

**Physician-Focused Payment Model Technical Advisory Committee  
Public Meeting Minutes**

**June 11, 2024**

**9:03 a.m. – 2:52 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<sup>2</sup> Strategies)\*

Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)\*

Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)

Terry L. Mills Jr., MD, MMM (Independent Consultant)

Jennifer L. Wiler, MD, MBA (Chief Quality Officer, UHealth Denver Metro, and Professor of Emergency Medicine, University of Colorado School of Medicine)

**PTAC Members in Partial Attendance**

Angelo Sinopoli, MD, PTAC Co-Chair (Executive Vice President, Value-Based Care, Cone Health)

Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)

Lawrence R. Kosinski, MD, MBA (Independent Consultant)

Soujanya R. Pulluru, MD (Independent Consultant)

**PTAC Members Not in Attendance**

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

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

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

Lisa Shats, PTAC Designated Federal Officer

Steven Sheingold, PhD

Nancy De Lew

***\*Via Zoom***

## List of Speakers and Handouts

### 1. Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models

Kurt Merkelz, MD, FAAHPM, Senior Vice President and Chief Medical Officer, Compassus\*

Natalie C. Ernecoff, PhD, MPH, Full Policy Researcher, RAND\*

Ira Byock, MD, FAAHPM, Emeritus Professor of Medicine and Community & Family Medicine, Dartmouth Geisel School of Medicine\*

Betty Ferrell, RN, PhD, Director and Professor, Division of Nursing Research and Education, Department of Population Sciences, City of Hope\*

#### Handouts

- Listening Session 2 Day 2 Presenters' Biographies
- Listening Session 2 Day 2 Presentation Slides
- Listening Session 2 Day 2 Facilitation Questions

### 2. CMS Panel Discussion

Susannah Bernheim, MD, MHS, Chief Quality Officer and Acting Chief Medical Officer, the Centers for Medicare & Medicaid Services (CMS), Center for Medicare & Medicaid Innovation (CMMI)

Jacob Quinton, MD, MPH, Medical Officer, Patient Care Models Group, CMS/CMMI

Suzanne Wensky, PhD, Director, Division of Health Systems Research, Research and Rapid Cycle Evaluation Group, CMS/CMMI

David Nyweide, PhD, Social Science Research Analyst, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Independence at Home Demonstration, CMS/CMMI

Julia Driessen, PhD, Economist, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Medicare Advantage Value-Based Insurance Design Model, CMS/CMMI

Meghan Elrington-Clayton, MPH, Director, Division of Financial Risk, CMS/CMMI\*

Laura Missett, MPA, Model Lead, Kidney Care Choices Model, Seamless Care Models Group, CMS/CMMI

Tonya L. Saffer, MPH, Director, Division of Healthcare Payment Models, Patient Care Models Group, CMS/CMMI

#### Handouts

- CMS Panel Discussion Day 2 Panelists' Biographies
- CMS Panel Discussion Day 2 Introduction Slides

### 3. Listening Session 3: Best Practices for Incentivizing Improved Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models

Marie P. Bresnahan, MPH, Director of Training, Policy, and Administration in the Viral Hepatitis Program (VHP), New York City Department of Health and Mental Hygiene (*Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus [HCV] using care coordination by employed physicians in hospital outpatient clinics proposal*)\*

Bruce R. Schackman, PhD, Saul P. Steinberg Distinguished Professor and Executive Vice Chair, Department of Population Health Sciences, Weill Cornell Medicine; and Director, Center for Health Economics of Treatment Interventions for Substance Use Disorder, HCV, and HIV (CHERISH)\*

Jason H. Feuerman, President and Chief Executive Officer, LTC ACO\*

Bruce Leff, MD, Professor of Medicine and Director, Center for Transformative Geriatric Research, Division of Geriatric Medicine, The Johns Hopkins University School of Medicine\*

Diane E. Meier, MD, FACP, Founder, Center to Advance Palliative Care\*

### **Handouts**

- Listening Session 3 Day 2 Presenters' Biographies
- Listening Session 3 Day 2 Presentation Slides
- Listening Session 3 Day 2 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 Overview**

Angelo Sinopoli, PTAC Co-Chair, welcomed the Committee and members of the public to the second day of the June 10–11, 2024, public meeting. He explained that the first day of the public meeting included opening remarks by Elizabeth (Liz) Fowler, from the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI), about CMMI models that target seriously ill populations. The Day 1 proceedings also included several guest speaker presentations on providing patient-centered care, improving outcomes, and measuring quality for patients with complex chronic conditions or serious illnesses in population-based total cost of care (PB-TCOC) models. Co-Chair Sinopoli then reviewed the agenda for the day, noting that guest speakers represent a variety of perspectives, including previous PTAC proposal submitters who addressed relevant issues in their proposed models.

Co-Chair Sinopoli indicated that a public comment period would be held in the afternoon. Participants must register to provide an oral public comment, and public comments are limited to 3 minutes. He stated that the meeting would conclude with Committee discussion of comments for inclusion in the report to the Secretary (RTS). Co-Chair Sinopoli then invited Committee members to introduce themselves and their experience with addressing the needs of patients with complex chronic conditions or serious illnesses in PB-TCOC models. Following Committee member introductions, Co-Chair Sinopoli acknowledged James (Jim) Walton's contributions to the meeting preparations although he was not in attendance.

### **Listening Session 2: Optimizing the Mix of Palliative Care and End-of-Life Care in PB-TCOC Models**

#### **SMEs**

- Kurt Merkelz, MD, FAAHPM, Senior Vice President and Chief Medical Officer, Compassus
- Natalie C. Ernecoff, PhD, MPH, Full Policy Researcher, RAND
- Ira Byock, MD, FAAHPM, Emeritus Professor of Medicine and Community & Family Medicine, Dartmouth Geisel School of Medicine
- Betty Ferrell, RN, PhD, Director and Professor, Division of Nursing Research and Education, Department of Population Sciences, City of Hope

Co-Chair Lauran Hardin moderated the listening session with 4 SMEs on optimizing the mix of palliative care and end-of-life care in PB-TCOC models. Full [biographies](#) and [presentations](#) are available.

Kurt Merkelz presented on opportunities for enhancing palliative care and related outcomes in PB-TCOC models.

- There is a lack of defined methods to meet the outcomes that are most important for this patient population.
- The current model used to treat the population of patients with serious illnesses is flawed when applied to the older adult population with a chronic illness. For example, care plans can be ineffective because they do not align with the realities of aging with chronic illness management.
- Dr. Merkelz shared that his work aims to improve and standardize care delivery to address gaps in post-acute care settings, including the overemphasis on acute medicine coupled with biomechanical rehabilitation. The current model assumes restoring function and health is possible and desirable. However, for the aging population, particularly for individuals with chronic illnesses, this goal is often unattainable.
- Dr. Merkelz's work has been influenced by the RIGHTCARE Foundation. The RIGHTCARE model includes substantive outcomes that are aligned with specific actions necessary to bring about desired change.
- Palliative care is the driver of outcome-focused care.
- Care for seriously ill patients should be focused on substantive outcomes, not independent goal attainment. Family members and caregivers should be partners in the care provision, which should be focused on meeting the needs of the patient and not on self-reliance.
- The care plan for patients admitted to rehabilitation hospitals, skilled nursing facilities (SNFs), long-term acute care hospitals (LTACHs), and home health focuses on physical performance and self-reliance activities. However, this focus can lead to high safety risk and low medication adherence and does not consider burden of care or quality of life.
- Using an outcomes-focused methodology for palliative care can raise the bar for high-value care for individuals with serious illness. He suggested that we need to de-emphasize medication and symptom management and instead focus on family support and proactive management. It is important to ensure compliance, monitor changes early, and mitigate risk to keep patients stable.
- A well-defined care model provides a comprehensive framework that includes training, treatment planning, tools, and metrics to validate goal attainment. This framework can equip a wide range of stakeholders.
- Individualizing standard care practices can support improvements in current quality reporting programs.
- Compassus used the care delivery model and achieved Community Health Accreditation Partner (CHAP) certification as an age-friendly provider. This opportunity extends beyond post-acute care services and goes directly into our communities. First responders, emergency rooms (ERs), and community providers can join forces and help the community be a risk-reduction program.
- Palliative care guiding substantive outcome methodologies can transform care for patients with serious illnesses.

