

OVERVIEW OF THE APM

Under this APM, an individual who has been diagnosed with a chronic disease would choose a Chronic Care Management Team that is participating in the APM to provide care management services for one or more of the patient's chronic conditions. The patient would be classified into one of four need/risk categories based on characteristics that affect their likelihood of exacerbations and hospitalizations and the intensity of care management services the patient would need to prevent exacerbations and hospitalizations.

The Chronic Care Management Team would receive a quarterly Care Management Payment in addition to any fee-for-service payments the Team received for office visits, procedures, etc. needed to treat the patient's conditions. The amount of the Care Management Payment would be higher for a patient in a higher need/risk category. Except for patients in the Very High Risk category, the Team would not receive a quarterly Care Management Payment if the patient was admitted to the hospital during the quarter for reasons related to the chronic conditions the Team is supposed to be managing. For Very High Risk patients, the Team would be expected to maintain or reduce the rate at which the patients were being hospitalized before receiving the care management services.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable hospital admissions.

DETAILS OF THE APM

1. Opportunity for Savings and Quality Improvement

Many patients with a chronic illness are admitted to the hospital one or more times during the course of a year because the symptoms of their illness become uncontrolled and sufficiently severe that they require inpatient treatment. This occurs with many different types of chronic conditions, including asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, and inflammatory bowel disease. For example, a patient with emphysema (one form of COPD) who does not use long-acting bronchodilators properly could develop severe difficulty breathing and require treatment with oxygen and medications in a hospital.

Each of these unplanned hospital admissions is expensive for both the patient and their health insurance plan. In addition, the patient may develop additional health problems during their hospital stay (e.g., a hospital-acquired infection), and if the patient is employed, they will miss work for several days. Reducing the likelihood

and frequency of these hospital admissions could generate significant savings for payers and achieve better outcomes for the patients.

2. Changes in Care Delivery Needed and Associated Costs

a. New and Different Services to Be Delivered

A variety of demonstration projects have shown that a large percentage of hospital admissions for exacerbations of a chronic disease can be avoided if a physician practice that is treating patients for the disease provides additional services to the patients. These services include:

- additional education to the patient about the situations that can cause exacerbations in their chronic illness and about steps that the patient can take to prevent these situations, training for the patient in how to use medications or other treatments, and education about the actions the patient should take to minimize the severity of symptoms when problems occur;
- visits to the patient's home to identify any factors that could make exacerbations more likely and help the patient correct those factors;
- regular contacts with the patient by phone, email, or other means to identify signs that their condition may be worsening and to make any appropriate changes in medications or other treatments;
- rapid response when it is determined that a patient's condition is worsening so that it can be treated without hospitalization whenever possible.

These services are generally referred to as "care management" services, since they do not involve treatment of the disease *per se*, but rather a set of complementary activities designed to improve the outcomes of treatment.

In most cases, it will be more efficient and effective to have a nurse or a trained community health worker deliver most of these care management services rather than a physician or other clinician. The patient's primary care provider or a specialist will have to determine whether changes in medications or other treatments are needed when the patient's condition worsens, but nurses, educators, and community health workers can provide most or all of the other services.

b. Cost of Delivering the New Services

The exact costs of delivering the care management services will vary depending on the type of staff used, the salary/wages needed to recruit and retain such staff in the community where they will work, the methods used for contacting patients, the time clinicians need to spend overseeing the new services and responding to issues identified by the care management staff, and other factors. However, the major driver of the costs will likely be the number of personnel needed to provide effective care management services. This will depend on:

- the number of patients in the practice who have the condition and the caseload that an individual staff member can effectively manage. If there are more patients than one nurse (or other type of staff) can effectively manage, then an additional staff member will be needed;
- the amount of time each patient will need from the staff to effectively address the patient's needs. This will depend on factors such as the patient's health literacy, the type of insurance coverage they have for medications, the relative severity of the patient's condition, and the presence of other specific comorbidities that affect the patient's likelihood of having an exacerbation of the chronic condition. Not every other health problem the patient has will have a significant impact on their ability to manage the chronic condition, but some (e.g., depression) can have a very significant effect. If a practice has a high percentage of patients with characteristics that will require more care management time, the maximum caseload that a staff member can handle will be smaller and the cost per patient will be higher.

