PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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Tuesday, June 11, 2024

PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair*
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO*
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS, JR., MD, MMM
SOUJANYA R. PULLURU, MD
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT

JOSHUA M. LIAO, MD, MSc
JAMES WALTON, DO, MBA

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE

*Present via Zoom

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

9:02 a.m.

* CO-CHAIR SINOPOLI: Good morning. We'll get started again this morning.

* **Welcome and Co-Chair Overview - Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models Day 2**

Welcome to day two of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

My name is Angelo Sinopoli. I'm one of the Co-Chairs of PTAC, along with Lauran Hardin.

Yesterday, we began our day with opening remarks from CMS[1] Deputy Administrator and CMMI[2] Director, Dr. Liz Fowler, and she provided some insight into the Innovation Center's models targeting the seriously ill population.

We also had several expert panelists and presenters who shared their perspectives on how to provide patient-centered care, improved outcomes, and measure quality for patients with

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[1] Centers for Medicare & Medicaid Services

[2] Center for Medicare and Medicaid Innovation

complex chronic diseases and serious illness in population-based total cost of care.

Today, we have a great lineup of experts for two listening sessions and a special session with CMS leadership. We've worked hard to include a variety of perspectives throughout this two-day public meeting, including the viewpoints of previous PTAC proposal submitters to address relevant issues in their proposed models.

Later this afternoon, we will have a public comment period and welcome participants either in person or via telephone to share. As a reminder, public comments will be limited to three minutes. If you have not registered to give an oral public comment, but would like to do so, please email prior to the 2:30 p.m. session today. Again, that's ptacregistration@norc.org.

Then the Committee will discuss our comments for the report to the Secretary of Health and Human Services that we will issue on addressing the needs of patients with complex chronic conditions or serious illness in population-based total cost of care models.

*** PTAC Member Introductions**

Because we might have some new folks

online who weren't able to join yesterday, I would like the Committee members to please introduce themselves today. Share your name and your organization. If you would like, you can tell us about the experience you may have had with this topic. I'll cue each of you, as we go through the introductions.

I'll start. I'm Angelo Sinopoli. I'm a pulmonary critical care physician, presently the Executive Vice President for Value-Based Care at Cone Health. I've spent most of my career in large integrated health systems as the chief clinical officer, and have built clinically-integrated networks and enablement companies to help support their performance.

We will start out by introducing the people who are on Zoom. If we can start with Lauran?

CO-CHAIR HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse and Chief Integration Officer for HC2 Strategies. I've spent the better part of the last 20 years directly serving clients with serious and complex illness, starting one of the earliest play-and-care programs and children's hospice programs, and then, leading a complex care model that scaled to multiple states and was recognized by the National Academy of Medicine.

I was part of the team that started the National Center for Complex Health and Social Needs, and I've spent the last 10 years partnering with communities, large health systems, states, community-based organizations, and payers, designing models for complex and underserved populations.

And now, let's go to Jay.

DR. FELDSTEIN: Hi. I'm Jay Feldstein. I'm trained in emergency medicine. I practiced emergency medicine for 10 years, and then, spent 15 years in the health insurance world in commercial and government programs, and the last 10 years, have been the President and CEO of Philadelphia College of Osteopathic Medicine.

CO-CHAIR SINOPOLI: And is Josh on at this point? No? Okay.

So next, we'll go around the table, starting to my left with Jen.

DR. WILER: Hi. Good morning. My name is Jennifer Wiler. I'm an emergency physician by training. I'm the Chief Quality Officer at UCHealth’s Metro Region and Co-Founder of UCHealth's Care Innovation Center, where we partner with digital health companies to grow and scale their solutions at the point of care. I'm also a tenured professor at the University of Colorado School of Medicine and a former co-developer of an Alternative Payment Model considered by this Committee.

DR. LIN: Good morning. My name is Walter Lin. I am the founder and CEO of Generation Clinical Partners. We are a group of medical providers in the greater St. Louis area specializing in the care of the seriously ill and those with complex chronic conditions living in assisted living facilities and nursing homes.