For additional details on Dr. Merkelz's presentation, see the [presentation slides](#) (pages 2-16), transcript, and [meeting recording](#) (08:13-19:28).

Natalie Ernecoff presented on lessons learned about providing concurrent hospice services.

- The Medicare Hospice Benefit does not cover disease-directed therapies that are related to the primary hospice diagnosis. Because hospices are unable to afford coverage of many disease-directed therapies, hospices often require discontinuation of disease-directed therapies before enrolling. Patients who could benefit from disease-directed therapies are often forced to choose between therapies that can improve their quality of life versus hospice care. As a result, few patients elect Medicare's Hospice Benefit. Patients who elect the benefit tend to do so near the end of life.
- Concurrent care is the continuation of disease-directed therapies upon enrollment in hospice to support patient goals as they approach the end of life.
- Dr. Ernecoff described findings from several evaluations of concurrent care, including concurrent care in pediatrics, Veterans Affairs (VA) settings, and end-stage kidney disease. A VA evaluation of concurrent care for patients with cancer showed that chemotherapy was used after hospice enrollment and led to fewer intensive care unit (ICU) admissions and cost savings. There was no change in survival between patients who received concurrent care in hospice versus typical hospice services.
- Dr. Ernecoff developed a collaborative program between nonprofit hospice and dialysis companies where they negotiate a contract rate to cover the cost of dialysis treatment and transportation. Findings showed approximately half of the enrollees did not use any dialysis after enrolling in hospice. Patients who received dialysis upon hospice enrollment had a mean hospice length of stay of 17 days.
- The Medicare Care Choice Model (MCCM) paid a higher per capita fee for hospices. Eligible diagnoses were limited to cancer, chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), and human immunodeficiency virus (HIV) / acquired immunodeficiency syndrome (AIDS). The MCCM program was associated with decreased inpatient care utilization, lower costs, and higher caregiver-reported experience. Many hospices withdrew from the model and cited difficulties with identifying eligible patients.
- The Value-Based Insurance Design (VBID) model integrates hospice into Medicare Advantage. In this model, hospices can provide transitional concurrent care at a higher per capita fee in the first month of enrollment. Early findings indicate low enrollment into the model and in hospice. There was no change in hospice utilization between VBID participating comparison plans in the first year. The VBID model will sunset in 2024, and the evaluation will continue.
- Components of effective concurrent care include accurate patient identification and referral pathways; good communication and workflows; education and engagement for clinicians, patients, and families; and coordinated care.
- Dr. Ernecoff described 2 main takeaways from the presentation:
  - Concurrent care is a feasible and effective option to promote timely, patient-centered care and retain autonomy near the end of life.
  - Payment models for concurrent care require operational clinical models. Models should include modifiable care plans, interdisciplinary care coordination, clear workflows, education, and ongoing communication between clinicians, patients, and families.

For additional details on Dr. Ernecoff's presentation, see the [presentation slides](#) (pages 17-33), transcript, and [meeting recording](#) (19:35-33:39).

Ira Byock presented on patient perspectives and physicians' roles in caring well through the end of life.

- Dr. Byock provided an overview of the culture of mainstream Western medicine, which views illness and injury through a problem-based lens. However, from a patient's perspective, health, illness, and injury are personal. When an individual receives a serious diagnosis, their family shares the illness.
- Patients mention the names of other people when asked what matters to them the most. Patients do not want to be a burden or to suffer; they want to retain dignity and feel heard, seen, and understood.
- Personal well-being through the end of life can be fostered with a shift of focus from caring for illness and injury to caring for the whole person.
- Dr. Byock developed a continuum of human caring that is built on Maslow's Hierarchy of Needs. The model includes human essentials (e.g., food, shelter) and the medical problem-based model, as well as personal opportunities.
- Dr. Byock described the Institute of Medicine's 6 component taxonomy of quality. One of the components was patient-centered care. Decisional support is a major opportunity to transition from the medical problem-based model to a whole-person approach.
- Physicians often avoid advance care planning (ACP) and goals of care (GOC) conversations because conversations about death and dying are uncomfortable. These conversations can have a major impact on the patient's decisions, such as what treatments they choose versus avoid. These conversations can also be a source of professional satisfaction for clinicians.
- Quality standards are needed for ACP and GOC conversations and to normalize these types of conversations.
- Shared decision-making is a partnership between the physician and patient.
- A team-of-teams approach is needed to do the best job possible. Palliative care is one team that should be involved when people have a serious illness.
- Dr. Byock presented research findings from the Providence Health System indicating that the greatest code status change was among patients who received palliative care and had a GOC conversation. In addition, people who had GOC conversations had higher satisfaction with their care.
- Concurrent palliative care should be normalized; palliative care is an extra layer of support.
- Dr. Byock described research findings showing that patients who received palliative care earlier versus later had fewer days in the hospital.
- Physicians can assist patients with shared decision-making and treatment decisions, accompany individuals through difficult times, improve patients' well-being, and preserve and foster patients' opportunities to grow through the end of life.
- There already is an existing model that works: concierge medicine. Patients want a concierge physician. This model may improve clinician satisfaction.
- Several promising approaches for caring for this patient population include the following:
  - Personalizing the electronic health record (EHR) so it is less problem-based;
  - Incorporating social determinants of health (SDOH) and quality of life indices into the EHR;
  - Showing patients' thumbnail photos in the EHR;
  - Using artificial intelligence (AI) to change how patient-reported outcome measures are collected; and
  - Using whole-person, well-being dashboards.

For additional details on Dr. Byock's presentation, see the [presentation slides](#) (pages 34-59, transcript, and [meeting recording](#) (33:40-48:19)).

Betty Ferrell presented on addressing the workforce challenges related to caring for patients with complex chronic conditions or serious illness through clinical leadership.

