagement, shared decision-making • The benefits of this payment redesign include reducing reporting burden and increasing flexibility and accountability for physician practices • Will drive more physicians to value based payment models, including some included in this report such as CPC Plus and the ACOs with two-sided risk • For non-APMs, establishes more significant two-sided risk for quality performance than currently exists in PQRS • However, physicians not designated as an APM and not performing well face significant reductions in payment, which may further impact their ability to provide quality services to patients with serious illness

Removing Barriers to Person-Centered Care Act (CMS): This proposed legislation aims to establish a pilot program promoting an alternative payment model for person-centered care for Medicare beneficiaries with serious illnesses. Payments will be received through Medicare FFS claims and participating practices will receive shared savings contingent upon performance and cost savings. In addition, participating organizations will receive pre-implementation grants to support various activities including training, collaboration across settings, and HIT infrastructure.						
Setting: Collaborative group of providers Population: Medicare beneficiaries with serious illness Scale: Not implemented	Type: Shared savings HCP-LAN Category: 3A Payment/Incentive Structure: • Medicare FFS with shared savings • Expenditure benchmarks will be determined and used as basis for determining shared savings • Grants for pre-implementation activities	• Measure domains: o Patient and family experience of care o Access to needed services (medical and supportive), such as timely referral to hospice o Completion of care planning documentation, such as health care proxies, advance directives, and portable treatment orders o Consistency of care with documented care preferences o Screening for physical symptoms, such as dyspnea, nausea, and constipation o Utilization of health care and support services o Process for identifying and developing quality measures	• Eligibility o Application due October 1, 2018 o Describe information about each provider of services, physician, and practitioner in the collaborative o Description of implementation plan for the demonstration including intended uses of grant amounts under paragraph o Strategy for the continued participation of community-based social services organizations, including faith-based organizations, in the care of the target Medicare beneficiary population o Description of how the collaborative intends to use the waivers and expanded services and to conduct the demonstration project o Subject to the availability of such measures, a description of how the collaborative will collect and report on data pertaining to the recommended set of quality measures and additional measures o Description of how the collaborative will identify its target Medicare beneficiary population for the demonstration project	Objectives: • Waives requirements under title XVIII that limit access to care • Expanding serious illness care services to patients	• The Secretary will pilot a 3-year demonstration project to provide services and supplies under Parts A and B of title XVIII • Priority to organizations that are located in States that use/in process of developing a uniform POLST • Geographic diversity • Pre-implementation grants available • Maturity: Not active; proposed legislation that would go into effect in January 2019	• Would establish an ACO like structure focused on serious illness • Includes appropriate serious illness related measures, such as patient and family experience and care planning documentation. • Expands access to curative treatment for patients in hospice • Promotes person-and-family centered care

Global Payment Models						
Program of All Inclusive Care for the Elderly (PACE) (CMS): PACE is a Medicare and Medicaid program that supports the health care needs of the elderly in a community-based setting. Operationally, PACE is a three-way partnership between the federal government, the state, and PACE organization that enables broader transformation of care through vertical communication. It is a capitated payment model on a monthly prospective-payment system for eligible enrolled program participants. For Medicare Part A participants who are also eligible for Medicaid, the State is obligated to reimburse for some Medicare Part B premiums. The participating PACE organization accepts the capitation payment amounts as payment in full from Medicare and Medicaid. This allows providers to deliver all necessary services rather than limiting them to those reimbursable under Medicare and Medicaid FFS plans. The capitation rates paid by Medicaid are designed for cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility eligible population not enrolled in the PACE program. The Medicare rates are based on pre-ACA rates, unadjusted for Indirect Medical Education, and adjusted for risk frailty.						
Setting: Community-based care Population: Medicare and Medicaid beneficiaries; frail elderly population Scale: • 26 states and DC enacted PACE enabling legislation • 45 programs	Type: Capitated payment model HCP-LAN Category:4B Payment/Incentive Structure: • Risk adjusted PBPM paid by blended funds from Medicare and state Medicaid program • Obligation for payments shared by Medicare, Medicaid, and individuals who do not participate in either • Medicare, Medicaid, and private payments for acute, long-term care, and other services are pooled • The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility eligible population not enrolled in the PACE program	• PACE organizations have the flexibility to design their quality assessment and performance improvement (QAPI) programs[37] • QAPI must include the use of objective measures to demonstrate improved performance in: o Utilization of services o Participant and caregiver satisfaction o Outcome measures derived from data collected during participant assessments o Effectiveness and safety of staff provided and contracted services • Non-clinical areas including grievances and appeals	• Requirements: o Must include governing body/authoritative representative o Be able to provide the complete service package regardless of frequency/duration of services o Have a physical site and staff to provide services o Safeguards against conflicts of interest o Demonstrated fiscal soundness o Have formal participant Bill of Rights o Have a process to address grievances and appeals o Must develop, implement, evaluate and maintain an effective data-driven quality assessment and performance improvement program (QAPI) • PACE organization responsibility: o Verify participants' status at time of enrollment either dually eligible or Medicare Part A and/or B o Non-dually eligible participants must continue to pay applicable Part A, B, and D premiums o Submit risk adjustment/encounter data when applicable to CMS	Objectives: • Enhance the quality of life and autonomy for frail older adults • Maximize dignity of and respect for older adults • Enable frail older adults to live in their home and in the community as long as medically/socially feasible • Preserve and support the older adult's family unit Outcomes:[38] • Lower rates of nursing home utilization/in-patient hospitalization o Most notable in participants with higher ADL limitations • Higher utilization of ambulatory services • Reported better health status and quality of life • Associated with lower mortality rate • Cost savings results have been mixed	• Balanced Budget Act of 1997 established PACE as a permanent entity within the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state plan option • Operationally, PACE is a three-way partnership between the Federal government, the State, and PACE organization • Maturity: In Implementation	• PACE financial model allows providers to deliver all services to meet participants' needs rather than limit them to those reimbursable under Medicare and Medicaid FFS • Participants are not required to pay deductibles or copayments for services and drugs • Patient- and family-centered care that is coordinated across care teams • Significant ties to the community • Focus on social, as well as medical, needs • Potential for cost savings

