Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

June 10, 2024
9:31 a.m. – 4:50 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC^2 Strategies)*
Angelo Sinopoli, MD, PTAC Co-Chair (Executive Vice President, Value-Based Care, Cone Health)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lawrence R. Kosinski, MD, MBA (Independent Consultant)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Independent Consultant)
Soujanya R. Pulluru, MD (Independent Consultant)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer, UCHealth Denver Metro, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance

Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)*

PTAC Members Not in Attendance

James Walton, DO, MBA (President, JWalton, LLC)

Department of Health and Human Services (HHS) Guest Speaker

Elizabeth (Liz) Fowler, JD, PhD (Deputy Administrator, Centers for Medicare & Medicaid Services [CMS] and Director, Center for Medicare and Medicaid Innovation [CMMI])

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

***Via Zoom**

List of Speakers and Handouts

1. **PCDT Presentation: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

   Walter Lin, MD, MBA, Preliminary Comments Development Team (PCDT) Lead

   Handouts

   - Public Meeting Agenda
   - PCDT Presentation Slides
   - Environmental Scan on Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models

2. **Panel Discussion: Providing Patient-Centered Care for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

   Erik Johnson, MBA, Senior Vice President, Value-Based Care, Optum Advisory*
   Richard A. Feifer, MD, MPH, Chief Medical Officer, InnovAge*
   Kristofer L. Smith, MD, MPP, Chief Medical Officer, Landmark Health*
   Marshall H. Chin, MD, MPH, Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics, Department of Medicine, University of Chicago, and Co-Director, RWJF Advancing Health Equity Program Office*

   Handouts

   - Panel Discussion Day 1 Panelists' Biographies
   - Panel Discussion Day 1 Introduction Slides
   - Panel Discussion Day 1 Discussion Guide

3. **Roundtable Panel Discussion: Provider Perspectives on Improving Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

   Matthew Wayne, MD, CMD, Chief Medical Officer, CommuniCare*
   David Gellis, MD, MBA, Vice President and National Medical Director, Medicare Population Health Programs, One Medical Senior Health*
   Cheryl Phillips, MD, AGSF, Sr. Program Consultant, The John A. Hartford Foundation
   Olivia Rogers, RN, MBA, Vice President and Chief Nursing Officer, Visiting Nurse Association of Texas*

   Handouts

   - Roundtable Panel Discussion Day 1 Panelists' Biographies
   - Roundtable Panel Discussion Day 1 Introduction Slides
   - Roundtable Panel Discussion Day 1 Discussion Guide

4. **Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

   Brynn Bowman, MPA, Chief Executive Officer, Center to Advance Palliative Care*
   Paul Mulhausen, MD, MHS, Chief Medical Director, Iowa Total Care, a Centene health plan*
   Caroline Blaum, MD, MS, Assistant Vice President, National Committee for Quality Assurance*
   David Kendrick, MD, MPH, Chief Executive Officer, MyHealth Access Network*

Handouts

- Listening Session 1 Day 1 Presenters' Biographies
- Listening Session 1 Day 1 Presentation Slides
- Listening Session 1 Day 1 Facilitation Questions

***Via Zoom**

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available online: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Update

Lauran Hardin, PTAC Co-Chair, welcomed the Committee and members of the public to the June 10–11, 2024, public meeting. Co-Chair Hardin explained that the Committee has been exploring themes that have emerged from proposals that the public has submitted to PTAC and releasing a public report to the Secretary of Health and Human Services (HHS) with its findings on each theme. Co-Chair Hardin noted that PTAC plans to soon post its September 2023 Report to the Secretary on Encouraging Rural Participation in Population-Based Total Cost of Care (PB-TCOC) Models. She shared that PTAC will also be posting a series of issue briefs summarizing key insights from the Committee's work with developing and implementing PB-TCOC models.

Co-Chair Hardin stated that providers face challenges with addressing the needs of patients with complex chronic conditions or serious illnesses, particularly in PB-TCOC models. She noted that this topic is of interest to the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center) and introduced Dr. Elizabeth (Liz) Fowler, the Director of CMMI.

Dr. Fowler indicated that the work of the Innovation Center and the nature of its partnership with PTAC have shifted as the value-based care landscape has progressed. In the Innovation Center's second decade of work, it is focusing on lessons learned from the first decade of work, expanding on what works, closing gaps in its portfolio, and addressing complex issues with expanding initiatives and innovations from the CMMI models. Dr. Fowler noted that the CMMI team is excited to share lessons learned from model tests during this public meeting.

In addition to focusing on what works well, Dr. Fowler indicated that it is also important to focus on what has not worked. During the second day of the public meeting, the CMMI team will discuss prior efforts with the Medicare Care Choices Model (MCCM) and the Independence at Home (IAH) Demonstration. Both models demonstrated improvements in beneficiary quality of care; however, CMMI also experienced challenges with evaluating models with limited participation. Dr. Fowler noted the need for greater integration of palliative care throughout the continuum of illness for patients with serious illnesses. One barrier to low use of palliative care at the end of life is a low referral rate by primary care providers (PCPs). As a result, CMMI provides flexibilities in some of its models (e.g., Accountable Care Organization Realizing Equity, Access, and Community Health [ACO REACH], Kidney Care Choices [KCC]) to encourage greater use of palliative care and concurrent care during a hospice stay. These flexibilities were included in the Hospice Benefit Component of the Medicare Advantage Value-Based Insurance Design (VBID) Model. However, this benefit component was impacted by limited participation and operational challenges, and the model will conclude at the end of this year.

Dr. Fowler noted that seriously ill patients require unique care delivery approaches. The Innovation Center's Guiding an Improved Dementia Experience (GUIDE) Model is the first model to address all elements recommended for serious illness care. Dr. Fowler concluded by stating that some of the most promising opportunities reside in building capacity, expertise, and relationships with PCPs.

Co-Chair Hardin invited Committee members to introduce themselves and their experience with addressing the care delivery needs of patients with complex chronic conditions or serious illnesses. Following Committee member introductions, Co-Chair Hardin shared that 4 PTAC members served on the Preliminary Comments Development Team (PCDT): Walter Lin (Lead), Larry, Kosinski, Lee Mills, and Lindsay Botsford. She introduced Dr. Lin, who presented the PCDT's findings from the background materials.

PCDT Presentation: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Dr. Lin delivered the PCDT presentation. For additional details, please see the presentation slides, transcript, and meeting recording (17:53-47:52).

- Dr. Lin described the objectives for the theme-based meeting, including discussing the characteristics of high-cost patients with complex chronic conditions or serious illnesses and the disproportionate impact these patients have on Medicare spending; understanding challenges and approaches related to improving care for high-cost patients; identifying opportunities for optimizing the use of post-acute care, palliative care, and end-of-life care in PB-TCOC models; and discussing performance measures applicable for high-cost patients with complex chronic conditions or serious illnesses.
- Dr. Lin noted that PTAC has received 35 proposals for physician-focused payment models (PFPMs), and at least 13 proposals included components related to addressing the needs of patients with chronic conditions and/or serious illnesses. The Committee found that 7 of the proposals met Criterion 7 (Integration and Care Coordination) of the Secretary's 10 regulatory criteria.
- Dr. Lin provided PTAC's working definition of patients with complex chronic conditions: patients with more than 1 morbidity, chronic condition, and/or comorbidity (lasting 12 months or more) who usually require a high complexity of treatment involving multiple health care providers across different specialties and settings.
- Dr. Lin also provided PTAC's working definition of patients with serious illnesses: patients with advanced illness and patients who are in their last years of life.
- Dr. Lin described MedPAC data demonstrating that the most expensive 1% of Medicare fee-for-service (FFS) beneficiaries account for 17% of Medicare FFS spending. At the other end of the spectrum, the least costly 50% of beneficiaries account for only 3% of Medicare FFS spending. Dr. Lin noted that the FFS system does not adequately incentivize providers to focus on this relatively small group of beneficiaries who are driving the majority of Medicare spending. Despite these challenges, payment incentives can be aligned under value-based care and can support care models that achieve higher-quality and lower-cost outcomes for this patient population.
- Dr. Lin suggested that high-cost beneficiaries can be classified into 3 health status categories: (1) patients with complex chronic conditions (controlled or uncontrolled); (2) patients with serious illnesses; and (3) patients who experience a one-time catastrophic health event. Dr. Lin noted

that the public meeting will not focus on patients who experience a one-time catastrophic health event.