- Nurses are pivotal to the workforce in serious illness care. Nursing care is central to the patient's and family's understanding of illnesses, how patients manage distressing symptoms, and how patients transition between health care systems.
- Nurses are a key component to creating a better health care system.
- Advanced practice nurses (APNs) are underutilized in serious illness care and have untapped potential to manage patients with serious, complex illness.
- *The Future of Nursing 2020–2030* report concluded that nurses are vital in providing initial assessment of needs of diverse populations, caring during diseased focused-care, supporting transitions to palliative care, initiating hospice care, managing urgent needs, supporting family caregivers, providing telehealth, and providing care at the end of life.
- Quality palliative care is the kind of care a person would want if they or a loved one was diagnosed with a serious illness. This care includes patient-centered care that attends to physical, psychological, social, and spiritual needs.
- Best practices for palliative care include assessment of the person and their family needs, assessment of symptoms and quality of life concerns, obtaining a clear understanding of the goals of care, providing early integration of palliative care, providing an early referral to hospice, and providing access to support for symptoms and changing needs.
- The Generalist-Specialist Model of Nursing in serious illness care, where clinicians can serve as generalists in palliative care, should be used across all settings.
- Dr. Ferrell described a National Cancer Institute (NCI)-funded project that recruits and trains oncology APNs to integrate palliative care into their oncology practice. At 12-month follow-up, documented changes in practice included increased family meetings, increased communication with oncologists and patients about prognosis and goals of care, increased referrals of families for bereavement support, and increased support for clinical staff supporting end-of-life care.
- Quality palliative care applies to every setting of care, including home care and nursing homes. Improvement of care in nursing homes begins with the workforce. The workforce should have competitive wages and benefits, appropriate staffing, education and training, and data collection and research methods.
- Dr. Ferrell described the End-of-Life Nursing Education Consortium (ELNEC), a partnership between City of Hope and the American Association of Colleges of Nursing (AACN). ELNEC trains nurses to improve serious illness care using the national guidelines for serious illness care. These guidelines informed the curricula used to teach clinicians to provide quality palliative care, including pain and symptom management, ethical issues, cultural and spiritual care, communication, loss and grief for patients and their families, and care in the final hours. The project uses a train-the-trainer model. Currently, it has trained over 1.5 million clinicians across disciplines.
- The nursing workforce is essential to transforming serious illness care.

For additional details on Dr. Ferrell's presentation, see the [presentation slides](#) (pages 60-76), transcript, and [meeting recording](#) (48:20-1:02:20).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (1:02:21-1:38:16).

Presenters discussed approaches to performance measurement within the context of palliative and hospice care in PB-TCOC models.

- We have national guidelines that define important dimensions to measure, such as pain management. We have identified key outcome measures for palliative care and those that are important to patients and their families.
- Families are burdened by polypharmacy and understanding a medication regimen. Patients often do not understand the importance of how to take medications. There is no system in place to validate whether the patient's medication system is correct. In addition, patients must know what to monitor and how to respond when problems occur.
- A focus solely on outcome measures may underemphasize structure and process measures. Structure and process measures are needed to deliver high-quality, value-based care.
- We must also measure the care experience and whether needs are met.

Presenters discussed how they address health equity within their organizations.

- Health equity needs to be integrated into all aspects of health care. Serious illness care is not one-size-fits-all. It is necessary to understand patients at the initial encounter to provide them with the best care.
- Clinicians need frontline training, actions, and tools to drive their performance and ensure that patients receive quality care.
- To transform the way care is delivered, the medical model needs to be made more porous to the needs and lived experiences of patients and their families.
- It is important to identify and be mindful of patients' structural barriers, such as living in a rural area with transportation barriers.

Presenters provided recommendations on how to change payment policy to better utilize palliative care services in the fee-for-service (FFS) environment.

- Although changes in payment policy are necessary, we also need to improve accounting practices. Palliative care is often viewed through the lens of a profit-and-loss (P&L) sheet, which always shows it losing money. However, palliative care reliably reduces TCOC, primarily by reducing the area under the curve of days in the hospital.
- Palliative care must be linked to a larger cost center—the entity that bears the patient's financial risk of TCOC—so the risk-bearing cost center sees the benefit of the losses or the lack of meeting its expenses that the palliative care cost center will realize.
- Increasing reimbursement for clinicians, home visits, and home-based level of care should be considered. Providing reimbursement for these types of activities leads to returns on TCOC. In addition, providing clinicians with meaningful outcomes can help them to feel empowered by the care they provide.
- The cost of treatment to meet the needs of people who receive hospice should also be considered. People are living much sicker for much longer, and their needs are more acute. Some of the disease-specific CMMI models are beginning to address this limitation of the hospice payment model.
- Patients in clinical trials often receive disease-focused therapy rather than a well-designed system of care. As a result, many of these patients end up in the emergency department (ED) and without advanced directives. We need to move beyond the dichotomy between patients either receiving palliative care to improve their quality of life or receiving care for their disease.

Presenters discussed whether the mortality metric serves as a perverse incentive (e.g., to have people enter hospice so they can be removed from the denominator of the mortality metric). In addition, presenters discussed whether perverse incentives exist to avoid ACP and GOC conversations in inpatient hospital settings given the challenges in receiving care in the post-acute and home-based space.



Presenters also discussed opportunities for payment policy outside of the TCOC space to improve performance and payment for palliative and hospice care.

- The mortality scores have not been particularly helpful except for procedurally focused specialties.
- We continue to avoid penalizing clinicians or systems that do not have GOC conversations or have advanced directives on file. Further, we continue to fund models that lack key components of quality and patient care.
- The United States' current misaligned, over-regulated health system impacts the ability to provide care. While the Medicare Hospice Benefit saves the health care system money, even for patients with long hospice stays, hospices are penalized for having long length-of-stay patients.
- Dying in a hospital is not inherently a sign of poor-quality, end-of-life care, or discordant with goals. Some patients are acutely ill near the end of life. Instead of getting patients into hospice at all costs, providing comfort-focused care in hospital settings should be considered. Comfort-focused care can also relieve caregiver burden.
- Family caregivers and social issues play a large role in the quality of patients' care. There are not currently many patient-centered models that recognize this role.

Presenters discussed their experiences with technology-enabled patient engagement and symptom management entities to decrease P&L (profit and loss).

- Goal alignment and decisional support are key to transforming care. There are technology-enabled solutions that can help with goal alignment to ensure that patients are routinely assessed on their symptoms, sources of stress, and major concerns so the health care team can address the patients' key priorities within the context of their households and families.
- There are models for remote symptom monitoring. For example, one model provides patient education for guidance on what to do based on different levels of symptoms.
- Predictive analytics can be leveraged to gauge the right time to increase interactions with the patient. If a patient is showing signs of higher risk of mortality, clinicians can increase the frequency of their visits and appropriately utilize resources.
- AI and EHRs may be able to help with prognostic prediction or to systematically identify patients with repeat acute encounters. This may help providers be more purposeful about GOC conversations or to know when to consider changing care plans.

## **CMS Panel Discussion**

### **SMEs**

- Susannah Bernheim, MD, MHS, Chief Quality Officer and Acting Chief Medical Officer, the Centers for Medicare & Medicaid Services (CMS), Center for Medicare & Medicaid Innovation (CMMI)
- Jacob Quinton, MD, MPH, Medical Officer, Patient Care Models Group, CMS/CMMI
- Suzanne Wensky, PhD, Director, Division of Health Systems Research, Research and Rapid Cycle Evaluation Group, CMS/CMMI
- David Nyweide, PhD, Social Science Research Analyst, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Independence at Home Demonstration, CMS/CMMI
- Julia Driessen, PhD, Economist, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Medicare Advantage Value-Based Insurance Design Model, CMS/CMMI
- Meghan Elrington-Clayton, MPH, Director, Division of Financial Risk, CMS/CMMI

- Laura Missett, MPA, Model Lead, Kidney Care Choices Model, Seamless Care Models Group, CMS/CMMI
- Tonya L. Saffer, MPH, Director, Division of Healthcare Payment Models, Patient Care Models Group, CMS/CMMI

Co-Chair Sinopoli moderated the panel discussion with eight subject matter experts (SMEs) offering their perspectives on the CMMI serious illness portfolio. For additional details, please see the transcript and [meeting recording](#) (00:03-57:52).