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

c. The Business Case for an Alternative Payment Model

An APM will be feasible for a particular chronic condition if analyses show that the expected savings from reduced rates of hospital admissions would be larger than the expected costs of delivering the care management services to patients who have that chronic condition. The analysis for a specific chronic condition would be based on:

- Estimates of the patient caseload that a nurse or other type of staff member can manage with the typical mix of characteristics of the patients who have the condition. These caseload estimates could be derived from the experience of demonstration projects in which similar services were delivered.
- The number of patients in a physician practice who have the condition. This would be based on medical records data from practices that would potentially participate and/or claims data from payers.
- The estimated cost of employing the staff and providing space, equipment, etc. to support their work. This

would be based on current labor market data and the experience of demonstration projects in which similar services were delivered.

- The rate at which patients with the chronic condition are currently being admitted to the hospital for exacerbations of the condition. This information could be obtained from healthcare claims data.
- Estimates of the reduced rate at which patients with the chronic condition who are receiving the care management services would be admitted to the hospital for exacerbations of the chronic disease. These hospitalization rate estimates could also be derived from the experience of demonstration projects.

3. Barriers in the Current Payment System

In general, under the current fee-for-service system, a primary care or specialty physician practice can only bill for face-to-face visits between a physician or other clinician (a nurse practitioner or physician assistant) and the patient. Assistance delivered through a phone call or email are generally not separately billable, and there is generally no payment for services delivered by a nurse, educator, or community health worker unless it is under the direct supervision of a physician or other clinician.

In recent years, several new billing codes have been added to the physician fee schedule by Medicare and other payers that allow physician practices to be paid for certain kinds of care management services in certain circumstances. However, the structure of these billing codes creates barriers to implementing care management services in the most efficient and effective way. For example, the Medicare Chronic Care Management Services payment is limited to patients with two or more chronic conditions, and the physician practice is required to document that it has provided at least 20 minutes of services to each patient each month in order to bill for the code.

Creating an APM would be appropriate if an analysis performed from the perspective of a physician practice showed that the revenue the practice could expect to receive from billing for services under the current payment system would be less than the costs of delivering the care management services in a way that would be expected to deliver the results assumed in the business case for payers.

EXAMPLE OF THE BUSINESS CASE FOR CARE MANAGEMENT FOR A CHRONIC DISEASE

The table shows a hypothetical example of 1,000 patients with a chronic condition. On average, about 13% of these patients are hospitalized during the course of the year for exacerbations of their condition. Stratification of the patients into four different need/risk categories shows that the rates of hospitalization vary significantly among the subgroups. Providers plan to hire registered nurses to provide education and self-management support to the patients; nurses who work with higher need/risk patients will have smaller caseloads. The provider expects to be able to reduce the overall rate of hospitalization by 50%, with different levels of reduction within each patient subgroup. The projected cost of the care management service is less than the expected savings from avoided hospitalizations, so paying to support the care management service would reduce total spending by 4%.

	<u>Current FFS</u>	<u>APM</u>	
Patients			
Total # of Patients	1,000	1,000	
Low Need/Risk Patients	450	450	
% Low Need/Risk Patients Hospitalized	5%	2%	
Medium Need/Risk Patients	325	325	
% Medium Need/Risk Patients Hospitalized	15%	6%	
High Need/Risk Patients	200	200	
% High Need/Risk Patients Hospitalized	25%	15%	
Very High Need/Risk Patients	25	25	
% Very High Need/Risk Patients Hospitalized	50%	30%	
Hospitalizations			
Total Hospitalizations	134	66	
Spending on Hospitalizations (\$10,000 per admission)	\$1,337,500	<u>\$660,000</u>	
Change in Spending on Hospitalizations		\$677,500 -51%	
Staffing for Care Management Service			
1 RN per 500 Low Need/Risk Patients		0.9	\$21
1 RN per 250 Medium Need/Risk Patients		1.3	\$42
1 RN per 100 High Need/Risk Patients		2	\$104
1 RN per 25 Very High Need Patients		<u>1</u>	<u>\$417</u>
Total RNs		5	
Cost of Care Management Services (\$100K/RN + 25% overhead)		<u>\$625,000</u>	
Total Spending on Hospitalizations and Care Management	<u>\$1,337,500</u>	<u>\$1,285,000</u>	
Savings		\$52,500 -4%	

4. Design of the APM

The lack of adequate payment in the current fee-for-service system could be addressed by modifying the current billing codes or creating one or more new billing codes specifically designed to support the desired care management services. However, simply modifying the fee schedule would provide no assurance to the patient or payer that the services paid for would achieve the desired results.