- Dr. Lin described a Venn diagram showing the relationship between high-cost beneficiaries and those with complex chronic conditions or serious illnesses. He noted that the focus of the public meeting will be on the intersection between high-cost patients with either complex chronic conditions and/or serious illnesses. Treatment for these patients attempts to lower their high-cost status by controlling the complex conditions, delaying the progression of disease, reducing treatment complications, and/or providing goals that are concordant with end-of-life care.
- Dr. Lin described an example of a patient care journey for a patient with congestive heart failure (CHF).
- Dr. Lin introduced a new ASPE analysis of Medicare FFS beneficiaries with the highest Medicare Parts A and B spending from 2017 to 2023. Results included the following:
    - Whereas the number of beneficiaries decreased over time, Medicare spending increased over time. There was a 3.2% compound annual growth rate for overall per capita Medicare FFS spend during the study years.
    - The top 10% of most costly FFS beneficiaries accounted for nearly 60% of all Medicare Part A and Part B spending in 2023. The bottom 90% of FFS beneficiaries accounted for 43% of all spending. This distribution held constant across the study years, which included the years of the pandemic.
    - In 2023, the average per capita spending for the costliest 5% of FFS beneficiaries was over $129,000 compared with $54,000 for the top 6 to 10% of FFS beneficiaries and approximately $16,000 for overall FFS per capita spending.
    - Relative to the average beneficiary in overall Medicare FFS, FFS beneficiaries with the highest spending had a higher mortality rate; consisted of a larger proportion of Black, non-Hispanic beneficiaries; were disproportionately more likely to be dually eligible for both Medicare and Medicaid; and had more chronic conditions.
    - Among the top 1% most costly beneficiaries, the share for Part B (drugs) spending increased by 10 percentage points between 2017 and 2023.
    - Compared with the previous calendar year, 27 to 29% of beneficiaries remained in the top 5% category, and an additional 12 to 13% of beneficiaries moved to the top 6 to 10% category. About 40% of the costliest beneficiaries remained in the top 10% in the following calendar year.
    - Beneficiaries in the top 5% of spending who remained costly in the following calendar year were, on average, younger, had more chronic conditions, were more likely to be dually eligible and non-Hispanic Black, and were more likely to live in ZIP codes of lower socioeconomic status (SES).
- Dr. Lin described challenges associated with caring for high-cost patients with complex chronic conditions or serious illnesses: patient identification and prevention, provider challenges (e.g., ensuring sufficient provider time with patients), clinical care needs, patient engagement, and health equity.
- Dr. Lin described opportunities for improving care and achieving cost savings for high-cost Medicare beneficiaries. Among beneficiaries with complex chronic conditions, opportunities included intensive outpatient team-based medical care and/or disease management programs. Among beneficiaries with serious illnesses, opportunities included improving quality and cost of

care through increased focus on palliative care and hospice. Dr. Lin noted that these opportunities to improve care are not mutually exclusive.

- Dr. Lin described 2 possible trajectories for end-of-life care for this patient population: (1) a hard-landing trajectory, where aggressive care is continued over time until the patient's death; and (2) a soft-landing trajectory, which introduces palliative care over time with final care under hospice before the patient's death.
- Dr. Lin highlighted objectives for improving the care of high-cost patients with complex chronic conditions or serious illnesses, including providing goals-concordant care, delaying progression of chronic diseases, catching acute exacerbations early to enable outpatient treatment, and reducing treatment burden and complications of treatment.
- Dr. Lin described several strategies to improve care for the highest cost patients for CMMI models and CMS initiatives. The strategies were organized by patient health category, including the following:
    - Examples of strategies for patients with complex chronic conditions (uncontrolled) included specialized multidisciplinary care teams, care coordination, and medication management.
    - Examples of strategies for patients with serious illnesses in active treatment included incentives to enhance care coordination, person-centered care, and outpatient treatment of acute exacerbations.
    - Examples of strategies for patients with serious illnesses and complex chronic conditions in active treatment included caregiver training, education, and support, and concurrent care services.
- Dr. Lin described potential performance measures for this patient population, including process measures, outcomes measures, utilization measures, and cost measures. Examples of possible population-based, episode-based, and palliative/end-of-life care performance measures were provided for each of the 4 types of performance measures.
- Dr. Lin described several payment methodology challenges related to caring for high-cost patients and patients with complex chronic conditions or serious illnesses, including attribution or assigning accountability, aligning incentives across settings of care, benchmarking the highest cost beneficiaries against the general Medicare population, risk adjustment, retrospective reconciliation, issues affecting smaller and rural providers (e.g., small patient panel size), and effective payment models. Dr. Lin also described potential solutions to address each challenge.
- Dr. Lin noted 2 primary goals for PTAC's 2-day public meeting:
    - To understand existing effective care models that address the needs of this patient population; and
    - To explore opportunities to develop new payment models that can improve quality of care and lower costs for this patient population.
- Dr. Lin concluded the presentation by reviewing the topics associated with patients with complex chronic conditions or serious illnesses in PB-TCOC models that would be discussed during this public meeting: providing patient-centered care, improving outcomes, best practices for measuring quality and outcomes, optimizing the mix of palliative and end-of-life care, and incentivizing improved outcomes.

Co-Chair Hardin invited Committee members to ask questions and comment on the PCDT presentation. Committee members discussed the following topics. For more details on the discussion, see the transcript and meeting recording (47:53-56:43).

- Committee members discussed what surprised them the most regarding the findings presented today.
- The large difference between $129,000 in the costliest 5% versus the average of $16,000 FFS spend was surprising.
- It was also notable that only 40% of patients stayed within the top decile of most costly patients in the following year. Initially, there was discussion amongst the PCDT and the Committee about this finding. The Committee looks forward to doing additional analysis of the potential impact of patient mortality and switching to Medicare Advantage.
- The relatively slow growth in overall spend from 2017 to 2023, which was an average of 3.27%, was surprising. But this rate is somewhat encouraging because it may be below the inflation rate.
- It may be that the increase in spending for Part B drugs is similar for Part D drugs.
    - We tend to think it is a positive sign to see hospital costs go down; however, the Part B spend on drugs balances that out. Instead of spending money on providing palliative care or professional services, the money is spent on the unit cost rate on drugs without necessarily prolonging life. Thus, we need to question whether we are shifting costs from what used to be a hospital cost center to now providing high-cost drugs.
- The ASPE analysis provides important insights for people who remain in the top decile the following year versus people who remain for 2, 3, 4, or 5 years, which reflects the life of many CMMI models. There is a question of whether we would arrive at additional insights if we reframed the focus to the top 1 or 5% of patients with complex care needs rather than the top 1 or 5% of spending.
    - The palliative care literature suggests aggressive interventions do little to improve health and survival at end of life. In addition, patients, caregivers, and families are typically more satisfied with care that follows a soft-landing trajectory. There are opportunities to improve care and lower costs at the same time.
- Seeing how the population changed over time was surprising. Building programs or pilots based on patient diagnoses may be unsuccessful. There may be better ways to characterize patients who remain in the top 1% of spending.

Panel Discussion: Providing Patient-Centered Care for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

SMEs

- Erik Johnson, MBA, Senior Vice President, Value-Based Care, Optum Advisory
- Richard A. Feifer, MD, MPH, Chief Medical Officer, InnovAge
- Kristofer L. Smith, MD, MPP, Chief Medical Officer, Landmark Health
- Marshall H. Chin, MD, MPH, Richard Parrillo Family Distinguished Service Professor of Healthcare Ethics, Department of Medicine, University of Chicago, and Co-Director, RWJF Advancing Health Equity Program Office

Co-Chair Hardin moderated the panel discussion with 4 subject matter experts (SMEs) offering their perspectives on providing patient-centered care for patients with complex chronic conditions or serious illnesses in PB-TCOC models. For additional details, please see the transcript and meeting recording (00:00:22-01:23:56).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Erik Johnson introduced himself as the Senior Vice President of Value-Based Care at Optum Advisory, where he helps providers create contracts that shift risk closer to the point of care. Mr. Johnson shared that managing complex chronic conditions and serious illnesses requires consistent risk stratification of the population pool, utilizing team-based care, and removing patients' barriers of access to health care and their health care benefits. Concentrating on complex and poly-chronic populations proves financially advantageous, offering opportunities to lower utilization rates and enhance the overall quality of care. For additional details on Mr. Johnson's background and organization, see the panelist introduction slides (slides 2-4).
- Richard Feifer introduced himself as the Chief Medical Officer of InnovAge, where he leads clinical services, population health analytics, and network management. InnovAge is a Program of All-Inclusive Care for the Elderly (PACE) provider/payer that provides care for high-cost dual-eligible beneficiaries who meet state eligibility criteria for nursing home placement. Dr. Feifer noted that InnovAge is incentivized to keep people living independently as long and safely as possible because it is responsible for the cost of long-term care under Medicaid capitation payments. He emphasized the importance of several high-value care delivery approaches, including team-based care, goals of care and advanced care planning, integrated end-of-life and palliative care, holistic (versus disease-focused) care, emergency room (ER) diversion, high-performance nursing facility / assisted living facility (NF/ALF) networks, and addressing social determinants of health (SDOH). He advised being cautious of polypharmacy, unnecessary cancer screenings, and the scope of Part D pharmacy coverage. For additional details on Dr. Feifer's background and organization, see the panelist introduction slides (slides 5-7).
- Kristofer Smith introduced himself as the Chief Medical Officer of Optum at Home, a large risk-bearing entity that is clinically and financially responsible for Dual Eligible Special Needs Plan (D-SNP) and Medicare Advantage beneficiaries. He noted that comprehensive programs, including both proactive and reactive aspects, are needed to reduce costs and improve outcomes for patients with multiple substantial conditions. Financial reconciliation methods under current complex care models are unsustainable because they create too much uncertainty and inconsistency. Dr. Smith discussed a few mistakes to avoid, such as creating interdisciplinary teams with overlapping responsibilities and quickly scaling programs that have early positive results but have yet to be proven effective over time. For additional details on Dr. Smith's background and organization, see the panelist introduction slides (slides 8-11).
- Marshall Chin introduced himself as a practicing general internist and Co-Director of the Robert Wood Johnson Foundation's (RWJF's) Advancing Health Equity Program Office, where he leads care, payment, and systems transformation with a focus on anti-racist health equity. Dr. Chin noted that equitable interventions require holistically addressing medical and social needs, effective communication with patients and families, team-based care, and cultural tailoring. It is critical to intentionally design interventions to address health equity by incorporating payment and accountability metrics. For additional details on Dr. Chin's background and organization, see the panelist introduction slides (slides 12-17).

Panelists discussed clinical characteristics and challenges associated with treating high-cost patients with complex chronic conditions or serious illnesses in total cost of care (TCOC) models.