[37] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pace111c10.pdf
[38] https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PACE_Outcomes.pdf

			o Identify payers that are primary to Medicare and determine the amounts payable o Coordinate benefits to Medicare participants with the benefits of primary payers • PACE Participant Eligibility: o Must be Medicare or Medicaid beneficiary, or dually eligible o Age 55 years or older o Live in the service area of a PACE organization o Be able to live safely in the community • Requires nursing home level care, as certified by the state			
Medicare Advantage (CMS/private payers): The Medicare Advantage (MA) program offers Medicare beneficiaries with access to benefits from private plans as a substitute for Medicare Part A and B rather than traditional FFS. Some MA plans also integrated Part D coverage. Health plans that participate in MA receive monthly capitation payments for each Medicare enrollee. The payments are decided through a base rate which reflects the projected costs of an average beneficiary and a risk score which indicates the relative cost of the enrollee to the national average beneficiary. Enrollment in the MA program has continued to increase since 2004.						
Setting: Across the care continuum Population: Health plans participating in Medicare Advantage and their members Scale: Nationwide	Type: Capitation with bonus payments, with varying payment structures from MA plans to providers HCP-LAN Category: 4B Payment/Incentive Structure: • Medicare benefits (Part A and B) received through private health plans including HMO, PPO, Private FFS, SNP, MMSAP • Capitated payments (per enrollee) • Bonus payments by achieving an overall rating of 4-stars or higher on CMS 5-star rating system • Separate payments for Part D benefits	• Measure set (see Table 1) • Measure domains: o Safer patient care o Patient-centered care o Effective care coordination o Effective prevention and treatment o Promotion of healthy living o Effective communication o Improving affordability	• MA plans delivered through private sector for beneficiaries that meet the following criteria: o Reside in the service area of the plan. o Have Medicare Parts A and B o Do not have End-Stage Renal Disease • Hospice benefit carved out of MA	Outcomes: • In 2016, 31% of people on Medicare enrolled in MA plan o Since 2004, beneficiaries enrolled in private plans tripled from 5.3 to 17.6 million in 2016 • Projections indicate that companies offering MA plans may respond to payment changes depending on circumstance which may have implications for beneficiaries' options, out of pocket expenses, and access to providers • Evidence suggests that beneficiaries in MA plans use more preventive services and less intensive end of life care services compared to traditional	• Maturity: Active	• Plans take full risk for patients with serious illness • Encourages coordination across settings of care • Evidence of increased use of palliative care and less intensive services in the end of life • Hospice benefit carved out of Medicare Advantage