The Alternative Payment Model described below can enable payments to be made for care management in a way that ensures patients will benefit and spending will decrease:

a. Defining the Eligible Patients and Physician Practices

i. Eligibility Criteria for Patients

Patients would be eligible to receive services supported by the APM if:

- (1) they have a “chronic condition” consisting of one or more chronic diseases that are included on a specified list of chronic diseases, and
- (2) either
 - (a) their condition has reached a specified level of severity and/or
 - (b) they have other characteristics increasing the risk of hospitalization.

Eligibility could be based on different combinations of minimum severity levels and other characteristics in order to focus on all patients whose risk of exacerbation-related hospitalizations would be sufficiently high to justify delivering care management services.

ii. Designation of the Chronic Care Management Team by the Patient

A Chronic Care Management Team (consisting of the physicians or clinicians in a single practice, clinicians from two or more collaborating practices with different specialties, or clinicians employed by a hospital or health system) would be eligible to participate in the APM if the Chronic Care Management Team treats patients with the chronic condition and is willing to deliver care management services supported by the APM to eligible patients.

If an eligible patient wanted to receive the enhanced services and avoid hospitalizations, the patient would designate one of the Chronic Care Management Teams participating in the APM to manage their care for the condition for a period of at least three months. The patient could change this designation at the beginning of any calendar quarter. Only one Chronic Care Management Team could receive payments under the APM for an individual patient during each three-month period. For patients who have multiple chronic diseases that require coordinated management, the Chronic Care Management Team would be responsible for providing high-quality, coordinated care management services for

all of the diseases (i.e. for the patient as a whole), rather than any individual disease.

Before the patient designated the Chronic Care Management Team to manage their care, the Team would describe the care management services it would commit to deliver to the patient. Before accepting the patient, the Team could ask the patient to commit to actions that would support good outcomes (e.g., taking prescribed medications, contacting the practice when a problem arises, etc.).

In order to receive payments from a patient’s health insurance plan, the Chronic Care Management Team would need to verify and document that the patient met the eligibility criteria and document that the patient had designated the Team to manage their care.

b. Removing the Barriers in the Current Payment System

i. Stratification of Patients Based on Need/Risk

For each chronic condition, criteria would be defined for stratifying patients into four categories of need and risk: (1) Low Need/Risk, (2) Moderate Need/Risk, (3) High Need/Risk, and (4) Very High Risk. The criteria would be based on characteristics of patients that are expected to affect the patient’s likelihood of exacerbations and hospitalizations and the intensity of care management services the patient would need in order to prevent exacerbations and hospitalizations. The specific criteria would differ for each condition; for example, the measure of the severity of disease would inherently be specific to each disease. The “Very High Risk” category would be limited to patients who have unique characteristics creating a high degree of uncertainty as to whether and how hospital admissions can be avoided.

If an eligible patient has selected a participating Chronic Care Management Team to manage their care, the Team would evaluate the patient and classify the patient into one of the four need/risk categories. A patient’s category could change from one calendar quarter to the next if the patient’s characteristics change (e.g., if the severity of their disease increases).

ii. Quarterly Payments for Care Management Services

The Chronic Care Management Team would be eligible to receive a standard, pre-defined Care Management Payment for each eligible patient on a quarterly basis from the patient’s health insurance plan, in addition to any other fee-for-service payments the Team received for office visits, procedures, etc. The Team could use the revenues from the Care Management Payments to pay for the nurses or other staff, equipment, travel, etc. needed to deliver the care management services. The Team would have flexibility regarding the exact services it delivered, the type of personnel it used, etc.

The amount of the Care Management Payment for a patient in a particular category would be based on the estimated average per-patient cost a Team would incur to deliver care management services to patients in that category, with adjustments for performance as de-

scribed below. A higher amount would be paid to the Chronic Care Management Team for patients in the higher need/risk categories. (These payments would be the type of stratified, bundled, condition-based payments described in Option 6 in Section VI.A, i.e., the payments would differ based on the patient's characteristics, rather than on the services provided, and a provider receiving the payment would have the flexibility to deliver multiple services and combinations of services.)