- Robust attribution models that track patients' health care utilization can effectively identify high-risk patients in TCOC models. The Centers for Medicare & Medicaid Services (CMS) has provided several effective attribution models; however, the need to understand patients' social contexts and access barriers remains. To address the root causes of illness, providers must ask non-medical questions; incorporating non-clinical factors into care plans is a promising opportunity in the health care industry. Technical challenges related to interoperability also must be addressed to better manage the needs of patients with complex chronic conditions in TCOC models.
- Identification of high-risk patients is not an issue in the PACE program because all patients are elderly, frail, and at high risk for medical complications. Instead, PACE providers must focus on managing this unique population, focusing on transitioning their care toward a primary care model from fragmented or emergency-based care. This shift requires trust-building and cultural change. Providers should treat patients as complex individuals rather than focusing solely on diseases and medications. A greater focus on behavioral health, polypharmacy, and the involvement of caregivers is also needed. Additionally, providers should initiate discussions about goals of care and advanced care planning to integrate palliative care appropriately into the treatment plan.
- Populations with multiple chronic conditions, mental health issues, and social challenges require tailored, individualized care. To address equity issues, providers should collect data on factors like sexual orientation, gender identity, race, ethnicity, and language. Current data systems do not capture nuances such as ethnic subgroups and intersectionality. Better data systems are needed to identify specific populations and conduct root-cause analyses to address disparities effectively. Trust-building and communication are also critical to meeting the unique needs of diverse individuals and communities.
- The intersection of medical complexity and frailty must be considered when identifying patients for high-intensity care models, as these patients tend to be persistently high-cost. It is often challenging to get patients to participate in these models, and patient incentives may be needed to encourage their engagement. The distinction between co-management and primary management is also important. Patients with complex chronic conditions need actual care provided in a timely manner rather than just care coordination.
- While many organizations claim to prioritize culture, often culture-related aspects like equity are not effectively incorporated into practices. True cultural change requires a focus on caring for the patient and community health, rather than solely on efficiency. There must be a genuine belief in and commitment to equity across the entire organization.

Panelists discussed payment mechanisms that could help incentivize better team-based care.

- It is important to consider the types of visits that are emphasized in Medicare and other risk-bearing models. For example, the annual wellness visit in Medicare Advantage is a metric that drives adherence and incentivizes providers, and this metric could be incorporated into other Medicare programs. Another example is a safety net health system that identified transportation barriers for Medicaid individuals after hospital discharge. They suggested asking questions at discharge to address such barriers and highlighted the potential benefits of covering non-emergency transportation services.
- Medicare should cover transportation and advanced care planning conversations when transitioning toward TCOC models. There have been favorable shifts in reimbursing for advanced care planning, which have been especially important when providing care for high-risk

populations. Alternatively, efforts to pay for care coordination have been more controversial. Outside of primary care settings, care coordination may lead to fragmentation rather than integration.

- Patients are often overwhelmed by different providers contacting them about various aspects of care, so it is critical to clarify who is responsible for patients to minimize unnecessary contact and prevent overwhelming patients. Programs should also consider using financial incentives to encourage patients to participate and engage in services (e.g., pay patients $25 per phone call with their care navigator). More broadly, population health efforts should move from demonstrations to mandatory long-term programs. Short-term demonstrations are not financially viable for most organizations because they cannot handle the risk and revenue changes over time.
- From the perspective of Federally Qualified Health Centers (FQHCs) and safety net institutions, program participation is difficult due to small margins and limited infrastructure to meet program requirements like reporting and data analysis. Upfront investment in infrastructure, such as analytics and coaching support, as well as a phased approach to program participation, starting with pay-for-reporting, and gradually moving to upside and downside risk, could help encourage FQHC and safety net institutions' participation in TCOC models. In addition, genuine patient and community involvement is needed to drive meaningful change in health care. Power-sharing structures within governance can help ensure that patient and community voices are central in decision-making processes. For example, the National Advisory Committee includes current and former Medicaid beneficiaries, leading to more impactful discussions and decisions.
- Patients should be paid to participate in health care programs, and the participation of caregivers and families should also be incentivized, particularly in caring for complex and frail populations. Caregivers and families are crucial members of the care team, but effective incentivization methods are lacking. This area warrants further research and investigation to find ways to financially incentivize both providers and families to engage with each other.
- In a few states, there is a paid caregiver program, which incentivizes the engagement of family members and helps alleviate the significant shortage of paid caregivers that some areas are experiencing.

Panelists discussed the definition of team-based care.

- Telephonic communication can be effective, especially when it originates from the primary care team. Frequent touchpoints from the primary care team, whether in person, via video, telephone, or within homes, should be encouraged. In PACE, there are 11 members of the interdisciplinary team. Conceptually, however, the essence of team-based care lies in addressing individual patient needs. For the PACE population, which includes the frailest individuals, care teams must include members with backgrounds in therapy, social work, primary care, nursing, and other specialties. Payment models should incentivize cohesive team delivery of services rather than fragmented approaches.
- The principles outlined in the National Academies Primary Care report emphasize having a responsible figure in charge, establishing trusting relationships with patients and families, and integrating various specialties or services into the care plan. Providers of telephonic interventions from outside groups may not be viewed as equal members of the care team and may struggle to build trust with patients. Trust and communication are the most critical components of team-based care but are often undervalued, both financially and culturally, in current health care systems.

- The interdisciplinary team should not be overcomplicated. For example, although pharmacists can be beneficial in primary care settings, not every patient requires their expertise. Primary care physicians or advanced practice clinicians should possess skills in areas like primary palliative care and medication management, reducing the need for additional specialized team members. A tighter team structure, including a doctor, nurse practitioner, nurse, social worker, and possibly physical therapist, is typically sufficient.

Panelists discussed opportunities for Medicare to emulate real-world tightly managed programs.

- The PACE capitated financial model effectively incentivizes investment in care delivery and improvement for InnovAge. Given its frail, often end-of-life population, InnovAge observed high costs related to end-of-life care and hospice. Recognizing that hospice costs were fully covered under its capitation model, it questioned whether patients were receiving the right care experience. InnovAge found that the care was fragmented rather than integrated, prompting it to invest heavily in palliative care. This included training, hiring staff for round-the-clock care, and providing services in patients' homes and centers. Incentives must be aligned with care goals, and care delivery systems should be given the opportunity to adapt accordingly.
- The Committee should focus on scalability, primary care, technology, and incentive alignment across programs. Regarding scalability, programs that can be implemented across geographies and populations should be prioritized. Primary care should be financially rewarded, and investing in technology and analytics is critical to identifying patient populations and their needs. Lastly, incentives across Medicare and Medicaid should be aligned, particularly for health systems and physician groups serving diverse patient populations. Progress has been made in this area but further alignment across multiple programs is needed.
- While cost-savings opportunities are higher for more severely ill individuals, there is concern in the equity field about applying a strict cost-saving perspective primarily to marginalized populations. Delivery of high-value care to marginalized populations is important, even if it does not generate significant cost savings. Careful consideration should be given to the value equation, especially for marginalized populations, when making policy decisions.

Panelists discussed ways to promote care coordination while avoiding duplication of efforts.

- The primary care provider and system should be held financially responsible for care coordination, including any failures of care coordination. As seen in the PACE model, the primary care system will effectively manage care coordination tasks when it is financially incentivized to do so.
- While care coordination can improve patient experience and reduce caregiver burden, it may not effectively reduce TCOC if implemented as a standalone service. An interdisciplinary team should be responsible for providing longitudinal care, urgent care, and palliative support, tailored to individual patient needs, including social determinants of health and behavioral health. There is faulty logic in requiring follow-up appointments with primary care providers in care coordination programs, as it often pushes patients back into ineffective care environments.
- Most patients have highly involved family members managing their care coordination across various health care systems. However, care coordination should be structured to alleviate the burden on family caregivers. It is important to consider who or what structure could take on the role of integrating care across different settings, making the process easier for patients and their caregivers. Both incentives and a cultural shift within the health care system are needed to improve care coordination.

Panelists discussed ways to encourage primary care providers to use value-based care models.

- There are several actionable strategies that can encourage primary care providers to participate in value-based care. First, providing prospective payments to provider groups ensures sufficient financial support so that they can avoid high patient volumes. Protecting practices from downside risks during the transition can also encourage participation—something that is currently seen in private equity ventures. It is also important that providers understand that taking on risk for complex patients requires investment in urgent care capabilities within practices. Incentivizing high-quality palliative care is also critical, including an emphasis on outcomes, such as the percentage of patients who expire under hospice care, rather than payment for merely reporting advanced care planning documentation.
- Current incentives for primary care providers are inadequate. There is a growing trend among primary care providers seeking a faster transition to risk-based payment models, driven by a desire for more control over patient care and intervention. Upfront capitated payments can facilitate smoother cash flow and enable proactive patient outreach. In addition, incremental adjustments to fee schedules are insufficient to drive meaningful change. Programs should also consider implementing readiness criteria for physicians to participate in new payment programs, ensuring that they have the necessary capabilities to manage risk effectively.
- Primary care services, including care coordination, communication, and trust, are crucial to addressing systemic issues in health care. The National Primary Care Report from 15 to 20 years ago outlined solutions to primary care payment, many of which have yet to be implemented. The most recent National Primary Care Report focused on implementing high-quality primary care, particularly in terms of payment and regulatory mechanisms. The report discussed 4 payment options, ranging from fee-for-service to global payment models, and emphasized the need to align incentives and culture to prioritize primary care. The Committee should review the payment chapter of the report for further insights into existing data and potential solutions.
- Primary care providers should be given financial incentives and freedom to innovate and find solutions. With longer patient visits, primary care can prevent costly hospitalizations or emergency visits. Additionally, performance metrics should focus on quality and operational performance. Regarding hospice metrics, measuring the percentage of patients who die under hospice care can create the wrong incentives. A valuable but underused metric is the percentage of patients who had a hospitalization in the last month of life. This metric encourages proactive identification of high-risk patients, facilitates advanced care planning, and reduces unnecessary hospitalizations.

Panelists shared their final thoughts on providing patient-centered care for patients with complex chronic conditions or serious illnesses in PB-TCOC models.