DR. PULLURU: Good morning. Chinni Pulluru. I'm a family physician by trade, previously at Walmart, Chief Clinical Executive. Currently, I'm a founder, founded a genetics company, as well as serve to advise in value-based care transformation. Prior to that, I spent 15 years leading the end-to-end value-based care delivery of DuPage, now Duly Health and Care, which is a large multi-specialty group, one of the largest in the country.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a practicing family physician in Houston, Texas. I also serve as a Regional Medical Director with Amazon One Medical, supporting our practices across the Midwest and Texas. Prior to that, I worked in large health systems in residency education. I also serve as the President-elect of the Texas Academy of Family Physicians.

DR. MILLS: Good morning. I'm Lee Mills. I'm a family physician. I am a principal at Strategic Health Consulting and have spent most of my career in leading and operating value-based care transformation activities, including multiple CMMI models over the last 20 years. I spent the last four years as Chief Medical Officer at a commercial and government program health plan leading those value-based benefit design and care transformation efforts.

Thank you.

DR. KOSINSKI: Good morning. I'm Larry Kosinski. I am a gastroenterologist by training. I practiced for 35 years in the Chicagoland Metropolitan Area, but I am now retired from that.

I've spent the last 10 years of my life in value-based care, trying to build value-based solutions for specialists, specifically, gastroenterologists. I founded a company named SonarMD, which arose out of a PTAC proposal. We were one of the first PTAC proposals after PTAC was formed back in 2017, and we now have this deployed in the commercial space.

I also am a Board member of the American Gastroenterological Association, consult for a number of companies, and am the Chief Medical Officer of Jona Health, an AI-driven microbiome start-up.

CO-CHAIR SINOPOLI: Thank you all.

One of our members, Dr. Jim Walton, is unable to join us for this meeting, but we certainly want to thank him for all of his contributions to the meeting preparations.

At this point, I'm going to turn things over to Lauran to lead the next listening session.

Lauran?

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

CO-CHAIR HARDIN: Thank you so much, Angelo.

Good morning.

At this time, I'm excited to welcome

four guest experts for our listening session who will present on Optimizing the Mix of Palliative Care and End-of-Life Care in Population-Based Total Cost of Care Models.

At this time, I ask our presenters to go ahead and turn on video, if you haven't already.

After all four experts have presented, our Committee members will have plenty of time to ask questions.

The full biographies of our presenters can be found on the ASPE PTAC website, along with other materials for today's meeting.

So, I'll briefly introduce our guests.

Presenting first, we have Dr. Kurt Merkelz, who is the Senior Vice President and Chief Medical Officer of Compassus.

Kurt, please go ahead.

DR. MERKELZ: Thank you. Thank you for the introduction, and it's an honor to address this esteemed Committee and panel.

I wish to quickly just make a comment regarding attribution. My focus is on the highest-cost, highest-needs users of health care, those individuals with polychronic disease states that significantly impact function and account for recurrent hospitalizations.

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This is the opportunity. There is currently a lack of any defined methodology to meet the outcomes most important for this population's success. And in turn, it accounts for much of the high cost in rehospitalizations that occur.

I have only a very short time. So, I want to lead with a definition of my thesis for today's presentation. A model of care or methodology is the mechanism for linking theory to practice. It may be the most practical and important tool for a professional.

The current model being used to treat the serious illness population is fundamentally flawed when applied to the elderly population with chronic illness -- not only for achieving intended outcomes. In many instances and cases, it exacerbates the very challenges faced by these patients.

Health care providers, including nurses, therapists, physicians, are constrained by current practice. Though well-intentioned, care plans are mostly rendered ineffective because they do not align with the realities of aging and chronic illness management.

The persistence of a lack of standardized best practice is a disservice to actually both patients and health care professionals.

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My work over the past decade has been to help identify and improve systems of care across a continuum of integrated services, including palliative care, hospice, home health, and infusion services.

I have been engaged specifically in improving and standardizing care delivery to fill the gap that currently exists in the post-acute care setting, which is an overemphasis on acute medicine coupled with biomechanical rehabilitation. This rehabilitation model was really born out of young war veterans coming back from injuries from which they needed to recover and when physical recovery was mostly possible and necessary.