Panelists introduced themselves and provided background and lessons learned from the implementation and evaluation of past and current CMMI models that address the needs of Medicare beneficiaries with complex chronic conditions or serious illnesses. Full [biographies](#) and [panelist introduction slides](#) are available.

- Susannah Bernheim noted that the CMS panel discussion would focus on 6 CMMI models developed to address the needs of patients with complex chronic diseases or serious illnesses. The 6 models include both prior models previously evaluated and current, as well as recently announced, models.
  - Dr. Bernheim shared that CMMI was given the authority to test new payment and service delivery models; models could be expanded if found to maintain or reduce spending and maintain or improve quality. However, even when CMMI models are not expanded, they may still contribute to lessons learned or transition to other models. For example, the Accountable Care Organization (ACO) Investment Model (AIM) was pulled into the Medicare Shared Savings Program (MSSP) and renamed the Advanced Investment Payment Program.
- Jacob Quinton outlined the goals of the CMS panel discussion. The panel would provide a quick snapshot of the work currently being done by CMMI to address the needs of Medicare beneficiaries with complex chronic conditions or serious illnesses. The models described during the panel discussion would provide an overview on how the serious illness model portfolio has progressed over the last decade. Dr. Quinton shared the CMMI models that staff will present on today: the Medicare Care Choices Model (MCCM), the Independence at Home (IAH) Demonstration, the Value-Based Insurance Design Hospice Component (VBID Hospice), the ACO Realizing Equity, Access, and Community Health (REACH) High-Needs Model, the Kidney Care Choices (KCC) Model, and the Guiding an Improved Dementia Experience (GUIDE) Model.
  - Dr. Quinton shared that the IAH Demonstration ran from 2012 through 2023; MCCM ran from 2016 through 2021. The VBID Hospice, ACO REACH, and KCC Models are currently running, and the GUIDE Model was just announced.
- For additional details on Dr. Bernheim’s and Dr. Quinton’s backgrounds and organization, see the [panelist introduction slides](#) (slides 3-6).
- Suzanne Wensky introduced herself as the Director of the Division of Health Systems Research in the Research and Rapid Cycle Evaluation Group at CMMI.
  - Dr. Wensky shared the evaluation findings from the MCCM. The MCCM was designed to test a new option for Medicare beneficiaries to receive treatment for terminal conditions while also receiving supportive care from participating hospices. In contrast, the Medicare Hospice Benefit forces patients to forgo curative treatment for their terminal conditions to receive hospice care. To be eligible for MCCM, beneficiaries must have had cancer, COPD, CHF, or HIV/AIDS; a life expectancy of 6 months or less; and not be enrolled in the Medicare Hospice Benefit.

Over 6 years, 7,263 beneficiaries enrolled in MCCM. Enrolled beneficiaries received assessments, care plan development, care coordination, symptom management, 24/7 access to a care team, and counseling.

- CMMI found that MCCM enrollees spent more days at home and were 15 percentage points less likely to receive aggressive, life-prolonging treatment in the last 30 days of life. MCCM reduced net Medicare expenditures by 30%, mainly by decreasing hospitalizations and increasing hospice use earlier in the disease trajectory. MCCM enrollees and caregivers reported high levels of satisfaction with the care they received under the model. However, despite these favorable outcomes, the model suffered from low model uptake and low market penetration, limiting the generalizability of these results.
- Only 3% of all hospices nationwide participated in MCCM, and only 5 participating hospices enrolled 46% of MCCM beneficiaries. Many Medicare beneficiaries were not eligible for enrollment because they were enrolled in Medicare Advantage, and many of the participating hospices were in markets with high Medicare Advantage penetration. Other factors that contributed to low model participation or withdrawal included the fact that MCCM was a voluntary model, MCCM payments did not sufficiently cover operating expenses according to participants, and many MCCM hospices were affiliated with a palliative care program.
- Hospices that were successful in enrolling beneficiaries, providing high-quality care, and reducing Medicare expenditures, were those that implemented a “no wrong door” referral policy, gained enrollees’ trust, engaged enrollees and caregivers in ongoing education, and provided enrollees with a person to call after hours.
- Although CMS did not expand MCCM, it is a promising approach to transforming care delivery at the end of life. Palliative care and concurrent hospice care continue to be tested in the ACO REACH and the KCC Models.
- For additional details on Dr. Wensky’s background and organization, see the [panelist introduction slides](#) (slides 7-12).
- David Nyweide introduced himself as a Social Science Research Analyst in the Research and Rapid Cycle Evaluation Group and the Evaluation Lead for the IAH demonstration at CMMI.
  - IAH was a demonstration authorized by Congress so CMMI did not have control over the timeline and key design and evaluation parameters of the demonstration. The key goals of IAH were to reduce total spending and improve the quality of care for high-need, high-cost patients seen by practices that specialize in home-based primary care. In return, those practices could earn incentive payments similar to shared savings in ACO-type models. Patient eligibility criteria included enrollment in Medicare FFS, not in long-term care or hospice, having at least 2 chronic conditions, requiring human assistance with at least 2 activities of daily living, and being hospitalized and receiving acute or subacute rehabilitation services in the prior 12 months.
  - CMMI found that using event-defined eligibility was problematic because if the event was high-cost, patients will most likely experience a downward trajectory in cost after the event. At the same time, incentive payments had an upward trajectory from a national cost trend from the prior year. The divergence in these 2 trends became apparent when an evaluation determined in 2019 that there was no difference in spending between IAH patients and the comparison group. Setting accurate target expenditures can be difficult and was compounded in IAH due to the relatively small number of patients in each of these practices.

Spending among a small number of expensive patients tends to be more volatile and makes hitting target expenditures accurately more difficult.

- Throughout the demonstration, a median practice had 400 to 500 patients. The total number of patients reached as high as 10,000 patients in Year 5; however, the number greatly declined as many practices switched to participate in other CMMI models. Further, to evaluate total spending, evaluators had to pool all patients across all practices because spending at the practice level was unstable and unreliable due to low numbers.
- Through the first 8 years of the demonstration, only 2 years showed statistically significant decreases in total spending. It is possible there could have been decreases in total spending in other years; however, the small number of practices and patients did not allow evaluators to see a decrease.
- Of note, only 4% of Medicare FFS beneficiaries were possible targets for this demonstration, and practices had a difficult time reaching critical mass. If designing a model similar to IAH in the future, it would be important to make the accountable unit larger than a single practice.
- The practices at IAH were responsible for 6 quality measures. They could qualify for incentive payments if they met performance thresholds for any 3 of the 6 quality measures. In addition, practices had to keep costs below their individual spending targets. Most practices were successful at meeting the performance threshold for the 3 quality measures when choosing claims-based measures. Practices were not as successful with meeting the threshold for site-reported measures, mostly because practices did not report site-reported measures.
- 3 key takeaways from the IAH demonstration design were: 1) avoid event-based patient eligibility; 2) consider the size of participating entities and the accountable unit; and 3) when using participant reporting quality measures, ensure that those are tied to the incentive structure of the model.
- For additional details on Dr. Nyweide's background and organization, see the [panelist introduction slides](#) (slides 13-19).
- Julia Driessen introduced herself as an Economist for the Research and Rapid Cycle Evaluation Group and the Evaluation Lead for the Medicare Advantage VBID Model at CMMI.
  - The VBID has been in operation at CMMI since 2017. Dr. Driessen focused on the hospice component of the VBID Model, which began in 2021 and will conclude on December 31, 2024. This model allows Medicare Advantage Organizations (MAOs) to include the hospice benefit as part of their benefit packages. For participating plans in the VBID Hospice model, in addition to the Medicare Hospice Benefit, they were also required to offer related services including palliative care and transitional concurrent care. The plans had flexibility with setting up their benefit structure. They also had the option to offer supplemental benefits related to hospice. Additionally, while the network adequacy requirements were phased in over a period of time, beneficiaries maintained their choice of hospice. In 2021, nine MAOs entered 49 plans into VBID Hospice. Currently, in 2024, there are 13 MAOs and 78 plans participating. The last 2 evaluation reports released for VBID in 2022 and 2023 included a separate evaluation of VBID Hospice assessing results from Performance Years 2021 and 2022.
  - There was significant variation in how MAOs approached operationalizing the model, such as network formation, concurrent care criteria, and palliative care models. Further, plans newly entering the model reported more substantial implementation challenges versus plans entering their second year in the model.