- The Committee should delve deeper into integrating specialty care into health care models, particularly concerning specialized care for specific patient populations. Involving specialty care and ensuring specialists' active participation in care models are critical for improving overall patient outcomes.
- The distinction between identifying individuals based on diagnoses versus characteristics is critical, particularly for the frail population. Characteristics such as frailty, recurrent falls, and frequent emergency room visits for non-emergent needs are key identifiers for patients who need outreach. In addition, high-risk populations require 24/7 access to care to ensure trust and discourage the use of more costly and lower-value care options.
- The panel discussion focused on 2 areas that are key to health equity: care reorganization and payment. However, a 3rd area—values and governance—deserves additional attention. The

Committee should consider how to align payment policies with health equity values, such as holistic patient management and community health.
- The Committee should engage with chief financial officers (CFOs), as they play a crucial role in determining the adoption and scalability of programs. CFOs are key decision-makers who hold the power to determine the financial viability of initiatives. It is also important to understand the financial challenges faced during model demonstrations to inform future program development.

Roundtable Panel Discussion: Provider Perspectives on Improving Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

SMEs

- Matthew Wayne, MD, CMD, Chief Medical Officer, CommuniCare
- David Gellis, MD, MBA, Vice President and National Medical Director, Medicare Population Health Programs, One Medical Senior Health
- Cheryl Phillips, MD, AGSF, Sr. Program Consultant, The John A. Hartford Foundation
- Olivia Rogers, RN, MBA, Vice President and Chief Nursing Officer, Visiting Nurse Association of Texas

Co-Chair Sinopoli moderated the panel discussion with 4 subject matter experts (SMEs) offering provider perspectives on improving outcomes for patients with complex chronic conditions or serious illnesses in PB-TCOC models. For additional details, please see the transcript and meeting recording (00:00:06-01:31:44).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Matthew Wayne introduced himself as the Chief Medical Officer at CommuniCare Family of Companies and Personalized Health Partners (PHP). CommuniCare is a family-owned business that has expanded over the past 40 years to include 130 skilled nursing facilities in 7 states. PHP is the medical practice of CommuniCare comprised of primary care physicians, a psychiatrist, a physiatrist, and nurse practitioners. Most of the patients it serves are in a capitation of care model (institutional special needs plan [I-SNP] and High Needs ACO REACH), which has prompted CommuniCare's shift to value-based care. Dr. Wayne is board-certified in internal medicine and geriatric medicine and has served in executive leadership roles for the past 15 years. Dr. Wayne shared 4 goals of value-based care in his organization: building a relationship with its patients, defining goals of care important to its patients, following best practices in chronic disease management, and prioritizing timeliness of care. For additional details on Dr. Wayne's background and organization, see the panelist introduction slides (slides 2-4).
- David Gellis introduced himself as the Vice President and National Medical Director of Medicare Population Health Programs at One Medical, which is now part of Amazon Health Services. One Medical developed a nationally scaled global capitated risk model for senior-focused clinics and was an early participant in the Global and Professional Direct Contracting (GPDC) / ACO REACH model. The One Medical care model focuses on improving the quality of primary care and has recently deployed home-based and hybrid virtual programs for high-need and complex patients. Dr. Gellis shared that the use of global risk contracts has supported investments in integrating behavioral health and promoting health equity and high-touch care, but requires program stability, predictability, and accurate benchmarks and quality metrics. Dr. Gellis also mentioned that ACO REACH provides structures to align incentives across patients, PCPs, specialists, and

facilities; however, CMS can improve program and payment design. Artificial intelligence and machine learning (AI/ML) technologies can support care for complex patients. For additional details on Dr. Gellis' background and organization, see the panelist introduction slides (slides 5-7).

- Cheryl Phillips introduced herself as a fellowship-trained geriatrician with decades of clinical, health policy, and health systems experience and interest in post-acute long-term care. Dr. Phillips is currently a Senior Program Consultant at the John A. Hartford Foundation, which funds the Age-Friendly Health Systems initiative. Dr. Phillips explained that the conversations being had today about the care of patients with serious illnesses and complex needs have not changed from 30 years ago and that the care has become too complex. She described 7 essential elements for care design, including team-based care, value-based payment models, and a focus on the 4Ms framework (Mobility, Medication, Mentation, and What Matters). Dr. Phillips noted the challenge of care coordination and integration of specialty providers and how care is multidisciplinary rather than transdisciplinary. For additional details on Dr. Phillips' background and organization, see the panelist introduction slides (slides 8-10).
- Olivia Rogers introduced herself as the Chief Nursing Officer at the Visiting Nurse Association of Texas, a 90-year-old organization that provides Meals on Wheels, hospice, and palliative care in Texas. Ms. Rogers stated that her organization also has a large community health worker program to address unmet social needs. Her organization participated in CMMI's Medicare Care Choices Model (MCCM) that tested community-based supportive palliative care services from hospice providers. She noted that MCCM was successful because it focused on the relationships between the patient and their care team and followed best practices in chronic disease management. Currently, her organization participates in ACO REACH, providing supportive palliative care to patients with WellMed Medicare Advantage. Ms. Rogers noted that a significant concern in her organization is late admission to hospice or other appropriate care. MCCM allowed patients to choose palliative care in their homes without foregoing disease-directed therapy, which filled the gap for patients between home-based and hospice care. She advocated for the relaunch of MCCM because of how transformative the model was for her community. For additional details on Ms. Rogers' background and organization, see the panelist introduction slides (slides 11-19).

Panelists involved with ACO REACH discussed areas for improvement.

- The beneficial aspects of ACO REACH for primary care-based models include global capitation with advanced primary care payments, beneficiary enhancements, Medicare Part B cost-share waivers, and safe harbors for value-based care. To improve program stability, CMS could provide information on how patients will transition from ACO REACH, when the program is due to end in 2 years, to another program or model. CMS can align the legal framework to allow for seamless provision of care. Finally, CMS can support primary care-led specialty integration models.
- In the post-acute and long-term care (nursing home) setting, only a small proportion of residents meet the criteria for receiving high-needs care through ACO REACH. Some of the technical aspects of ACO REACH are challenging for the nursing home setting. For example, durable medical equipment is bundled in nursing homes and is therefore difficult to capture in the risk-adjustment equation.

Panelists discussed effective approaches for proactively identifying high-cost patients with complex chronic conditions or serious illnesses and addressing their needs.

- Identifying and addressing this patient population's social needs and risk factors are essential; this includes their living environment, basic needs, access to caregivers, and functional risks.

CMS is starting to discuss the integration of social risk factors and needs into models of care and quality measures. Global payment models, risk-adjustment equations, and quality or performance measures are missing this social aspect.
- Dr. Gellis shared that his organization has a custom electronic medical record (EMR) that collects information on social needs and risk factors from care teams. It is integrated with claims data to build a predictive machine-learning model that considers social risks, such as living alone. The custom EMR is a challenge for data interoperability, but it does allow the collection of much more nuanced and rich information on contextual factors. The additional burden of manually entering social risk information into the EMR is a concern that generative AI may also be able to address.
- Ms. Rogers recommended considering integrating social services organizations embedded in the community, such as is done with her organization that operates hospice and palliative care on top of meal delivery, into machine learning models as an additional data point to identify the high-needs population. The target population for these social services programs often live alone, do not have reliable caregivers, and struggle to meet basic needs such as finding transportation and paying bills.
- Payers are not well connected with community-based organizations and have difficulty finding a common language to communicate effectively. Payers are also not communicating well with the primary care physicians. Finding a mechanism to create a web of communication between the community-based organizations, the provider communities or physician networks, and the payers is essential.

Dr. Wayne discussed how his organization cuts the cost of caring for a population of patients with complex chronic conditions or serious illnesses by 20 to 30% under a TCOC model. Compared with a traditional fee-for-service (FFS) model, the TCOC model provides a much stronger infrastructure for care that is predictable, accessible, and consistent in the post-acute long-term setting. In his organization’s facilities specifically, there is a provider in the building able to respond immediately on at least 3 to 5 days of the week. On days that a provider is not in the building, such as after hours or on weekends, telehealth services are provided. Delivering this level of coverage would be much more challenging in an FFS environment.

Panelists discussed the vision for transdisciplinary care.
- The center of the hub of transdisciplinary care is goal-oriented care in partnership with the patient. These goals should be documented in the medical record to align care across provider disciplines. The primary care team would serve as the central coordinator of services for the high-risk, high-needs patient as opposed to being relegated to triage and referral as it is now. To achieve this vision, primary care payment methodologies need to change to reflect its high value and increase the size of the primary care pie. This change would require the American Medical Association (AMA) or Resource Utilization Committee (RUC) to change their policies to redistribute a portion of the income currently paid to specialists to primary care instead. The current system reinforces a fragmented and expensive subset of services that do not meet the needs of the high-needs population. In addition, provider reviews of treatment plans need to focus more on the goals of care rather than the person’s diseases.
- The pie analogy works well with the TCOC model as it is easy to visualize how the pie is divided. For example, currently almost 85% of the pie is specialists and hospitals. Those with decision-making power can see that and address how to change payment and incentives. With a FFS model, it is not possible to see the whole picture. Paying for and incentivizing behavioral health has been successful in the TCOC model due to the ability to integrate it into primary care.

Panelists discussed ways to decrease administrative costs to reduce health care spending.