The amounts of the Care Management Payments would be periodically adjusted based on analyses of the actual costs incurred by Chronic Care Management Teams that successfully achieve the performance targets.

iii. Patient Cost-Sharing

The patient would not be required to pay any portion of the standard Care Management Payment. The patient would continue to pay cost-sharing for other separately billable services they received.

If it wished to do so, a Chronic Care Management Team would be permitted to charge more than the standard Care Management Payment amount for one or more categories of patients, and if the patient chose to use that Team, the patient would need to pay the difference between the Team's charge and the standard payment amount.

c. Creating Accountability for Utilization and Spending

i. Measures of Utilization/Spending

Two measures of utilization and spending would be used:

- **Rate of Condition-Related Admissions.** A participating Chronic Care Management Team would be accountable for how often its patients are hospitalized for exacerbations of the chronic condition. A definition would be developed as to which hospital admissions would be considered as related to the condition and which would not. If the "chronic condition" is defined as two or more chronic diseases, the condition-related admissions would include any admissions related to any of those chronic diseases, but not to other chronic diseases or acute conditions. The Team would only be accountable for the *rate* of condition-related admissions, not the amount of *spending* on the admissions, because the Team would not be able to control changes in the amounts paid to the hospital for an admission nor would it be able to control what happened to the patient after the patient was hospitalized that could lead to higher hospital spending.
- **Total Spending on Condition-Related Services.** In addition, a participating payer would measure the total amount of spending on all services that participating patients received that were related to the condition being managed under the APM. The Chronic Care Management Team would not be accountable for total spending, but the payer would monitor the total spending measure to determine whether the APM was increasing or reducing total spending related to the condition.

ii. Target Performance Rates for Condition-Related Hospital Admissions

Calculation of Benchmarks

- **Patients in the Low, Moderate, and High-Risk categories.** For patients in each of these categories, the national rate of hospital admissions for exacerbations of the condition would be calculated or estimated for similar patients during the year prior to implementation of the APM. Estimates would be made if data are not available during that year for all of the criteria needed to assign patients to the four categories. These rates would be the Benchmarks for the Chronic Care Management Teams participating in the APM. (This would be a "prior performance for similar patients" benchmark as described in the first alternative in Section VI.B.2.c.)
- **Patients in the Very High Risk category.** For the specific patients in the Very High Risk category who are being managed by the Chronic Care Management Team during the quarter, the proportion of those patients who were admitted to the hospital during the prior 1-2 years would be calculated and used as the Benchmark for that category for those patients. If prior years' data are not available for the patients, if their condition is newly diagnosed, or if the factors leading to their classification are new, then they will be assumed to have a high baseline rate of admissions based on their high-risk characteristics. (This would be a "prior performance for the same patients" benchmark.)

Determination of Target Changes

A Target Change would be defined for each of the four categories, based on the reduction in the rate of hospital admissions needed to offset the estimated spending on Care Management Payments for the patients in those categories. (This would be the "minimum change needed for success" as described in Section VI.B.2.d.)

Calculation of Target Rates

The combination of the Benchmark and the Target Change would define the Target for each category, i.e., the maximum percentage of patients expected to be hospitalized each quarter when care management services are being delivered. The Targets would be prospective, i.e., they would be defined before the participating Teams began delivering services. Except for the Very High Risk patients, the Targets for all participating Teams would be the same. Once the initial Targets were set, they could remain unchanged until such time as there was evidence that it was feasible to achieve lower rates or that the current rates could not be achieved by most Chronic Care Management Teams.

iii. Accountability for Hospital Admissions (Patients Not Classified as “Very High Risk”)

Outcome-Based Payment Amount

The Chronic Care Management Team would only receive a Care Management Payment for a patient during a calendar quarter if that patient had no condition-related hospital admission during that quarter. If the patient was hospitalized during the quarter for a reason related to the chronic condition being managed, the Team would receive no payment for the care management services delivered to that patient during that quarter.