This mindset operates under an assumption that restoring physical function or health is consistently possible and desirable. However, for the aging population, particularly those with chronic illnesses, this goal is often unattainable, unsustainable, and unless complete achievement is obtained, it actually leaves them at significant risk.

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My work has been influenced greatly by the RIGHTCARE Foundation. The RIGHTCARE Research Initiatives are deeply rooted in the needs, issues, and concerns of specific patient populations and community-based organizations that serve them. Collaboration with communities and patient partners ensures that the research is not only relevant, but also responsive to the challenges faced by our communities and patients.

At the heart of my own care delivery model and the RIGHTCARE model are substantive outcomes, - outcomes- that matter to payer source, providers, and patients - that- can be realized, and in reality must be achieved. Each outcome is strategically aligned with specific actions that are necessary to bring about the desired change to key factors that determine success or failure for each individual patient.

Next slide.

Currently, palliative care is known to improve the negative aspects to quality of life, mostly by addressing symptoms and stress of serious illness. Additionally, there are known positive outcomes from advanced care planning, timely transition to hospice, and some impact in rehospitalization. However, palliative care as the driver of outcome-focused care, supporting individuals in receiving the necessary and needed care, has the greatest opportunity for impact.

Next slide.

To illustrate the gaps, consider this recent case of an average serious illness patient. This patient presents with multiple chronic conditions and limited function. The care plan devised for such a patient under the existing care structure focuses primarily on physical rehabilitation, such as performance and components, like strength, range of motion, endurance, balance, restoring self-reliance. And nurses are often performing all the required tasks for medical condition management.

This patient was found by me at home with no medications; no knowledge of what her medications were; no system to follow the regimen; innumerable safety risks, with an inability to safely have her needs met.

This is not a unique or one-off. This is found in almost every home of every patient I evaluate.

Next slide.

Care for the seriously ill patient needs to focus on care that supports substantive outcomes, not independent goal attainment. Family members/caregivers must be partners in care provision with a focus on supporting the patient in having their needs met, not self-reliance.

Palliative care, by using specific care methodologies, focusing on substantive outcomes and validation of training and compliance, like medication reconciliation, medication adherence systems, medication compliance, caregiver assessments and training, and risk mitigation, offers a real solution. A proactive methodology addresses the real needs of patients.

Next slide.

Many seriously ill patients have been hospitalized precisely because of their inability to manage the very same self-reliance activities we drive after discharge. This analysis from 23,000 treatment plans underscores the need for a shift in how we approach the care of this population.

As shown, the care plans for patients admitted to rehab hospitals, skilled nursing facilities, LTACHs[3], and home health, most often focus on physical performance and self-reliance activities. These care plans across the board overlook the core needs of these patients, leading to high numbers of safety risks and poor medication adherence.

Little to no attention is paid to burden of care and quality of life. The actual number of safety risks present often increases for individual patients with serious illness due to an over-focus on self-reliance, pushing patients to achieve mobility or self-medication provision beyond what they safely should be doing on their own, to meet often misaligned goals.

Next slide, please.

Palliative care using an outcome-focused methodology can raise the bar of high-value care for individuals with serious illness. This approach identifies the essential outcomes that must be achieved and maintained to ensure a patient's success and reduce health care expenditure. It provides a comprehensive framework, including treatment plans and metrics,

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[3] Long-term acute care hospitals

and can empower a wide range of stakeholders.

Most seriously ill patients are not yet hospice-appropriate. So, what is needed is to de-emphasize medications and symptom management and align on substantive outcomes that address the needs of seriously ill patients.

Successful care often involves family support with proactive management, which our system can often fail to provide adequately. We need to ensure compliance, monitor for changes early, and mitigate risk to keep patients stable. What is lacking, again, is a specific methodology or accounting that can be measured and validated that ensures best practices are employed by every clinician at every encounter.

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Palliative care using outcomes-focused methodology represents the pinnacle of high-value care for individuals with serious illness. A well-defined care model provides the comprehensive framework, including the training, treatment planning, tools, and the metrics to validate goal attainment. A framework of resources such as this empowers and equips a wide range of stakeholders. By realigning the quality equation, this method can dramatically lower the total cost of care, enhancing both patient outcomes and the efficiency of care delivery.

Next slide.