- When comparing ACO REACH to Medicare Advantage plans, there is room to reduce administrative costs, which currently amount to 15% of Medicare Advantage overhead, without sacrificing the benefits of care coordination and data systems. There is also room to reduce administrative spending associated with risk-adjustment systems and routine wellness visits. Technology can help increase efficiency of current processes and reduce the administrative burden in these areas.
- Payments are largely driven by the setting where a person receives a service, which naturally creates redundancies in services provided and in administrative costs. Home-based care, for example, is treated as another episode of care.
- The complexity of the health care system results in too many dollars spent on contracting, the infrastructure for financial management, and reporting of quality measures and outcomes. These 3 areas, while necessary, need improvements in efficiency.
- Returning to the pie analogy, the pie for social services organizations is fixed, and thus there is very little room to bring on administrative staff to handle reporting requirements without sacrificing the quality of patient care. A balance must be struck between the time and effort required to care for rural patients and on meeting reporting requirements. Additionally, despite an organization serving a high-need patient population, it is still difficult to identify or predict which patients will have the highest needs and costs because information on aspects outside of diagnoses, such as social needs and risk factors, is not readily available. There needs to be a standardized way to identify these patients across disciplines and settings.

Panelists discussed challenges with current risk stratification systems in which the sum of a person's diagnoses drives payment in value-based care.

- The Risk Adjustment Factor (RAF) scores that currently drive payments in risk stratification systems do not measure what matters for high-need patients. Caregiver support, behavioral factors, and social needs are not captured through the Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures; CMS and the National Committee for Quality Assurance (NCQA) are aware of this. The Oregon Health Sciences University will release a paper shortly showing that the integration of the 4Ms into the medical record across settings of care improved outcomes and reduced costs for the highest need and most complex patients.
- Frailty-based measures are good candidates for quality measures. They are independent of age and diagnosis and focus on the ability of the patient to function and live independently.
- In the MCCM model, patients of all ages admitted to hospice or palliative care must meet certain scores on measures like frailty measures, such as the Karnofsky score and Functional Assessment Staging Tool (FAST) that assess the degree of functional impairment.
- The machine learning model in Dr. Gellis' organization uses a claims-based frailty measure.

Panelists discussed anticipatory or proactive disease management across disciplines, especially for socially complex patient populations.

- The potential of AI is promising for collecting social information; however, the more challenging question is how is that information used, owned, and managed. Having a holistic perspective that integrates social needs and health equity is a good starting place for creating the desired systems and measures. Again, measures are needed that provide goal-oriented and coordinated care and effectively assign ownership.
- The 4Ms have been a useful framework to create a shared language that improves communication with other care providers and with patients. For example, in an integrated

cardiology program, the conversation between providers and between provider and patient is not solely about when a valve is being replaced but also considers patient goals and opinions (e.g., a patient wanting to retain mobility).

- Ms. Rogers stated that her organization was successful in partnering with a health information exchange (HIE) that enabled information sharing about a person's participation in the Meals on Wheels program with other health systems and providers in Dallas. The hope was that this information would inform care as social services organizations can be used to predict health outcomes. In turn, the organization can use information on the number of hospitalizations and ER visits to stratify patients according to need and cost.
- The FFS model has a narrow lens focused on serving the patient's current needs and quickly transitioning to the next patient. There are no incentives to evaluate risk factors to predict future disease or to educate patients when providers are being paid in 10- to 15-minute increments. The capitated model is a step in the right direction.

Panelists discussed how services that are tied to good health outcomes, instead of direct clinical care, could be compensated within a TCOC model.

- Ms. Rogers shared that her organization is a large nonprofit that uses fundraising to cover some of the Meals on Wheels program costs and the costs of hospice and palliative care for uninsured patients. She shared that it raises $8 million to $9 million per year, on average. It also has state contracts for the Meals on Wheels program that allow it to partner with other organizations to support transportation. The community health worker program is funded by community block grants and donations. During the community health worker visit, individuals are screened for mobility issues, medication compliance, living alone, caregiver access, and the existence of advanced directives. This program has been successful in keeping people out of the hospital because it connects clients with home-based care provided by visiting physician groups comprised of nurse practitioners and physicians. This home-based approach can provide care for patients when palliative care or hospice is not yet needed. Although the community health worker program has been successful in improving outcomes and reducing costs, the main challenge is finding payers.
- Payment for these types of supplemental services, such as community health workers, in Medicare Advantage plans is through quality bonuses. These bonuses are based on Hierarchical Condition Category (HCC) scores, RAF scores, and Star Ratings. The Medicare Payment Advisory Commission (MedPAC) has acknowledged the importance of these supplemental services and suggested examining how these services are paid for in traditional Medicare. Global payment systems for the whole person must be at the provider level to drive the desired outcomes. Given that there is no new money, these supplemental services must be integrated into the broader picture of care.
- Ms. Rogers shared that her organization would love to see these supplemental services paid for by health care plans because they are a huge driver of outcomes.
- Dr. Gellis suggested that payment for these benefits should be judicious and tied to performance and quality measures like other health plan services. He indicated that his organization's model had a global transportation benefit for all dual-eligible patients who did not show returns on investment. Stratifying or segmenting the dual-eligible population according to the highest need could help indicate how to make this benefit cost-effective. Placing the responsibility and accountability for arranging such services also needs to be closer to the patient receiving care.

Panelists discussed aspects of models, such as the MCCM, that support a soft versus hard landing and how this type of care can be paid for and incentivized.

- MCCM was a concurrent care model that allowed patients to choose palliative care in the home without forgoing disease-directed therapy. In a subsequent concurrent care model called the pediatric hospice program, youth under the age of 21 and their families could choose hospice without losing aggressive hospital-based treatment due to the Affordable Care Act. Many youth and families in this program do not opt for the aggressive treatment because their needs are being met by the hospice team that conducts frequent in-home visits. When roughly 75 to 80% of patients from MCCM transitioned to the pediatric hospice program, their care team did not change, which could be attributed to the continuing success of these programs. Patients and their families initiated the transition to the hospice care program, which is likely due to the supportive relationships they developed with their care team in the MCCM. The MCCM final report shows that the program achieved CMMI goals of quality outcomes, patient satisfaction, and cost reduction for a complex patient population. Ideally, hospice programs and supportive palliative care would grow nationwide. Ms. Rogers noted 2 improvements that could be made to MCCM, including expanding diagnoses and raising payments to attract more hospices to participate.
- Dr. Gellis shared that his organization has a program called One Medical In Home, which is an in-home model of care using community health workers and nurse practitioners. The program has 2 care trajectories: the first is the management of multiple chronic illnesses for a prolonged period to achieve improvement; and the second is hospice care. Having more resources and policy solutions to support the transition to enhanced in-home services and hospice care would be helpful—for example, making the connection back to the primary care team to provide knowledge about the patient's care journey and to create continuity of care.
- The core of palliative care is spending time with the patient, and thus creating models that allow clinicians to spend time with the patient to form a close relationship. Supporting time spent with the patient is goal-oriented care and makes palliative care successful.
- Palliative care is successful in terms of working with the patient to shape their care journey.

Panelists shared their final thoughts on improving outcomes for patients with complex chronic conditions or serious illnesses in PB-TCOC models.

- Dr. Gellis indicated that 1 area that was not discussed explicitly is how TCOC models for high-risk patients are aligned to address health equity for the most underserved patient populations. He shared that his organization's model embedded health coaches from the community into the care plan, which improved trust and reduced barriers to accessing care. However, some programs for patients with complex chronic conditions are working only for white, wealthy patients, despite disproportionately enrolling patients with longstanding disparities in health and access to care. Measuring and reporting on these disparities over time should be more apparent. Health equity plans that focus on feeding data on disparities to clinicians and operators have been useful.
- In hospice care, providers and health systems are penalized for caring for the most difficult and expensive patients as these patients often have worse outcomes (e.g., Medicare Advantage Star Reporting). Providers should be incentivized to care for these patients across care settings and to leverage social workers.
- Creating efficient and useful quality measures is essential to reducing the burden of reporting.
- Based on experience, there are certain features specific to unsuccessful and successful models. Models that have not survived often provide local incentives that require a local champion and

are disease-focused and episodic. Successful models are whole-person focused, embedded into the delivery system, and longitudinal.

Listening Session 1: Best Practices for Measuring Quality and Outcomes Related to Caring for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

SMEs

- Brynn Bowman, MPA, Chief Executive Officer, Center to Advance Palliative Care
- Paul Mulhausen, MD, MHS, Chief Medical Director, Iowa Total Care, a Centene health plan
- Caroline Blaum, MD, MS, Assistant Vice President, National Committee for Quality Assurance
- David Kendrick, MD, MPH, Chief Executive Officer, MyHealth Access Network

Committee member Lindsay Botsford moderated the listening session with 4 SMEs on best practices for measuring quality and outcomes related to caring for patients with complex chronic conditions or serious illnesses in PB-TCOC models. Full biographies and presentations are available.

Brynn Bowman presented on measuring patients' quality of care during the last year of life.

- Ms. Bowman described the goals of the Center to Advance Palliative Care (CAPC) for which she is the Chief Executive Officer.
    - CAPC provides implementation support for improving access to specialty palliative care services. It also builds tools and training for health care organizations across the country to help them identify patients with serious illnesses who have unmet needs, evolve care delivery to anticipate and prevent crisis, and provide high-quality care that is aligned with what matters most to patients and families.
- It is important to first define and clarify who patients with “serious illness” are. Serious illness is often thought about as a list of diagnoses (e.g., cancer, advanced heart failure). However, a diagnosis alone does not adequately predict cost, utilization, or mortality.
- Palliative care interventions have been shown to improve quality and, as a result, reduce health care costs.
- Ms. Bowman highlighted the work of Amy Kelley and her colleagues who, in 2018, analyzed Medicare data to characterize the population who would benefit from primary or specialty palliative care services. This work resulted in defining “serious illness” as a health condition that carries a high risk of mortality and either: 1) negatively impacts a person’s daily function or quality of life; or 2) excessively strains their caregivers.
    - This definition of serious illness does not rely solely on a list of diagnoses but integrates evidence of unmet needs and includes caregivers. Caregivers are responsible for care coordination and clinical care for patients with serious illness, including administering medications. The demands of caregiving and the support needs of caregivers are often ignored.
- Ms. Bowman again highlighted the work of Amy Kelley and her colleague, Melissa Aldridge at Mount Sinai, for the Institute of Medicine’s report *Dying in America*, published in 2015 that looked at the top 5% of spenders and found:
    - 11% were in their last year of life.
    - Nearly half (49%) were short-term, high-cost Medicare beneficiaries who experienced a discrete high-cost event (e.g., car accident) and in the subsequent year returned to baseline levels of care utilization and spending.