Educating providers and patients to ensure understanding of the hospice benefit and when it may be needed was a challenge for participating plans, and reporting requirements, administrative processes, and reimbursement issues were deemed to be challenges for participating hospices.

- Utilization of model services was lower than MAOs expected. In the first 2 years of implementation, the model evaluation did not identify an impact on hospice enrollment or care patterns. However, the evaluation did show a small increase in positive hospice care experience for those participating in the model.
  - Qualitative interviews were conducted with participating plans, hospices, and beneficiaries. Many recipients of palliative care were not familiar with the services; however, those who were aware reported positive experiences.
  - VBID Hospice is the first model or program to offer the Medicare Hospice Benefit outside of traditional Medicare. Key takeaways include: 1) new collaborations (e.g., between plans and hospice) create opportunities for improved coordination; however, they take time to establish; 2) new services require substantial education for all entities; 3) there is inherent tension between trying to provide flexibility for participants and being prescriptive; and 4) plans were met with substantial administrative requirements to operationalize the Medicare Hospice Benefit.
- For additional details on Dr. Driessen’s background and organization, see the [panelist introduction slides](#) (slides 20-24).
  - Meghan Elrington-Clayton introduced herself as the Director of the Division of Financial Risk at CMMI.
    - The ACO REACH model is one of CMMI’s initiatives to help address the needs of seriously ill patients within ACOs. The high-needs population ACOs were designed to facilitate high-quality, high-touch, tailored care to Medicare beneficiaries with complex health care needs. The high needs ACO type allows participation by organizations focused on complex high-needs beneficiaries to test whether provider-led entities can replicate the successful clinical approaches of the Program of All-inclusive Care for the Elderly (PACE) and similar models of care in a broader Medicare FFS population. These approaches focus on interdisciplinary teams that emphasize preventive care and meet regularly to update patient care plans in response to changes in functional and health status. In addition, these approaches aim to manage patients’ care across all settings, facilitate smooth transitions between settings, and reduce hospital readmissions.
    - Traditional ACO components such as risk-adjustment methodology have been less compatible with the dynamic and high-acuity profile of the sickest and costliest patients. CMMI made 4 key design changes for high needs ACOs: 1) to qualify for alignment, beneficiaries had to meet a minimum risk score threshold, have a post-acute utilization level, or have mobility/frailty status; 2) lowered the beneficiary population size for high needs ACOs due to their smaller panel sizes; 3) based benchmarks for high needs ACOs on regional expenditures (versus historical expenditures for traditional ACOs); and 4) used a modified risk-adjustment model, the CMS Hierarchical Condition Category (HCC) concurrent risk adjustment model, to better capture rapid changes in health status as patients become seriously ill.
    - High needs ACOs prioritized investments in expanding staffing capacity, practice-level infrastructure, complex care management, and enhanced primary care, including offering behavioral health and extended hours. They have made greater use of primary care advanced practice providers, such as nurse practitioners and physician assistants, and provide home-based touchpoints of care.

An evaluation found that high needs ACOs are associated with an increase in hospice use and a decrease in other post-acute utilization. In addition, high needs ACOs are serving a greater percentage of dually eligible patients and patients from racial and ethnic minority groups than traditional ACOs. Individuals can learn more about the impact of high needs ACOs in the second annual evaluation report for the ACO REACH model, which is expected to be released in the summer of 2024.

- It remains a challenge to define high-needs eligibility criteria. Because of small population sizes and high mortality rates, high needs ACOs have found it challenging to grow. Further evaluation of the CMS-HCC concurrent risk-adjustment model is needed to determine incorporation of additional subpopulations and care models. High needs ACOs tend to generate more shared savings than traditional ACOs, which may be expected due to risk-adjustment benchmarking policies that are designed to maximize their payment stability. However, further exploration is needed to determine if the current incentives policy is appropriately balanced with net savings potentials for the month.
- For additional details on Ms. Elrington-Clayton’s background and organization, see the [panelist introduction slides](#) (slides 25-29).
- Laura Missett introduced herself as the Model Lead for the Kidney Care Choices (KCC) Model within the Seamless Care Models Group at CMMI.
  - The KCC Model focuses on patients with chronic kidney disease stages 4 and 5 or end-stage renal disease (ESRD), and transplant beneficiaries. Beneficiaries are aligned to nephrology professionals instead of dialysis facilities to promote early intervention. Two different risk options are offered: 1) the CMS Kidney Care First Option (KCFO) for nephrology practices only; and 2) the Comprehensive Kidney Care Contracting (CKCC) option for nephrology practices, transplant participants, and others who provide kidney care.
  - This model introduced 3 innovative payments: 1) the chronic kidney disease quarterly capitated payment (CKD QCP); 2) the home dialysis true-up payment (HDTU); and 3) the kidney transplant bonus (KTB).
  - Currently, model implementation is at the halfway point with approximately 130 model participants and will be ending on December 31, 2026.
  - In the first 2 years, the retrospective trend adjustment (RTA) was larger than anticipated; therefore, risk corridors are being added beginning in Year 3. The model has exceeded participant expectations with 100 ACO participants from 10 organizations. Further, there are more care coordination organizations participating in the model than expected.
  - Challenges include difficulty with benchmarking and small population sizes. The small population also makes it difficult to meet beneficiary minimums for the evaluation. There are also challenges in deciding which procedures, medications, and devices to carve out for the model. Further, there are challenges with beneficiary attribution, participation in other models/programs, determining how to measure quality of life for patients, and difficulties with implementing Benefit Enhancements (BEs) such as the Concurrent Care BE or the Kidney Education BE. The first evaluation results will be released at the end of the summer 2024.
- For additional details on Ms. Missett’s background and organization, see the [panelist introduction slides](#) (slides 30-33).
- Tonya Saffer introduced herself as the Director of the Division of Healthcare Payment Models in the Patient Care Models Group at CMMI.