Specific substantive care delivery models can be developed, are developed, and can be implemented with significant success. Standardized care practices in an individualized way have supported significant improvements in many of the various regulatory quality reporting programs currently in use. And there is still so much more for us to learn and optimize in this area.

Next slide. And actually, if we can go to the next slide?

Compassus, using the care delivery model, achieved CHAP[4] certification as an age-friendly provider in some of their home health agencies. This opportunity extends beyond post-acute care services and directly into our communities.

First responders, ERs[5], community providers, all joining forces around agreed-upon outcomes, can make the entire community a risk-reduction program and is actually currently being realized. RIGHTCARE has made significant impact

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[4] Community Health Accreditation Partner

[5] Emergency rooms

in a three-year pilot with Scottsdale Fire Department, which is now live.

Using substantive outcomes training, Senior Solutions recently achieved CHAP certification as an age-friendly provider for private duty care, validating the commitment to high-quality care.

The Life Profile Assessment and Care Planning derived from RIGHTCARE research sets Senior Helpers apart in their ability to execute on keeping seniors out of the hospital by supporting clients by effectively, again, managing their medical conditions, eliminating safety risks, improving quality of life, and supporting family caregivers. This initiative not only elevates their service quality, but also positions Senior Helpers as a leader in the rapidly evolving field of age-friendly care.

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We need to stop rearranging the chairs in providing the same focus of care and hoping for a different outcome. Palliative care guiding substantive outcome methodologies can transform care for the seriously ill. By implementing, supporting, and measuring these outcomes, we can achieve better health, reduce costs, and enhance patient and provider satisfaction.

I thank you so much for your time this morning.

CO-CHAIR HARDIN: Thank you so much, Kurt. That was very interesting.

We're holding questions from the Committee until after all the presentations are done, but I'm sure there will be lots of additional questions.

Next, we're excited to have Dr. Natalie Ernecoff, who is a Full Policy Researcher at RAND.

Welcome, Natalie. Please go ahead.

DR. ERNECOFF: Thank you so much for having me. I'm excited to be here today.

You can go to the next slide.

I am a health services researcher. I do work in innovative systems, interventions for people living with serious illness, particular in the hospice space.

And today, I will be talking about concurrent care in a hospice context specifically. I'll start out with some background, and like Kurt, I like some historical context. So, we'll start there, and then, move into some best practices and models of concurrent care; how those models impact outcomes; and what are some of the challenges with care coordination and care delivery in this space.

Next slide, please.

So, the Medicare hospice benefit was signed into policy in 1982. At the time, the policy included a requirement of a six-month prognosis; invoked relatively inexpensive medications for management of pain and symptoms, primarily in cancer. And the model was developed in cancer care. It also was a home-based model. Unlike other hospice models internationally, the home-based care model allowed the policy to remain cost-neutral.

One important feature of the Medicare hospice benefit is that it does not cover disease-directed therapies that are related to the primary hospice diagnosis. For example, if your primary hospice diagnosis is cancer, the Medicare hospice benefit does not cover chemotherapy or radiation, including if that's for palliative intent. And that's what we'll talk about today.

It's important to note that the policy at the time was intended to be inclusive, to meet patient needs. Most people who are receiving hospice had cancer, and from the time they exhausted their disease-directed curative treatment options, very few people were living to that six-month prognostic time horizon.

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So, 40 years later, the policy remains relatively unchanged. In today's climate, we see that patients are forced to make, as Casarett and colleagues called it, "the terrible choice." Hospices are unable to afford the coverage of many disease-directed therapies. So, they often require discontinuation before enrolling, even if those disease-directed therapies can provide comfort-oriented palliative intent.

Some examples include palliative dialysis; blood transfusions for people with blood cancers, which can improve dramatic fatigue; and palliative radiation to reduce tumor size marginally, if there's a tumor pressing on a nerve causing pain, for example.

Patients who could benefit from those disease-directed therapies are often forced to choose between that therapy that can, indeed, help make them more comfortable in many cases and the improved quality of life and additional support, including psychological support, social support, spiritual care that comes with hospice.

But we do see that few patients faced with this choice elect the hospice benefit, and those who do elect the Medicare hospice benefit in this scenario often access the services very near the end of life with less opportunity to see their full benefit.