    - Approximately 40% had persistent high costs of health care. This group is comprised of patients with complex chronic conditions and serious illnesses who are not at the end of life.
- Quality care for patients with serious health conditions and unmet needs includes hospital or home-based palliative care. Hospital palliative care improves patient and family satisfaction while also reducing readmissions, intensive care unit (ICU) utilization, length of stay (LOS), and cost per day. Home-based palliative care is shown to save up to $12,000 per enrollee to health care plans and Accountable Care Organizations (ACOs), while reducing emergency department (ED) visits, admissions, readmissions, and hospital LOS.
- Palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering with the goal of optimizing quality of life for patients, families, and caregivers. Palliative care is available at any stage of a serious illness. Early palliative care involvement is associated with better outcomes for patients.
- Focusing quality improvements and measurements solely on those nearing the end of life, misses the opportunity to improve quality of life over time and does not address the 40% of the top 5% of spenders who consistently incur the highest health care costs. If high spending is a poor indicator of quality care, measuring quality for patients with serious illness and unmet needs across the trajectory of their illness needs to be considered. Palliative care outcomes and services signal what is important to measure to address care quality.
- Two validated measures for individuals with serious illness are patient experience with: 1) feeling heard and understood; and 2) receiving desired help for pain. These measures were developed through a collaboration with the American Academy of Hospice and Palliative Medicine and RAND and validated in the outpatient palliative care population. These are 2 patient-reported outcome performance measures (PRO-PMs) that were endorsed by the National Quality Forum (NQF) in 2021 but have not yet been implemented into Medicare programs.
    - The measure development process incorporated patient perspective to assess what matters most to patients and families.
    - Feeling heard and understood is about listening for unmet needs that could be addressed, as well as trust building between the clinician and their patient, and provides a sense that the clinicians, patients, and caregivers are on the same team. This may not directly impact cost and utilization but can indirectly impact both (e.g. understanding when procedures are or are not aligned with patients' goals, treatment adherence, avoiding a crisis ED visit because patients and families have a goal of care plan that addresses symptom exacerbation).
    - Pain is a major driver of emergency department visits. The construction of the measure around patient experience with receiving desired help for pain incorporates the same core concept of being listened to and trusting one's clinician.
    - A starting place might be to use these measures in demonstration models focused on serious illness, like the Enhancing Oncology Model (EOM).
    - These measures evaluate quality in 2 domains (i.e., communication and pain management) where race-based inequities for patients with serious illnesses exist. Black patients and caregivers consistently report lower-quality clinician relationships and communication. Additionally, Black and Hispanic patients are less likely to be believed when they report pain and less likely to have that pain well managed.

    - These patient measures align with CMS' Strategic Plan to improve equitable care and are validated in the palliative care population. They assess key factors driving utilization and measure domains of care where inequities currently exist.
- Additional measures to consider for general use across Medicare programs are found in the hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures. These are validated measures that speak to the quality of coordination, the timeliness of care, and the quality of clinician communication. These include education for the patient and caregiver about how to manage symptoms and respond to a crisis, and assigning a point of contact to handle calls from patients after hours.
    - These measures are specific and assess the basic infrastructure that seriously ill patients need to be able to navigate adverse events safely and limit avoidable hospital care. These measures are also relevant regardless of diagnosis.
- ACO REACH is an example of a program that developed a strong foundation for quality measurement. ACO REACH focuses on addressing disparities for Medicare beneficiaries within underserved populations. The model employs measures such as the number of days spent at home, timely follow-up after acute exacerbations, and CAHPS. The ACO REACH CAHPS survey includes questions about the timelines of care received, the quality of communication, and whether patients feel they participated in a shared decision-making process with their clinicians. These are the right measures for patients with complex chronic conditions and serious illnesses and could be applied beyond the ACO REACH population.
- Traditional quality measures omit social needs, which is an important facet of patient experience and a major driver of utilization and outcomes. They cannot capture all of the patient's complex social needs and gaps in the social safety net, such as patients living in unsafe housing situations, patients who speak limited English and do not understand the instructions provided, patients who split medication doses because they cannot afford co-pays, or patients who have a cognitively impaired caregiver or a caregiver with multiples roles and responsibilities.
- In recent years, efforts have been made to collect information about patients' and caregivers' social risk factors, including the introduction of a new billing code for social determinants of health risk assessment. However, it is time to move beyond measuring patient social needs to assessing how health care plans and providers are addressing unmet social needs.

For additional details on Ms. Bowman's presentation, see the presentation slides (pages 2-13), transcript, and meeting recording (1:01-12:30).

Paul Mulhausen presented on the use of patient-reported outcomes for complex populations.

- Patient-reported outcomes amplify the voice of the patient in the assessment of value; help stakeholders move beyond process measures to include outcomes that matter to patients or members served in a health plan; and promote patient-centeredness in care and performance measurement.
- The language of patient-reported outcomes can be characterized in 3 ways: 1) patient-reported outcomes; 2) patient-reported outcome measures (PROM); and 3) patient-reported outcome performance measures (PRO-PM).
    - Patient-reported outcomes include a series of outcomes and reflections used to determine whether a patient has a problem and whether the care provided has helped them—for example, a patient reflects, "I feel depressed," or "my depression has gotten better."

  - Patient-reported outcomes can be quantified and measured. PROMs are a method by which the reported outcome can be collected into a single-item measure; for example, the Patient Health Questionnaire – 9 (PHQ-9) can be used to measure depression.
  - Translating a PROM into a PRO-PM requires aggregating the patient information into a valid and reliable measurement of performance; for example, the NQF 0711 measures the% of patients with major depression disorder and an initial PHQ-9 score > 9 and < 5 after 6 months of treatment.
- It is important to note that often a valid PROM may not always perform as well as a PRO-PM.
- It can be difficult to apply PRO-PMs to the population of people with serious illness due to their complexity. The language of population complexity can be summarized using the 5Ms: multicomplexity, mobility, medications, mind, and matters most.
  - A PROM that is disease- and episode-specific may not capture the experience or the important outcomes to a patient who has multiple conditions, caregivers, and providers, and could be receiving care across different settings. For example, home-based palliative care measures have not been validated in nursing homes or other settings. Therefore, it is important to consider how reliability and validity are being translated from one delivery setting to another.
  - The incidence and prevalence of dementia increase as people age, and dementia includes varying degrees of cognitive loss. Therefore, self-reporting surveys and tools need to be able to address these varying degrees of cognitive loss while also incorporating caregiver or proxy input.
  - It is important to be able to measure what matters most to people and ensure that performance aligns with patient goals. Many PRO-PMs are disease- and episodic-specific and may not capture an accurate experience of patients with serious illnesses.
- The majority of patient-reported outcomes fall into 6 domains: 1) health-related quality of life; 2) functional status; 3) symptoms and symptom burden; 4) health behaviors; 5) motivation and activation; and 6) patient experience and satisfaction (e.g., patient-reported experience measures [PREMs]).
- The inventory of PRO-PMs includes:
  - 615 HealthMeasures measures available in the English language;
  - 52 NQF measures, of which 30 are endorsed;
  - 57 CMS Measures Inventory Tool (CMIT) measures, of which 23 are consensus-based entity (CBE) endorsed;
  - 11 Public Access Focused on Therapeutic Outcomes (FOTO) measures (MIPS participants); and
  - 56 Partnership for Quality Measurement measures, of which 31 are CBE endorsed.
  - It is important to note that there is substantial overlap of PRO-PMs available between these different databases.
- Reliable and valid PRO-PMs that cut across domains and conditions may promote accountability in TCOC payment models. Additionally, cross-cutting PRO-PMs may address both quality and accountability needs in complex populations for serious illness. PRO-PMs that capture the performance of care coordination across comorbid disease states and providers may be uniquely valuable. Lastly, TCOC model demonstrations create opportunities for measure development and translational research that ensures reliability, validity, acceptance, feasibility, and alignment across payers.

- There are several barriers to utilizing PROMs with complex populations, including the disease and episodic focus of existing PRO-PMs, the repeated assessment of long-term conditions, the heterogeneity of measurement, and the heterogeneity of engagement.
- In summary, PRO-PMs present a high-value opportunity to bring the voice of the patient into the accountability and quality needs of TCOC payment models. Most PRO-PMs are disease-based or based on episodes of care and may not be valid or reliable performance measures in medically complex populations. Opportunities exist for measure developers and payers to develop cross-cutting PRO-PMs that more effectively meet the accountability and quality improvement needs of seriously ill, medically complex populations.

For additional details on Dr. Mulhausen's presentation, see the presentation slides (pages 14-24), transcript, and meeting recording (12:36-28:30).

Caroline Blaum presented on the development and standardization of health equity measures for patients with complex chronic conditions or serious illnesses.