- The GUIDE Model will be launched July 1, 2024, through which CMMI will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can achieve 3 primary objectives: 1) improve quality of life for people with dementia and their caregivers; 2) delay avoidable long-term nursing home care; and 3) enable more people to remain at home through end of life. Services are required to be delivered by an interdisciplinary care team comprised of a clinician with dementia expertise, as well as a care navigator.
- Medicare beneficiaries must be enrolled in FFS, not reside in a long-term nursing home, not have elected the Medicare Hospice Benefit, and not be enrolled in PACE. Prior diagnosis of dementia is not required due to the current underdiagnosing and/or misdiagnosing of dementia. Two validated publicly available tools will be available to assess whether patients have mild, moderate, or severe dementia, and patients will be subsequently placed into model tiers based on the assessment.
- The GUIDE Model includes 8 care delivery requirements, including caregiver respite to reduce caregiver burden, which represents the first time Medicare will pay for caregiver services. The goal is to reduce caregiver strain and nursing home placement. CMMI also will collect data on caregivers who are enrolled in Medicare FFS to assess the impact that respite might have on caregiver health and use of health care services.
- GUIDE is not a shared savings or capitated model. Participating dementia care programs will receive a monthly Dementia Care Management Payment (DCMP). The DCMP will be billed using G-codes under the physician fee schedule that are tied to whether the person living with dementia has a moderate or severe status, whether they have a primary caregiver, and the strain of that caregiver, resulting in different tiers for payment. The tiered DCMP will then be adjusted based on provider performance on a set of metrics, as well as a budget neutrality adjustment based on health equity (i.e., health equity adjustment). Qualification for the health equity adjustment will be based on the percentage of patients who are dually eligible and living in an area of high deprivation. The adjustment will be either positive or negative depending on whether the dementia care program is serving a high number of underserved beneficiaries. The dementia care programs will be able to bill for GUIDE respite services annually up to \$2,500 per person living with dementia who has a caregiver and in the moderate or severe payment tiers. In addition, to support new dementia care programs in underserved areas, CMMI will provide a one-time infrastructure payment for those who meet the qualifications.
- GUIDE was designed to be complementary with other models including primary care models. GUIDE clinicians and patients may also be participating in other CMMI models or shared savings program.
- For additional details on Ms. Saffer’s background and organization, see the [panelist introduction slides](#) (slides 34-40).

Panelists discussed ways in which CMMI models can be adjusted to incorporate longer timelines to allow for systems to invest long term and create sustainable infrastructures.

- When CMMI introduces models where providers are relatively inexperienced in value-based care, it is important to allow for ramp-up time. CMMI may extend the length of the model. It is also important for CMMI to consider how to support providers to succeed in value-based care and how to help sustain progress through either successor models or expansions to set providers up for success.

- As an example, GUIDE will run for 8 years to allow for a longer trajectory for the dementia population. A core objective is to delay reaching end of life or long-term nursing home placement, which likely would not happen under a typical 5-year timeline.

Panelists discussed ways in which CMMI could boost participation in models given that several models identified small numbers of participants as an evaluation challenge.

- CMMI has not directly created an incentive for specialists to care for patients with complex chronic conditions; however, CMMI has made a conscious effort to focus on areas with specific needs, as well as building into broader care model concepts that have shown positive results with this patient population.
- CMMI's work to facilitate integration within an ACO construct, as well as to establish the high-needs track within ACO REACH, may encourage more clinicians to choose to care for this population.
- GUIDE broadly defined providers with dementia expertise with the expectation that this broader definition will allow for palliative care providers, geriatricians, primary care providers, and general internists to participate in the model. Expertise was based on several factors to broaden the participant pool of clinicians.
- IAH was specifically targeted at practices that delivered home-based primary care as a solution to treating and caring for patients with high needs and high costs. A high needs type of ACO was not as prescriptive as IAH; it allowed providers to treat and care for patients through several care delivery mechanisms. Many IAH practices transitioned to ACO REACH for the flexibility and the opportunity to care for a broader set of patients.

Panelists discussed ways in which CMMI can raise awareness of the availability of these models and their associated benefits to both providers and patients.

- CMMI is aware of the challenges associated with educating the vast network of providers, given the variety of models, and is actively working on solutions.
- GUIDE is testing methods to improve model participation through directly sending letters to beneficiaries informing them of the GUIDE Model and listing participating dementia care programs in their service area. All CMMI models include robust learning and education for participants. CMMI is responsible for developing learning plans for providers and assisting with peer-to-peer-based education. For GUIDE, CMMI will assess peer-to-peer outreach and education, increasing participation. Providers most likely will offer the best solutions as they are closest to the patients.

### **Listening Session 3: Best Practices for Incentivizing Improved Outcomes for Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models**

#### **SMEs**

- Jason H. Feuerman, President and Chief Executive Officer, LTC ACO
- Bruce Leff, MD, Professor of Medicine and Director, Center for Transformative Geriatric Research, Division of Geriatric Medicine, The Johns Hopkins University School of Medicine
- Diane E. Meier, MD, FACP, Founder, Center to Advance Palliative Care

#### **Previous Submitter**

- Marie P. Bresnahan, MPH, Director of Training, Policy, and Administration in the Viral Hepatitis Program (VHP), New York City Department of Health and Mental Hygiene (*Multi-provider*,



*bundled episode-of-care payment model for treatment of chronic hepatitis C virus [HCV] using care coordination by employed physicians in hospital outpatient clinics proposal)*

- Bruce R. Schackman, PhD, Saul P. Steinberg Distinguished Professor and Executive Vice Chair, Department of Population Health Sciences, Weill Cornell Medicine; and Director, Center for Health Economics of Treatment Interventions for Substance Use Disorder, HCV, and HIV (CHERISH)

Committee member Lee Mills moderated the listening session with 5 SMEs on best practices for incentivizing improved outcomes for patients with complex chronic conditions or serious illnesses in PB-TCOC models. Full [biographies](#) and [presentations](#) are available.

Marie P. Bresnahan and Bruce Schackman presented a payment model for treatment of chronic hepatitis C virus (HCV) using care coordination in hospital outpatient clinics.

- Project INSPIRE was funded by CMS for 3 years, during which Ms. Bresnahan and colleagues implemented a care coordination model for HCV-infected, high-needs patients with multi-morbidity in New York City.
- Goals of the model were to improve outcomes and reduce costs by providing treatment for HCV to Medicaid and Medicare patients that included comprehensive social determinants of health assessments and integrated behavioral health services, in addition to medical care.
- The target population for this model evolved during the implementation period, beginning with older adults with chronic HCV and other illnesses and later included younger generations with HCV due to the opioid epidemic.
- Successful features of the model included:
  - The use of primary care teams comprised of peer specialists with lived experience, non-licensed care coordinators, and non-specialist providers;
  - Tele-mentoring to train these non-licensed and non-specialist health care workers; and
  - Payment models for each phase of treatment and a bonus payment to cover the time required to conduct tele-mentoring.

For additional details on Ms. Bresnahan’s presentation, see the [presentation slides](#) (pages 2-16), transcript, and [meeting recording](#) (00:53-12:14).

Jason H. Feuerman presented on lessons learned about approaches for implementing financial incentives for the care of high-risk Medicare Advantage patients in the LTC ACO.

- Financial incentives are necessary to shape care outcomes and should be tailored to each patient population to ensure that they are meaningful. Incentives should be paid in a timely manner according to the projected, and not realized, outcome (e.g., as close to the time of performance as possible).
- Key quality metrics to include in a program are emergency room utilization, hospital admission, proper utilization of specialty care and services, and over/under utilization of services.
- Key quality metrics should be tailored and relevant to the population and should require complete and accurate diagnosis coding to facilitate risk adjustment.
- A successful program should provide regular performance data to providers (e.g., data transparency), and the program and incentives should be simple and explained to providers to encourage buy-in.

- Potential unintended consequences of a value-based program to consider are deferment of specialty care and/or home and community-based services to reduce costs, and overlooking social determinants of health and additional factors that may affect care.
- Financial penalties do not work. Financial incentives should become an inherent part of the provider reimbursement structure to get providers out of the production mindset and more focused on achieving desired outcomes.

For additional details on Mr. Feuerman’s presentation, see the [presentation slides](#) (pages 17-24), transcript, and [meeting recording](#) (12:15-29:21).