The amount of the Care Management Payment the Chronic Care Management Team would receive for a patient classified into a particular category would be calculated by (a) estimating the per-patient cost of care management services for patients in that category, and (b) increasing that estimate by the Target percentage of patients not admitted to the hospital. For example, if the estimated cost of delivering services to patients in the moderate risk category was \$160 per patient per quarter, and the target rate of hospital admissions was 20%, then the payment per patient would be $\$160 / (1 - .20) = \200 . Under this approach, if the Chronic Care Management Team achieved the Target rate of admissions for patients in a category, then the Care Management Payments would match the expected costs of the care management services. If the actual rate of admissions is higher than the Target, the revenue from the Care Management Payments will fall short of the expected costs of the care management services, creating a financial penalty for the Chronic Care Management Team. If the rate of admissions is lower than the Target, the revenue from the payments will exceed the expected costs, creating a financial bonus for the Team.

Penalty for Failure to Impact the Performance Measure

After the initial year, if the rates of condition-related admissions in two or more categories are higher than the Target by a statistically significant amount when averaged over the previous 18 months, the Chronic Care Management Team would no longer be eligible to participate in the APM. The standard of statistical significance would be set at a level that balanced the expected rate of Type I and Type II errors based on the number of patients participating and the diversity of patient characteristics that affect the risk of hospitalization.

iv. Accountability for Hospital Admissions (Patients Classified as “Very High Risk”)

Base Payment Amount

The amount of the Care Management Payment a Chronic Care Management Team would receive for a patient in the Very High Risk category would be equal to the estimated per-patient cost the Team would incur to deliver care management services for patients in that category.

Penalty/Bonus for Performance

If the rate at which patients in the Very High Risk category were admitted to the hospital for exacerbations of the condition exceeded the Target by a statistically significant amount, the Chronic Care Management Team would repay 10% of the payments it had received for all patients in that category. If the admission rate was lower than the Target Rate by an amount that was both large in magnitude and statistically significant, the Team would be paid an additional 10% for all patients in the category. The standard of statistical significance would be set at a level that balanced the expected rates of Type I and Type II errors. For Teams with a large number of Very High Risk patients, these penalties/bonuses could be calculated and paid quarterly; for Teams with smaller numbers of patients, the penalties/bonuses would be calculated annually.

v. Accountability for Total Spending

The payer’s average total spending per patient per month on all services related to the condition would be calculated for the year prior to initiation of the APM. The average total spending per patient per month for patients participating in the APM would be calculated for the second year that the APM is in operation. If the average spending for patients in the APM is higher than the average spending prior to initiation of the APM, the payer could choose to terminate or modify the APM.

d. Creating Accountability for Quality

i. Measures of Quality/Outcomes

Two quality measures would be used:

- **Rate of Condition-Based Admissions.** The primary measure of quality would be the utilization measure used for spending accountability, i.e., the rate of hospital admissions for exacerbations of the chronic condition. In general, patients will have a higher quality of life if they do not have exacerbations requiring a hospital admission and if they do not have to be hospitalized.
- **Mortality.** In order to ensure that hospitalizations are not being reduced by discouraging patients from being hospitalized when they need to be, a secondary measure of quality would be the rate of death among the participating patients during the months in which care management services are being delivered.