- Complex patients experience fragmented care that is often burdensome, expensive, inequitable, and even dangerous.
- The majority of care for seniors with complex health statuses is not evidence-based. Major clinical trials are disease-specific and evaluate disease-specific outcomes. For example, people with multi-morbidities, disability, or frailty are not usually in clinical trials, and behavioral health and substance use disorders are poorly covered. Therefore, new and different evidence is needed that considers the uncertainty, trajectory, and complexity of patients with complex chronic conditions or serious illnesses and infuses equity throughout, using community engagement and best practices.
- The current measures for complex patients are often not relevant or exclude complex patients. They may cover important activities but can often feel like "checking a box." They also do not foster integration of personal and medical care.
- Future measures need to address equity and "what matters most" to the patient and improve communication between providers, patients, and families. They also need to be flexible and usable in many clinical settings with diverse populations and clinician types.
- There are many populations with chronic conditions and/or serious illnesses, including those with multiple chronic conditions, frailty, behavioral health conditions, substance use disorders, disabilities, sexual orientation and gender identity (SOGI) issues, and socioeconomic challenges and disparities, and those who are at end of life. Many process and structural measures currently exist that are useful; however, many are burdensome and do not address equity or issues experienced by complex patients.
    - The National Committee for Quality Assurance (NCQA) is developing measures that address social needs and social connections. Outcome measures focus mostly on intermediate outcomes (e.g., blood pressure targets, A1C targets for those with diabetes). However, patient-reported outcomes are needed to obtain comprehensive quality measures for complex patients.
- Because of NCQA's commitment to equitable care, NCQA has begun stratifying existing measures by race, ethnicity, and socio-demographics, including sexual orientation and gender identify (SOGI) information when applicable. NCQA is also considering developing new measures that include patient-generated information, such as patient experience and patient goals. It cares about current and advance care planning and measuring the delivery of gold-standard care with complex patients. NCQA works with patient partners and caregivers throughout

measure development. It is also participating in community engagement activities with individuals with lived experiences, as well as experts in the field through learning collaboratives.

- By stratifying by race, ethnicity, and other characteristics, NCQA aims to make health care inequalities transparent and to incentivize equity with benchmarks and performance scoring. Thus far NCQA has stratified by 22 HEDIS measures and developed a learning network with health care plans on the collection and reporting of race and ethnicity data and sources to access those data.
    - Not all 22 stratified HEDIS measures are targeted for patients with complex health statuses.
    - Through the learning network, NCQA has collaborated with 13 health care plans, all of which supplied qualitative data, and 11 provided quantitative data.
- NCQA also developed a new HEDIS measure within the last year—social need screening and intervention (SNS-E)—that is an electronic measure that reviews food, housing, and transportation needs using pre-specified screening instruments. If a person screens positive, they receive a corresponding intervention.
    - NCQA is working with CMS and other measure developers in ambulatory care and hospital care to ensure that all versions of the SNS-E are harmonized.
- NCQA believes that promoting health equity is accomplished through measuring what matters most to patients, their families, and their communities, and the health care system should be organized around what matters most. Specifically for people with complex care needs, their care should align with their health outcome goals. NCQA believes that measurement encourages clinicians to deliver goal-directed health care. For quality measures, health outcomes goals must be measured and tracked in a standardized way.
- NCQA has developed 3 person-centered outcomes (PCO) measures to be used for individuals with complex care needs. The first measure seeks to identify patient goals and ensure that a care plan is in place that addresses the goal. Use of this measure requires conversation and training between the clinician and the patient with the complex health status. The second measure focuses on following up and tracking identified goals (e.g., is the care plan working and helping the patient achieve their goals?). The third measure is an action outcome measure that seeks to identify those who have achieved their goals or made progress toward their goals.
- NCQA has tested these 3 PCO measures since 2018 among diverse populations, clinician types, clinical settings, and locations. It is currently working on making these PCO measures electronic.
- The analysis of the PCO measure data compares race, ethnicity, preferred language, social needs, and payer to better understand how the measure works among different populations. At least 50% of the individuals for which the measure has been used are from diverse populations.
- Qualitative testing results showed that these PCO measures improve communication and build trust among patients, caregivers, and clinicians, as well as raise clinician awareness. Quantitative results show significant decreases in hospitalizations, non-significant decreases in ED use, and improved patient experiences concerning care planning and patient activation.
- NCQA identified some best practices from this work including: 1) the importance of considering all areas of social demographic risk and location to better target inequities; 2) while race/ethnicity stratification is important, it is only 1 component; 3) linking equity to person-centered care is needed and should include identification of barriers to health and quality of life; 4) the importance of gathering perspectives from patients, families, and communities in addition to the health care industry; and 5) thinking deeply about the measurement process to ensure that equity is instilled, that people, not payment, are the focus, and that patient harm does not occur.

For additional details on Dr. Blaum's presentation, see the presentation slides (pages 25-52), transcript, and meeting recording (28:32-44:19).

David Kendrick presented on the use of technology and data to continuously improve the quality and outcomes for individuals with complex conditions or serious illnesses.

- A solid infrastructure and network are needed to ensure that data provide actionable results.
- Dr. Kendrick illustrated how scattered and fragmented the data are for 4 patients. He noted that those with complex chronic conditions or serious illnesses have the maximum data fragmentation possible. Additionally, administrative claims data are fragmented, with 20% of people changing insurance every year.
- Dr. Kendrick shared data from the 5 largest health systems in Oklahoma, highlighting the fragmentation of their data and demonstrating that patients do not solely use one health care system to meet all their health care needs. These data are consistent with Medicare data that found the average primary care provider must coordinate care with 225 other providers in 117 other organizations. In thinking about palliative care, these numbers could likely be doubled.
- Most health care providers are on an electronic health record (EHR) system. The larger health centers are using common EHR systems (e.g., Epic, Cerner, Meditech). However, patients often have medical records stored in multiple EHR systems. There is also a significant rise in the number of data sources per patient as age increases, with age being a proxy for complexity of care.
- This highlights the need for an infrastructure and network that connects all locations where patients receive health care services. It is important to note that these networks cannot rely solely on EHRs because medicine is not the only service provided; community services and federal, state, and local agencies are also involved. A community infrastructure is needed that supports networking all of these organizations.
- The MyHealth Access Network has an infrastructure available, established in 2009, that includes five million individuals with 12 years of clinical history and claims data and 6 years of social determinants of health (SDOH) data across a variety of community service organizations and health care systems.
    - All members of a team supporting a patient with complex chronic conditions have the same view of the patient's record.
- The MyHealth Access Network has changed the way it describes this infrastructure from health information exchange (HIE) to health data utility (HDU). Like an HIE, the HDU has governance with transparency, trust of stakeholders, committed service to a specific geography (i.e., state or region), substantial connectivity of health data within the service area, and cleaning and organization of individual identities and data for secondary uses. However, an HDU goes beyond an HIE in that it provides infrastructure for all community needs, use cases can be implemented within the HDU or through a range of partnerships, it integrates data from sources beyond health care (e.g., social services, education, crime), and can be used by stakeholders beyond health care (e.g., state agencies, tribal governments, employers, policymakers, homeless shelters, correctional systems).
- The HDU helps solve 4 problems with the current U.S. health care system: cost, quality, patient experience, and preparedness to respond to infectious disease outbreaks.
- Standardized patient assessment and performance measures collected within the HDU include patient-centric and system-centric measures:
    - Patient-centric measures incorporate self-reports from patients and family and include the PHQ-9; General Anxiety Disorder-7 (GAD-7); Screening, Brief Intervention, and

    Referral to Treatment (SBIRT); Accountable Health Communities (AHC); SDOH; Edmonton; and goals of care.
  - System-centric measures look at how well the team is working to support the achievement of Physician/Medical Orders for Life-Sustaining Treatment (POLST/MOLSTs), caregiver support and funding where available, family support, culture sensitivity including communication in a preferred language, and drug diversion protection.
- Dr. Kendrick shared 6 strategies to improve the technology used to collect data from patients with complex chronic conditions or serious illnesses, the timeliness of data collection, and the sharing of resulting data with providers. These include:
  - Participation with HDU/HIE by all parties engaged in the care of the patients. More than 75 HIEs/HDUs currently exist across the U.S. covering more than 300 million individuals.
  - Recognizing that patients may move beyond their current boundaries, it is important to ensure that the network has live data connections from as many sources as possible. To this end, the MyHealth Access Network developed the Patient-Centered Data Home which connects 40 of the more than 75 HIEs/HDUs that currently exist.
  - Subscribing to HDU alerting services for all admissions, discharges, and transfer events to capture all unexpected or unintentional events.
  - Utilizing referral coordination and management systems to plan and coordinate intentional care transitions for all expected and planned events.
  - Utilizing patient-centric standardized screening and referral systems for SDOH, depression, pain, happiness, and other patient-reported outcomes. MyHealth Access Network developed an SDOH mobile screening and referral application process to help reduce provider burden. Since 2018 when this application was launched, 4.6 million patients were provided the opportunity be screened, with over 1 million responding. It was found that uninsured patients have the highest need rate, and Medicaid patients have the second highest need rate. Additionally, social needs persist throughout all age groups, although patients aged 19 to 59 show the highest need rate.
  - Leveraging artificial intelligence (AI) well—for example, to communicate rapidly in the patient’s preferred language and honor their cultural heritage and background. HDU data can be leveraged to train AI models for risk identification and treatment optimization.

For additional details on Dr. Kendrick’s presentation, see the presentation slides (pages 53–100), transcript, and meeting recording (44:20-1:05:18).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (1:05:19-1:30:17).

Presenters discussed the evolution of the existing health care infrastructures and their ability to work together now and in the future, particularly when thinking about the importance of closed-loop referrals for patients with complex chronic conditions.

- Dr. Kendrick noted that health care infrastructures exacerbated the divide between social services and health care that was created several decades ago due to the mistreatment of behavioral health by medical care. The MyHealth Access Network HDU reviews all referrals equally regardless of the types of services provided. Some of the existing infrastructures are focused solely on treatment services and ignore prevention. However, screening has been found to be the biggest provider burden point and a focus of the MyHealth Access Network HDU.

- Other existing health care infrastructures such as Findhelp can be useful, particularly the closed-loop referral component. In Iowa, there has been a push to stand up a community hub that helps with data flow, on which others presented. As a clinician, there are benefits to completing assessments with patients directly rather than being presented with data via a form. It can be more challenging to integrate the data into day-to-day work or thinking about the patient when presented via a form.