Bruce Leff presented on the data sources and measures for monitoring quality, patient outcomes, and quality of life longitudinally across settings for patients with complex chronic conditions or serious illnesses.

- A latent class analysis of adult members of Kaiser Permanente Northern California found that almost one-quarter of the frail elderly patient population is not getting care.
- Single disease constructs are often irrelevant for care and quality assessment in the most medically complex patients.
- Critical factors strongly associated with outcomes in this patient population, such as functional status and social constructs like lack of social support, are much more likely to be captured in unstructured EHR data compared with claims data and structured EHR data.
- The trajectory of this patient population, once homebound, varies over time, changing between homebound states (i.e., whether the patient is independent, semi-homebound, fully homebound, in a nursing home, or deceased).
- The lack of centralized care creates challenges for attribution. Medicare beneficiaries overall do not experience consistency in their health care providers. Over a two-year period, beneficiaries with more than seven chronic conditions were assigned a median of 11 different physicians.
- The “North Star” of the effort to improve quality of care for this patient population needs to be clarified. Focusing on the top 5% of spending or on spending level thresholds in general may not achieve the desired goal if the patients in these spending categories do not have preventable costs and/or are not receiving poor quality care.
  - Focusing on identifying patients with rising risk and preventing them from entering the top 5% or 1% spending categories may be more actionable.
  - Clarifying the overall goal and whether it is achievable is useful. This process may reveal competing goals such as decreasing spending while also maximizing quality of care.
  - Maximizing quality of care may also not equate with maximizing quality of life.
- High costs and preventable costs are not the same. A study out of Harvard showed that the frail elderly constitute 8.6% of the Medicare population but account for 51.2% of total preventable spending.
  - This study estimates that preventable costs comprise 5 to 10% of total Medicare spending.
- The CMMI Independence at Home (IAH) Demonstration showed the success of home-based primary care through a shared savings mechanism. This model on average saved slightly under \$2,500 per beneficiary per year.
  - Of note, this model was not successful with timely payments of incentives despite being highly successful overall.
- Useful IAH Quality Metrics include follow-up contacts within 48 hours of hospital admissions, hospital discharges, and emergency department visits; medication reconciliation in the home

within 48 hours of hospital discharges and emergency department visits; all-cause hospital readmissions within 30 days; and annual documentation of patient preferences.

- Two metrics included in IAH that are not useful are hospital admissions for ambulatory care-sensitive conditions and emergency department visits for ambulatory care-sensitive conditions.
- The ACO REACH quality measure set is largely useful and aligned with the care that patients with complex chronic conditions or serious illnesses need (e.g., non-disease specific outcomes). The measure set includes claims-based measures such as “days at home for patients with complex, chronic conditions” for high needs ACOs only, as well as patient experience measures, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
- Some additional dimensions or constructs of quality to consider that need more work to operationalize include hospice referral rate, long-term care placement, care fragmentation, goal attainment approaches, and provider competency (see slide 40 for full list).
- Structures and processes required to provide high-quality care for this patient population are also important to consider and include interdisciplinary team training, 24/7 clinical responsiveness with a provider who knows the patient, concurrent palliative and disease-directed care, caregiver support, and entry for smaller practices (see slide 41 for full list).
- The work of quality improvement is not worthwhile unless the clinical practice has interest and ability to conduct process improvement.
- The culture of quality improvement in value-based models is narrowly focused on facility-based care with little to no recognition of home-based care. For example, 50% of CMS Merit-based Incentive Payment System (MIPS) quality measures that could be used for patients receiving home-based medical care did not have home-based visit codes. Regulators and payers need to include home-based care in quality and performance measurement.

For additional details on Dr. Leff’s presentation, see the [presentation slides](#) (pages 25-44), transcript, and [meeting recording](#) (29:26-41:22).

Diane E. Meier presented on best practices for integrating and incentivizing palliative care and hospice in population-based models.

- Palliative care encompasses the period during which patients can still benefit from disease-directed therapies, which may span decades and includes quality-of-life focused treatments.
- The patient population receiving palliative care is heterogeneous and often has used the emergency department to manage symptoms of chronic illness prior to entering palliative care.
  - Most ED visits are due to untreated symptoms or pain. These patients can be successfully cared for in palliative care with good symptom and pain management. Dr. Meier provided an example of a patient whose quality of life improved greatly after starting palliative care.
  - Palliative care improves quality and reduces cost by effectively caring for patients with serious illness and/or complex needs. Cost reduction comes with providing quality care.
- Structural requirements for palliative care to ensure quality and reduce cost include having an interdisciplinary team that can provide psychosocial/spiritual care, can be available by phone 24/7, and can conduct home visits as necessary.
- Strategies for integrating palliative care into TCOC models include:
  - Designate the palliative care team as the central communicator and coordinator of the patient’s care, communicate with the patient’s clinicians, adjust specialty palliative care services according to patient and family needs, and be responsive to patient needs 24/7.

- Require screening for palliative care needs in emergency departments using measures of frailty, SDOH, or recurrent hospitalizations or ED visits (see slide 55 for full list). Optum Health and Landmark are successfully identifying Mount Sinai’s high-need and high-cost population who should be screened for palliative care using machine learning. Health systems are not incentivized to do this.
- Explicit incentives are necessary based on lessons learned from the failure of value-based models alone to motivate behavior change among enough providers.
- Two examples of successful financial incentives in the hospital setting to increase the use of palliative care are the Elevance Palliative Care Quality Health Improvement Program (QHIP) Measure and the Highmark Quality Blue Palliative Care Measure.
- Three examples of successful financial incentives in the community setting are Cambia Regence Blue Cross Blue Shield, Highmark Health, and HealthFirst, who provide extra payments for referrals to palliative care.
- Dr. Meier outlined 5 options for CMS/CMMI to integrate and incentivize palliative care: 1) require hospitals and health systems in PB-TCOC models to have a palliative care policy and training program for staff; 2) require reporting on the number and percentage of patients receiving specialty palliative care services; 3) provide financial incentives using a fixed palliative care management fee and/or quality incentive for screening; 4) create a Current Procedural Terminology (CPT) G-code for palliative care screening; and 5) use new National Quality Forum (NQF)-endorsed patient-reported outcome measures to incentivize quality.
- Recommendations for hospice integration in PB-TCOC models include allowing concurrent or transitional care, incentivizing the treating clinician to continue visiting the patient, and providing 24/7 meaningful clinical response.
- Dr. Meier provided 3 examples of successful, concurrent hospice payment models: the Medicare Care Choices Model (MCCM), the VA Comprehensive End-of-Life Care Initiative, and the University of Pittsburgh Concurrent Hospice and Dialysis Program.

For additional details on Dr. Meier’s presentation, see the [presentation slides](#) (pages 45-62), transcript, and [meeting recording](#) (41:24-58:08).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (58:14-1:27:39).

Presenters discussed the cost savings achieved in their practices through value-based payment models, the level of reward required to change provider behavior, and how to ensure that reward reaches providers.

- Adoption of the program and engagement with the data by providers result in cost savings that are meaningful for very high-cost patients.
- Preventable costs in the frail elderly constitute a large portion; however, that is not the only patient population in the top 5% of total Medicare spending. The ethic to use data to improve outcomes and decrease cost is not embedded in the health care delivery system. The use of the data needs to be incentivized because it is not a routine process.
- The health systems employing physicians also do not incentivize the use of these data. Adopting processes that improve outcomes are not rewarded. The payment model and existing incentives need to be flipped to pay providers caring for the high-need, high-cost patients more than other providers (e.g., orthopedic surgeons).
- The health care workforce lacks geriatricians and palliative care providers. Special needs health care plans do not require that geriatricians lead those programs. These are examples of the

health care system not being set up to recruit and reward the care of high-need, high-cost patients. Aligning and increasing financial incentives in this area could also attract more future physicians to the practice of geriatric medicine, and palliative and hospice care.