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So, what is concurrent care? Concurrent care in this context is continuation of disease-directed therapies with palliative intent upon enrollment in hospice in an effort to support patient goals, as they approach the end of life. It's defined by these three guiding principles where the treatment is motivated by symptom management rather than curative intent. So, treatment plans can change.

The potential benefits and burdens of the treatment must be balanced with those of care and quality of life. And to that end, treatments must be reviewed regularly and treatment care plans modified because the clinical setting and patient physiology is changing pretty quickly and dramatically during this time. So, as soon as a treatment seizes to provide palliative intent, it's often discontinued before the very end of life.

Next slide, please.

So, where have we seen concurrent care already? Pediatrics in the United States is one example. So, for context, the Affordable Care Act prompted Medicaid policy change in 2010 to allow concurrent care for kids. There is a lot of state-level variation in how this is implemented, but, in general, evaluations of pediatric concurrent care have demonstrated increased hospice length of stay and fewer live discharges from hospice, allowing patients to continue to receive the benefits of hospice while getting some palliative benefit from their disease-directed therapy.

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Another example is from the VA[6] setting. VA administrators found in the early 2000s that hospice enrollment was low. The VA, of course, is not subject to Medicare rules, including the Medicare hospice benefit. And so, they decided to test models of concurrent care, starting in cancer.

These early evaluations in concurrent care in cancer found that chemotherapy was,

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[6] Veterans Administration

indeed, used after hospice enrollment. It was discontinued before the very end of life, consistent with a comfort-based care plan. And they found fewer ICU admissions, corresponding cost savings there, but no change in survival between people who received concurrent care in hospice and people who received typical hospice services.

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The VA also tested this in end-stage kidney disease. And these studies found that median hospice length of stay was, indeed, longer for people who received concurrent care. You can see here four days among hospice enrollees who did not receive concurrent care and 43 days among those who did. Dialysis is an interesting example because discontinuation of the dialysis also leads to a dramatically reduced prognosis, in many cases three or four days.

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So, all of this work informed some of what my team and I did in hospice and dialysis in the general population that is subject to the Medicare hospice benefit. So, we developed a collaborative program between nonprofit hospice and dialysis companies where they negotiated a contracted rate to cover the cost of dialysis treatments and corresponding transportation to the dialysis clinic from home.

We found that about half of concurrent care enrollees actually did not use any dialysis after enrolling in concurrent care. So, once they got their feet under them in hospice, saw the benefits that hospice could provide to them and their families, they decided that they did not want any additional dialysis treatments to improve their comfort.

We also saw the mean hospice length of stay was about 12 days. This is compared to the national average of about six days in people with end-stage kidney disease. And among that subset of people who did receive dialysis upon hospice enrollment, received that concurrent care, length of stay was about 17 days. So, these are people who maybe are slightly less acutely near the end of life and were able to really fully see that hospice benefit in greater than two weeks of enrollment.

This is an illustrative quote from a family caregiver involved in our program. And this family member said after a patient's death, "This was a way for us to let his body decide."

So, this is giving some agency back to patients and their families.

Next slide, please.

So, I want to talk a little bit about the policy landscape in this space, starting with the Medicare Care Choices Model. This came up yesterday.

MCCM paid a higher per capita fee to hospices, and then, fee-for-service Medicare covered the disease-directed concurrent palliative therapies.

The hospice was responsible for the administrative burden, including determining if patients were eligible, and the eligible primary diagnoses were limited to cancer, COPD[7], congestive heart failure, or HIV/AIDS.

So, MCCM did find higher hospice enrollment and about a week earlier than the non-participating hospices. The MCCM program was associated with decreased inpatient care utilization, which was associated with lower costs, and caregivers reported a better experience at the end of life.

It's important to note that most enrollees were from large hospices, and many

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[7] Chronic obstructive pulmonary disease

hospices withdrew from the model partway through. Hospices cited operational difficulties, including identifying eligible beneficiaries based on the relatively narrow, what they perceived to be, eligibility criteria based on diagnosis.

Next slide, please.

This is the ongoing value-based insurance design (VBID) model test, which carves hospice into Medicare Advantage, as opposed to the Medicare hospice benefit, which generally kicks people back to fee-for-service upon hospice enrollment.