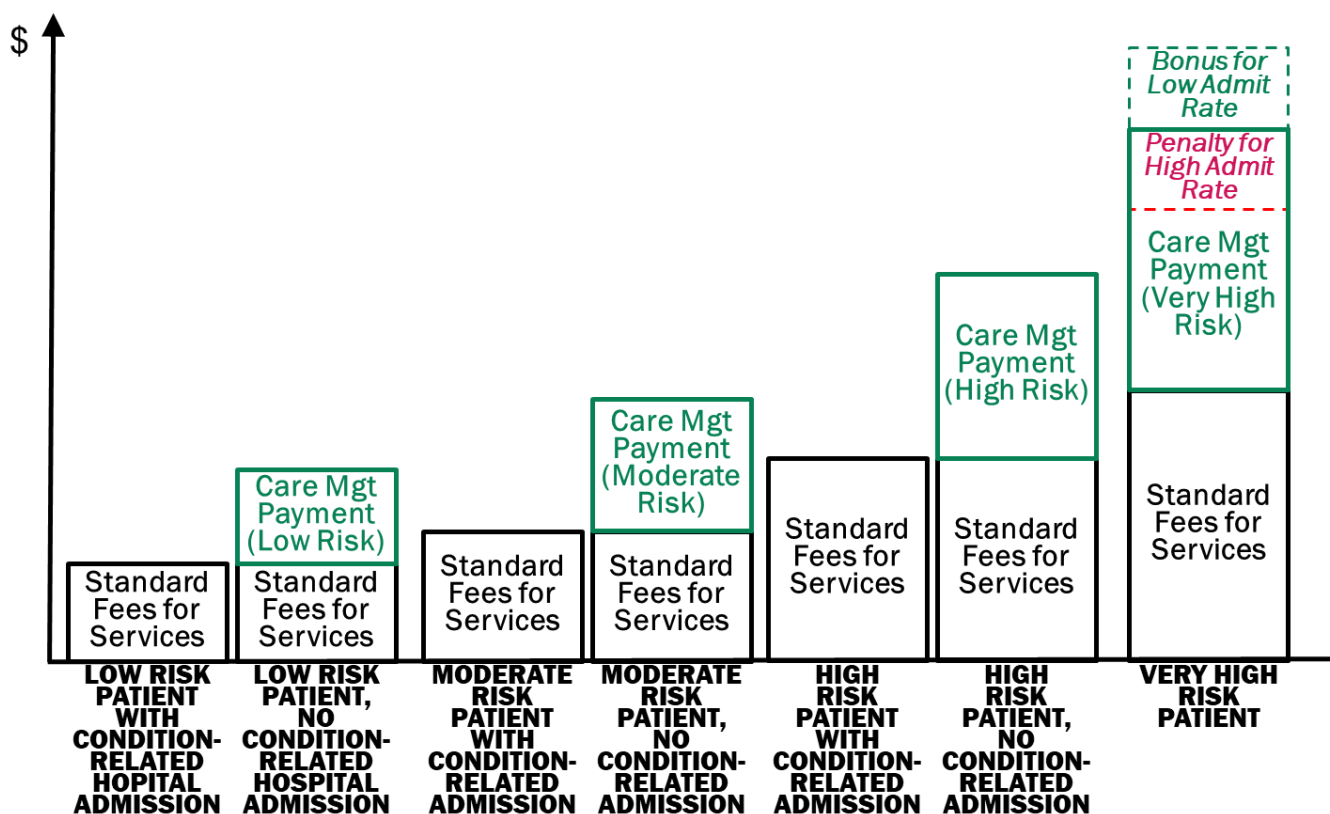
ii. Target for Mortality Rate

The rate of mortality for patients in each of the categories would be calculated for one or more years prior to the initiation of the APM. This rate would serve as the Target for that category under the APM.

iii. Accountability for Mortality

If the rate of mortality in one or more categories increased by a statistically significant amount for the patients of a Chronic Care Management Team that is participating in the APM, that Team would no longer be permitted to participate in the APM.

APM PAYMENTS AND ACCOUNTABILITY TO SUPPORT CARE MANAGEMENT FOR A CHRONIC DISEASE



5. Operationalizing the APM

In order for a Chronic Care Management Team to receive Care Management Payments under the APM, the team would submit a claim form on a quarterly basis for each eligible patient using one of four new codes:

- CM001 for a patient who meets the criteria for the Low Need/Risk category;
- CM002 for a patient who meets the criteria for the Moderate Need/Risk category;
- CM003 for a patient who meets the criteria for the High Need/Risk category; and
- CM004 for a patient who meets the criteria for the Very High Risk category.

The date of service on the claim would be the last day of the three-month period of care management services for which payment was being requested. The principal diagnosis code submitted with the billing code would be the condition being managed by the team under the APM. If the patient's eligibility was based on having a combination of two or more diseases, the principal diagnosis code would reflect the most severe disease and secondary codes would confirm the presence of the other diseases required for eligibility.

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

- The patient met the eligibility criteria for the APM and for the assigned Need/Risk category.
- The Team had delivered three months of care management services to the patient.
- For codes CM001, CM002, and CM003, the patient had not been hospitalized during the three-month period for an exacerbation of the condition on which their eligibility was based. If the patient had been hospitalized for a different reason, the Chronic Care Management Team would document why the hospitalization was unrelated to the condition that the Team is managing.