- There is likely not a dollar amount sufficient to change behavior but rather certain combinations of factors that would increase the amount of time a physician can spend with a patient and also improve the work environment. Payment models are needed that value time spent versus volume of patients. The IAH Demonstration and high needs ACOs may provide insights into the level of payment and incentives required to change behavior.

Presenters discussed the challenge of aligning financial incentives with the current workforce gap in palliative care and related primary care disciplines.

- The health care system needs leaders who can create systems that will achieve the desired outcomes. Better leadership could encourage educational programs to improve care delivery among primary care physicians, and guide and incentivize better care over the short term. Creating a leadership core comprised of palliative and geriatric physicians could bring understanding of settings of care and the importance of assessing functional status and SDOH. The business and financial leadership in health care are conditioned to focus on revenue and do not routinely consider the time it may take to realize projected savings.
- The home-based primary care practice at Mount Sinai was eliminated because it could not use cost avoidance as an explanation for generating savings within the FFS model.
- This was the premier academic home-based primary care practice in the U.S.
- Project INSPIRE relied on tele-mentoring to enhance the ability of primary care physicians to spend time with patients. To include tele-mentoring in the payment model, the lost revenue was calculated and introduced as a quality-based bonus payment because there was otherwise no payment mechanism to cover the time the provider spent in the tele-mentoring session versus seeing the patient in person. From the payer's perspective, no revenue was lost, and providers were motivated to participate because their skills were enhanced.

Presenters discussed the identification of patients appropriate for palliative and/or hospice care.

- Claims data are the most readily available and are beginning to be used to identify frailty. However, claims data exclude those who do not access care. In the IAH Demonstration, the fulfillment of 3 criteria was necessary: 1) the presence of 2 or more of a specific set of chronic conditions that are exceptionally costly; 2) history of hospitalization; and 3) history of receiving skilled home health care or time in a skilled nursing facility. This worked well in the IAH Demonstration; however, the measurement of functional and cognitive status was missing. These measures are critical to predict and identify the highest-cost patients. Health systems need a mandated, standardized method to assess functional status. Another measure to consider is homebound status, which is about 20% of the Medicare population.
- Currently this information on homebound status, functional status, and cognitive status is not in claims data, which are what is used to identify the high-risk population. What is easy is not what is accurate. Measures of living alone and caregiver stress could also be added to the list. This information is also not currently in the EHR. These factors are critical and are invisible to the health system and to CMS.
- Co-Chair Hardin commented on the lack of integration of health-related social needs and behavioral health depicted in the 2017 report by Dr. Jose Figueroa on the concentration of preventable spending among high-cost Medicare subpopulations.

- The analysis that ASPE conducted on the top 5% showed that the Area Deprivation Index was a major predictor of being a high-cost patient.

Presenters shared final thoughts to close the listening session.

- The financial incentives need to be mandated in addition to being structured appropriately. Getting the incentives in the hands of the providers may require a mandate by CMS, whether in the FFS setting, Medicare Advantage, or both.
- The services must be mandated as well by CMS; providers need to be financially incentivized and must meet quality standards.
- Linking these efforts to true quality and process improvement versus just checking a box is important. The VA has been successful in using mandates around care delivery. It has home-based primary care services at each of its medical centers and mandated interdisciplinary care teams.
- Targeted payments focused on a particular issue or patient population can make a difference. These smaller level changes can build momentum toward more systemic change.

### **Public Comment Period**

No public comments were provided.

### **Committee Discussion**

Dr. Wiler 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](#) (1:28:09-1:47:35).

- Financial incentives are critical to drive real-world impact, and the Committee should incorporate chief financial officer (CFO) panels in the future to understand finance-driven perspectives on PB-TCOC models. Effective incentives must be meaningful, timely, and tied to performance metrics. Quality metrics should be a guardrail guaranteeing a high standard of care rather than an inducement. Strong incentives often have unintended consequences, which must be carefully considered and mitigated. In addition to incentives, there should also be careful application of penalties.
- Chronic diseases have a disproportionate impact on health care costs, with a small portion of the population incurring significant costs. Programs and incentives tailored to single disease constructs are inadequate for addressing the needs of this diverse population.
- Data suggest that palliative and hospice care both improve care quality and lower costs. An ASPE research project could confirm that increasing the supply of palliative care leads to improvements in quality and decreased costs, like primary care. There is also a strong plea from palliative care providers for mandates tied to payment programs.
- The lack of specific codes and shortage of palliative care specialists make identifying patients for palliative care challenging. A potential solution could be using a single G-code to incentivize identification of patients for palliative care.
- It is critical to consider equity in health care policy and program development decisions, with particular attention to disparities in access. Individuals with lived experiences should be included in governance to ensure that their voices are represented in policy decisions.

- Patient-reported outcome measures are key quality measures, especially related to patients feeling heard and understood. It is important to provide patient choice within the health care system, including support services tailored to individual needs and facilitated by providers familiar with patients' histories. Although patient-provider relationships and trust can improve care quality and reduce costs, there is a lack of prioritization in current payment models.
- Across the health care system, a shift is needed from a crisis-oriented approach to one that proactively addresses symptom and disease management, as well as health-related social needs. All health care providers should be competent in explicit and concurrent care, as well as proactive anticipatory care.
- The inclusion of peers and non-licensed providers with lived experience in care teams shows potential to enhance care delivery and outcomes.
- Providing goal-concordant care is a key objective. Discussions around goals of care are particularly important when managing symptoms and pain among patients with complex chronic conditions or serious illnesses.
- Delaying chronic disease progression and catching acute exacerbations early are critical when caring for patients with complex chronic conditions or serious illnesses. This often requires intensive primary care and 24/7 availability for patient support.
- The FFS system is inadequate in meeting the needs of seriously ill patients and those with complex chronic conditions. In this system, it is financially challenging to hire much-needed palliative care specialists. TCOC environments better support provision of palliative care, which will generate a positive financial return and improve quality of care for seriously ill populations.
- Participation in TCOC payment models should be mandatory to drive meaningful change in health care delivery. There is misalignment of incentives in the current system, leading to the closure of geriatric fellowships by hospital CEOs due to lack of profitability.
- In some areas, such as in Philadelphia, home health care workers are unable to visit patients due to safety concerns related to neighborhood violence. This is just 1 example that illustrates systemic issues of equity and care access that must be addressed.
- It is important to identify ideal care models and then align payment incentives accordingly. There is also potential for immediate impact by mandating certain activities, such as collecting specific data elements and assessing functional status.

### **Closing Remarks**

Dr. Wiler and Co-Chair Hardin adjourned the meeting.

**The public meeting adjourned at 2:52 p.m. EDT.**

**Approved and certified by:**

//Lisa Shats//

8/16/2024

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Lisa Shats, Designated Federal Officer  
Physician-Focused Payment Model Technical  
Advisory Committee

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Date

//Lauran Hardin//

8/15/2024

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Lauran Hardin, MSN, FAAN, Co-Chair  
Physician-Focused Payment Model Technical  
Advisory Committee

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Date

//Angelo Sinopoli//

8/16/2024

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Angelo Sinopoli, MD, Co-Chair  
Physician-Focused Payment Model Technical  
Advisory Committee

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Date