Presenters discussed the proactive use of PROMs as a way of monitoring patients and whether it is performed electronically.

- PREMs are mostly used; however, they are presented to the patient in a variety of ways (e.g., hard copy, electronically, text messaging, in person) to increase the response rate. It is important to note the level of effort that goes into getting this information from patients. The majority of PREMs and PROMs available are relatively complicated—extensive surveys that can be difficult to administer. Much effort goes into ensuring that these are completed by patients and requires the use of a variety of strategies to achieve patient engagement.
- Completing PROMs and PRO-PMs are burdensome to both the provider and the patient or caregiver. One of the challenges is to ensure that the PROMs or PRO-PMs used are meaningful to patients and most important to providers. This is increasingly true among behavioral health patients, largely due to patients not feeling a sense of trust with clinicians. This highlights the fact that not all people with complex health status are the same.
- Dr. Kendrick explained that the MyHealth Access Network HDU focused first on primary prevention, which helped to increase response rates; however, there are many patients who have not responded. MyHealth Access Network is aiming to understand why patients have not responded. In many instances, the MyHealth Access Network has experienced greater trust among patients, most likely because patients are asked questions over the phone and not in person, creating a sense of confidentiality among patients.

Dr. Kendrick discussed how data utility could be used to relieve reporting burden among physicians unwilling to share their data with others, and foster true cross-community reporting at the patient, physician, and practice levels, as well as CMS' role in pushing this forward. Interoperability is powered and fueled by trust; therefore, it is important to consider how that trust can be developed. Policies and procedures have to be built that make everyone feel comfortable and adhere to national and federal standards (e.g., Health Insurance Portability and Accountability Act [HIPAA], 21st Century Cures). Governance needs to be established carefully to include competitors (i.e., competing health systems or health care plans). There also needs to be flexibility to ensure that the needs of both payers and providers are being met. CMS' role is critical as the largest payer and sets precedence for the rest of the nation; this infrastructure can exist, persist, and grow only if CMS is supportive of it. CMMI could use these nodes to deploy and test its innovation without having to do the rework of building data interoperability. CMS could also help with the competitive forces that are at play among the different reporting systems used by various community agencies and health care systems. It is also important to note that CMS is not the only federal agency with a role in data utility. Agencies such as the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) also use similar infrastructures.

Dr. Kendrick discussed the ways in which CMMI, CMS, or other regulatory bodies could leverage the HDU network. CMMI chooses regions that are eligible, and the HDU network could assist with identifying and providing metrics on those regions with good coverage, governance, and data interoperability. Giving precedence to provider groups that are already in these data exchange agreements and in a network that is actively pushing data where they need to go may also encourage other provider groups to join HDU networks.

Presenters shared their final thoughts on measuring quality and outcomes for patients with complex chronic conditions or serious illnesses.

- There are no validated quality measures that are cross-cutting across care settings and disease conditions. However, it is worth the investment in difficult data collection and measure development to create these measures. CMMI demonstrations are an excellent opportunity for measurement development and testing of PROMs. The importance of caregivers should be highlighted in this work. Caregivers need to be included in the unit of care and in the unit of quality measurement throughout development. Caregiver needs and level of distress need to be identified and addressed.
- The process measures that are available present a burden for patients and are not uniquely helpful to the care of this complex population. The work being done could help to shift the focus to what matters most to the patient and in turn might also reduce the burden in other quality reporting areas. The Guiding an Improved Dementia Experience (GUIDE) Model has a goal to develop the caregiver burden PRO-PM. This is a great example of an innovation model that addresses meaningful areas of quality that need to be promoted for complex populations.
- It is important to keep equity in mind when developing and testing new measures. There is a digital divide with complex patients, older adults, and people with disabilities who cannot access electronic materials. Additionally, some providers do not have the capability to access digital measures. Although we have the capability of addressing equity through technology, we also have the capability of making it worse if not careful. We must look at the digital divide from the point of view of all stakeholders.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day’s presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (00:02-24:56).

- The population of patients with complex chronic conditions or serious illnesses is the correct population to focus on when designing payment models to either improve or maintain quality of care while reducing Medicare costs.
- Key ingredients for models to improve the quality of care while saving costs include having an activated PCP and having the infrastructure in place to ensure availability of providers 24/7.
- Instead of measuring what matters most for this population of patients, currently diagnoses are being measured, and then payment is based on the diagnoses.
- This statement from an SME about care delivery is interesting: “We know what to do; this is an implementation issue.”
- Best practices for care delivery for this population include the following:
    - Being holistic and not disease-focused;
    - Developing effective communication and strong relationships that are culturally tailored;
    - Using close monitoring or high-touch care;
    - Conducting daily huddles to evaluate patient panels;
    - Responding promptly to acute episodic care concerns;
    - Engaging participation from both the patient and family;
    - Adding patients and caregivers to governance models;

  - Using primary management over co-management and providing more care than care management;
  - Making equity an explicit goal; and
  - Stratifying programs and data by patient characteristics rather than disease or diagnostic-only information.
- Best practices for system performance include the following:
  - Creating compelling incentives for participants;
  - Structuring incentives that ensure revenue flow;
  - Creating incentives to scale beyond pilots and ensuring that there is a focus on aligning Medicare with Medicaid strategies for these patient populations;
  - Driving attribution to primary care and thinking beyond Medicare Part B strategies;
  - Using a prospective payment to primary care and having real dollars available to create compelling incentives;
  - Protecting downside risk while developing or implementing a program;
  - Incentivizing partnerships with local and community-based safety net programs is key;
  - Eliminating friction to be more efficient, such as eliminating the reporting of data that do not impact outcomes; and
  - Considering measures that may be of high value from a risk-adjustment perspective (e.g., frailty for outcomes and risk adjustment).
- It is important to develop a reactive system with 24/7 access to disease and symptom management, as well as skill sets and systems for anticipatory management.
- Social needs should be proactively addressed in this patient population.
- Interdisciplinary teams should be developed wisely—for example, having the right number of people and roles at the table.
- Primary care is the center of this work, and further investments in primary care should be considered.
- Risk stratification should be run frequently (e.g., monthly) so that providers can observe real data when understanding what is happening for patients and their families.
- A Committee member stressed the importance of data integration. A holistic view is necessary to address health equity and health-related social needs (HRSNs).
- The correlation between social connection measures and loneliness may need to be investigated further.
- There is an emerging theme of personalization of care. Patient outcome and quality measures need to be examined to understand what exactly is being measured and what outcomes are being determined by those measures.
- Patient connection and trust is key. Outside care management organizations, virtual care management, and vendor-related care may not be as effective. Patient trust in the care provider is fundamental to getting the patient on board with their care.
- Caregivers should be compensated.
- Regarding interoperability, there are a lot of data, and not all data are contained in the EMR.
- Palliative care is necessary for all patients who need it. Patients and families who receive palliative care are happier, and palliative care saves the health system money.
- It is critical to not only engage patients but also engage their caregivers and family members. For this patient population, caregivers and family members may be able to provide more insights than the patients. Paying caregivers to participate may be a cost-effective strategy.
- While valuable from an access perspective, care coordination and virtual telephonic care may be fragmenting care and may not always deliver returns.

- We need to understand what the glide path should be to achieve CMMI's 2030 vision. A shift in prospective payment for primary care may be one solution.
- Trans-specialty care is larger than the physician's specialty. Critical contributions to the care of patients with complex chronic conditions or serious illnesses may come from community caregivers and organizations, not physicians.
- Implementing new pilots and new measures is burdensome for providers. The health data utility may revolutionize both the burden and accuracy of measures on a community-wide basis. CMS can empower this as it considers how to implement new pilots.
- We should consider ways to make the PCP medical career path more desirable. PCPs should have more power over their decisions, be compensated for outcomes and not volume, and have more control over specialists. Determining how specialists can be more reliant on the primary care base from which they are receiving patients is important. There is money in the system, and drawing from the physician fee schedule to compensate PCPs is not always the answer. The money also does not have to exclusively come from money for the specialists.
- We must have a longitudinal focus on patients with complex chronic conditions or serious illnesses because the outcomes are longitudinal.
- Meaningful, prospective, transdisciplinary, team-based payment is necessary.
- Compensating PCPs accordingly will help to achieve holistic care.
- Trust is foundational to health care. Virtual care can work if it is delivered by a trusted PCP. If care coordination comes from primary care, then virtual care can work.
- There are potential advantages to collaborating with major EMR companies. These companies can help to address challenges related to data and performance measures.
- Considerations for payment in new models include the following:
    - Baseline payments should not be reduced after 1 or 2 years. Large, up-front investments are necessary when caring for this patient population. Stable baseline payments will help.
    - Consider protecting providers in smaller organizations from downside risk if they are caring for patients with complex chronic conditions or serious illnesses.
    - It may be useful to consider a readiness template on what it takes to manage risk.
- Patients' voices are important. It is important to consider what incentives can be offered to patients and caregivers to participate, as well as to create measures that consider what matters most to patients and their caregivers.

Closing Remarks

Co-Chair Sinopoli thanked the presenters and Committee members for the day's discussions. He briefly outlined the sessions that would be occurring the next day. Co-Chair Sinopoli adjourned the meeting.

The public meeting adjourned at 4:50 p.m. EDT.

Approved and certified by:

//Lisa Shats//	8/16/2024
Lisa Shats, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date
//Lauran Hardin//	8/15/2024
Lauran Hardin, MSN, FAAN, Co-Chair Physician-Focused Payment Model Technical Advisory Committee	Date
//Angelo Sinopoli//	8/16/2024
Angelo Sinopoli, MD, Co-Chair Physician-Focused Payment Model Technical Advisory Committee	Date