If the patient's health insurance plan received a claim with a CM001, CM002, or CM003 billing code, before paying the claim, the plan would verify that the patient had not been hospitalized for an exacerbation of the condition being managed during the 90 days prior to the date of service recorded on the claim. If a hospitalization had occurred, the insurance plan could request additional documentation from the Chronic Care Management Team as to why the hospitalization was not related to the condition being managed.

A claim with a CM004 billing code would be paid regardless of whether the patient had been hospitalized during the previous quarter.

If the Chronic Care Management Team wished to charge patients more for care management services than the amounts that would be paid by their health insurance plans, the team would publish its charge for each of the four billing codes, and the patient would agree to the charge at the time that the patient was enrolling to receive care management services from the Team. The amount charged by a particular Team would be the same for all patients, regardless of their health insurance plan, and the Team would bill the patient for the difference between the charge and the amount paid by the plan.

At the end of each quarter, the Chronic Care Management Team would calculate the rates at which its patients had been admitted to the hospital for exacerbations of their condition. These rates would be calculated separately for each of the 4 categories and compared to the Targets for those categories along with a calculation of the statistical significance of the difference. Those comparisons would be provided to the Team's patients and to the health insurance plans for those patients.

The Chronic Care Management Team would make information on its condition-related hospital admission rates, the comparisons of the rates to the Target Rates, and its charges for care management publicly available so that patients could compare the cost and performance of different teams that manage that condition.

6. Implementing the APM

a. Obtaining Participation by Payers, Providers, and Patients

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

i. Advantages for Payers

- Participating health insurance plans could reduce spending on avoidable hospitalizations for plan members who have one or more types of chronic conditions.
- Health insurance plans could implement the APM by creating four new billing codes in their existing claims payment system.

ii. Advantages for Providers

- Participating Chronic Care Management Teams would receive additional payments that cover the cost of delivering the kinds of care management services needed to help their patients better manage their chronic conditions and avoid severe exacerbations that require hospitalizations.
- Participating Chronic Care Management Teams would receive higher payments to cover the higher costs of providing care management services to patients with greater needs.
- Participating Chronic Care Management Teams would have the flexibility to deliver care management services in the ways that are most feasible for the providers on the Team and most effective for their patients.
- Participating Chronic Care Management Teams would only be held accountable for whether a patient they had explicitly enrolled for services was hospitalized for an exacerbation of the chronic condition the Team had committed to manage, not for the costs of the hospitalization or for other services the patient is receiving from the members of the Team or from other providers. The Team would know in advance what rate of hospitalizations it would be expected to achieve for its patients.
- Participating Chronic Care Management Teams would know when to expect payment and how much to expect based on the bills they submit to payers and the cost-sharing charged to patients. The largest financial loss the Team could experience would be the loss of the payments under the APM.
- Participating Chronic Care Management Teams could bill for services using their standard billing systems.

iii. Advantages for Patients

- Patients would have the choice of whether to receive the services, based on a clear understanding of the services they would receive, the actions they would need to take, and the results they could expect to achieve.
- Patients would know that the providers on their Team would be rewarded for helping them avoid exacerbations of their diseases but would have no financial incentive to withhold needed care.
- Patients would know how much they would need to pay for the services before choosing to receive them.
- Participating patients would experience fewer severe symptoms from their chronic disease. They would receive more care at home and require fewer visits to emergency departments and fewer admissions to hospitals to treat severe symptoms.

b. Finalizing the APM Parameters

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

- **Criteria defining the four categories of need/risk.** The categories should be defined so that they distinguish which patients will be at higher risk of exacerbations and which patients will need more care management services in order to avoid hospitalizations. However, data may not be available on all of the factors that would be expected to affect need and risk, and the APM will need to be implemented in order to enable those data to be collected.
- **Dollar amounts of the Care Management Payments.** The payment amounts should be based on the cost the Chronic Care Management Team would incur in delivering the services, but the cost of the services will depend on the sizes of the patient caseloads that care management staff can support and the number of patients in each of the need/risk categories, and this can only be estimated after the services are actually implemented with support from the APM.
- **Benchmark rates of condition-related hospital admissions.** The performance Target and payment amounts will depend on the benchmark (baseline) rates of hospital admissions in each need/risk category, but this can only be determined after actual patients are classified into the need/risk categories.

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