Hospices can provide concurrent care, transitional concurrent care, at a higher per-capita fee in the first month of hospice enrollment at the beneficiary level. Reimbursement for concurrent care is related to the terminal condition, and the hospice retains responsibility for treatment plans and care coordination, which is the case at baseline, though concurrent care requires a bit more care coordination than is typical in a hospice setting.

So, the VBID model test is ongoing. Early findings indicate that there was low enrollment into the model and in hospice, and there was no change in hospice utilization between VBID participating and comparison plans in the first year, which was 2021. The VBID model will be sunsetting in 2024 and the evaluation will continue.

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What are components of effective concurrent care from the literature? The first is accurate patient identification and well-tread referral pathways, though those referral pathways may be diverse, both from outpatient and inpatient settings, upon an acute event that may precipitate hospice eligibility or appropriateness consistent with rules of care.

Good communication and workflows are essential for interdisciplinary collaboration. So, we have pretty tight teams that have pretty robust communication, as those care plans continue to shift close to the end of life.

Education and engagement is essential both for clinicians and administrators, and for patients and families, to facilitate goals of care conversations and whether concurrent care is a good choice to meet goals. These conversations in best-case scenarios start early and continue in an ongoing manner up until the point where someone's goals shift toward comfort and hospice becomes appropriate.

Care coordination is also essential and leads to smooth transitions, and the converse is also true. A lack of coordinated care can lead to particularly rough transitions in this new care coordination environment for hospice where they're working with other disease-directed providers.

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So, the key takeaways here are that concurrent care is feasible and effective to promote timely patient-centered care, to retain that autonomy via hospice near the end of life.

Feasibility of the model, however, is driven by interdisciplinary care coordination, clinical education, and clear referral pathways and operational support on the ground.

Payment models for concurrent care require those operational clinical models. This includes care plans that are modified over time, consistent with both patient goals and the clinical state; interdisciplinary care coordination across multiple clinical teams and providers; and clear, but flexible workflows that are met with education and ongoing communication between clinicians in all care delivery settings, patients, and their family caregivers.

Next slide, please.

Thank you.

CO-CHAIR HARDIN: Thank you so much, Natalie. Again, very interesting presentation as well.

Next, I'd like to welcome Dr. Ira Byock, who is an Emeritus Professor of Medicine and Community and Family Medicine at Dartmouth Geisel School of Medicine.

Welcome, Ira. Please go ahead.

DR. BYOCK: Thank you very much. Thanks to the Committee for having me.

I think my comments will complement those made by Dr. Merkelz and Dr. Ernecoff, and I hope they're helpful this morning.

Next slide, please.

I want to stay at a high level, at least initially. The culture of mainstream Western medicine sees illness and injury through a problem-based lens. That's very intentional.

Next slide.

This was concretized, if you will, and reinforced by Dr. Larry Weed's problem-oriented medical record, which is now reflected in billing codes and really focuses physicians, all clinicians, on the problems of illness and injury and the goals of care, longevity, rehabilitation, and alleviation of symptoms and suffering.

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But from patients' perspective, health and injury and illness are experienced as personal. These are personal experiences.

This, by the way, is my father in 1980 meeting my eldest daughter Lila, the only grandchild he got to meet. Dad was living with pancreatic cancer at the time.

Health and illness are personal -- next slide -- for each individual. But whenever an individual receives a serious diagnosis, his and her family shares in the illness.

Now, this conceptual shift, -next slide,-- from problems to patient experience may seem subtle and, like, you know, obvious, but it has remarkable implications for the skill set that we bring, the conceptual framework that we see the patient experience through, and what actions are brought about by our plans of care.

Next slide.

When you talk to people who are being wheeled into transplant surgery or facing cancer chemotherapy for the second, third, fourth, or more times, what matters most? The answer will always include the names of other people. This is a constant within the human condition that transcends language and ethnicity, color of skin, and really all the demographics.

People also want to make sure that they are not a burden to the people they love; that they retain some semblance of human dignity; that they do not suffer untoward and unresponded to symptoms and sources of distress, and that they feel heard, seen, and understood -- hopefully, not falling through the cracks of our problem-based medical model-driven system.