	• Hospice care is carved out of Medicare Advantage			Medicare although impact on outcomes is less clear[39]		
MediCaring Accountable Care Community Model (Altarum Institute Center for Elder Care and Advanced Illness): The model emphasizes the development of an individualized forward thinking care plan for each enrolled frail elder in a community. It is proposed to be financed through Medicare savings from effective care management and decreased utilization. The process includes delivering higher quality care frail elderly Medicare beneficiaries at a lower per capita cost. The savings generated by adhering to established evidence-based geriatric principles in the delivery of medical care would help fund community based long-term-services-and-support (LTSS) using a modified ACO structure known as an ACC. MediCaring aims to develop incentives, similar to that of ACOs, to be able to generate savings. A community board would monitor the quality and supply of services for frail elders based on public interest. The model conservatively projects a decrease in 20% from overall baseline medical costs and 5% from institutional long-term care costs along with increases in home care and primary care. These savings correspond to a 91% return on investment (ROI) over the first year startup period and a 249% ROI thereafter with the program then projected to be able to sustain its financing from savings. The overall projected savings over three years is $57 million.						
Setting: Community-based care and integrated delivery network Population: Frail elderly Scale: Not implemented	Type: Shared savings HCP-LAN Category: 2A Payment/Incentive Structure: • Modified ACO known as Accountable Care Community • Funded by shared savings generated through processes based on established geriatric principles • Proposed incentive structure uses public quality reporting and audits	• MediCaring ACC's would be able to develop quality metrics from locality specific data sets and display the progress as part of locally managed dashboards	• Collaboration across the care continuum • Age 65 years or older with two or more ADL needs, dementia, or those over the age of 85 years • Core Elements o Frail elders enrolled in a geographic community o Longitudinal, elder-driven care plans o Medical care tailored to frail elders o Incorporating health, social, and supportive services o Core funding: shared savings from prudent geriatric care (modified ACO) o Monitoring and improvement by a board representing community interests	Objectives: • Achieve sustainable costs while expanding availability of LTSS and improving patient autonomy • Better tailored services for older adults • A platform for coordinating and organizing appropriate medical intervention with social supports and ways to integrate these with existing supports from volunteers and paid caregivers • Prevents overuse of services Projected Outcomes: • Results from analysis of potential impact in four regions (NY, OH, OR, VA) • Collaboration across clinical leaders and community based organizations • Enrollment of 15,000 elders across 4 geographic locations • 20% decrease in overall medical costs • 5% decrease in institutional LTC costs • Increases in home and primary care • 91% ROI over year 1 and 249% thereafter • Total net cost savings estimated at $57 million	• MediCaring ACC encourages collaboration across health and social providers to ensure appropriate care • Care coordinators will align clinical and community-based services • A community board would monitor the quality and supply of services for frail elders • Maturity: In concept	• Comprehensive care model that delivers high quality, personalized care for frail elderly Medicare beneficiaries at a lower per capita cost • Savings generated by adhering to established geriatric principles in the delivery of medical care would help fund community-based LTSS • Provides a population based pragmatic way to plan and build a more coordinated and well managed eldercare system • Emphasis on prevention strategies and healthy aging

[39] http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/

Personalize Your Care Act 2.0 (CMS): This proposed legislation requires providers to deliver serious illness, palliative, and end-of-life care services to Medicare beneficiaries with terminal illness. Providers are reimbursed through capitated payments for services provided to their patients. This model is currently being proposed for legislation. The purpose of this model is to provide high-quality, person-centered, evidence-based care to patients experiencing serious illness.						
Setting: Home or institutional setting Population: Medicare beneficiaries with terminal illness Scale: Not implemented	Type: Capitated payment HCP-LAN Category: 4B	• Measure domains: o Documentation of patient preferences and goals o Effectiveness in carrying out care plan o Agreement to patient EOL care plan	• Patient eligibility: o Must have documented medical prognosis of a life expectancy 24 months or less o Require assistance with 2+ ADLs or meet such other criteria specified by the Secretary • The services and care are furnished concurrently with the receipt of services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made • Program for POLST that implements a clinical process and guided by a coalition of multi-stakeholders • Interdisciplinary care team provide: o Hospice care o Functional assessment of the individual and of the family caregiver (as appropriate) o In-home services and supports o 24-hour/7-day-a-week emergency supports o Care coordination and communication across settings and providers o Palliative care services as the Secretary deems necessary	Objectives: • Promote shared decision making • Person-and-family centered evidence-based care planning	• Amends titles XVIII and XIX of the SSA to improve end-of-life care and serious illness management • 3-year demonstration program to test the use of serious illness management and early use of palliative care under the Medicare program. May be extended for 4th and 5th year • Grants available for eligible entities to implement authorized services and training • Maturity: Not active; proposed legislation. o Must be implemented no later than 2 years after the date of the enactment of the Act	• Would ensure high-quality, person-centered care near the end of life, care must align with an individual's goals, values, and stated preferences. • Provides funding for eligible practices to implement this model into their delivery system • Increases documentation of patient preference and goals for the end-of-life