Next slide.

When you shift from caring for illness and injury to caring for whole persons, in addition to alleviating symptoms and suffering and working toward rehabilitating some functional independence, you can look at what exists in opportunities within the personal realm -- fostering personal well-being through the end of life, through experiences of illness, dying, caregiving. Now, I'll apply this shift in conceptual framework or expanded framework to doctors' roles in just a few moments.

Next slide.

During the pandemic, I sketched out for the teams that I was helping to direct within the Providence health system a notion of a continuum of human caring that includes and building on Maslow's Hierarchy of Needs, includes the human essentials of food and shelter from the elements; the medical problem-based model, which is fine for as far as it goes, of diagnosing and treating people's conditions, and making sure that we are aligning what we do with what people want, but also reminding us and visually giving us cues to the other work that we can do within the realm of the personal experience of the patient and family to provide them with real tangible benefits.

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I just want to remind people that, back in 2001, the Institute of Medicine, under the direction of Don Berwick's committee, created this six-component taxonomy of quality, saying that care has to be safe, effective, patient-centered, timely, efficient, and equitable.

Next slide.

And they defined "patient-centeredness" as "health care that establishes a partnership among practitioners, patients, and families, when appropriate, to ensure that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care."

Decisional support is one of the major opportunities that we have to transition from the medical problem-bound model of medicine to really a human care and whole-person approach that honors the opportunity and the potential within our human experience.

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It's easier to write those quality standards than to accomplish them. Why? Because it's hard to have these conversations, and, yes, you will be told multiple times that doctors simply do not have the time to have these conversations. That's partly correct, but, mostly, they avoid these conversations and use the lack of time as an excuse because it's hard to talk about anything having to do with illness and dying.

It's awkward within our culture, but for most Western cultures it feels like failure at times to talk about the eventual death of a person. Death is inevitable, but suffering is not. And these conversations have major impacts on patients' decisions and what they do, what treatments they choose to take or avoid.

Conversations can also, as hard as they are, be a source of satisfaction in the clinical experience of professionals, and that skill-building has been shown to be effective in making these conversations much easier and make them happen more commonly and with greater effect.

Next slide.

What to do? Well, we need to make quality standards about these conversations. Make them like completing an allergy list or a medication reconciliation -- to normalize it.

One of the ways to make it easier to introduce these conversations about advance care planning and goals of care are to simply say, "We ask everyone about their preferences," especially who they would want to speak for them if they became unable to speak for themselves. And we ask them to complete an advance directive.

Next slide.

The other thing that clinicians have to say is, "I have an advance directive, and so does every person in my family," which is true for me. I asked my two daughters to develop advance directives when they turned 18. I do so because it's normal, healthy adult behavior.

And I have an advance directive not because I teach this stuff and believe in it -- I do believe in it -- but because I have a family, and I know that, if I become seriously ill, my wife and daughters will wrestle with decisions about my care. I want to lift a little bit of the burden from their shoulders and give them clear authority to speak for me.

Next slide.

These days we talk about shared decision-making as a key component and process of quality. Shared decision-making has changed a great deal during my lifetime.

In the '60s, shared decision-making occurred when the doctor shared his decisions with you. But now -- next slide -- we realize that shared decision-making, as the IOM[8] mentioned, is a partnership. We doctors come to

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[8] Institute of Medicine

the clinical encounter, hopefully, expert in the diagnosis and treatment of the patient's condition. But patients are already expert in their personal values, their preferences, and priorities.

Next slide.

We need a "team of team" approach to really do the best job possible. And palliative care is one of the teams that should be involved when people have serious illness.

This is some actual system-wide data from the Providence health system over the year 2021 to 2022. I used it as an example of why it is important to have these conversations.

Now, what I'm showing here is data on people with serious illness by Dartmouth Atlas criteria who were admitted to an acute care hospital. And we looked at, does these patients' code status change during hospitalization? We used code status change as a leading indicator for Triple Aim goals, if you will. So, you didn't have to wait for a cohort to die and look back.

And you'll notice that, if patients with serious illness become acutely ill and admitted to the hospital, about 19 percent of them change code status. If they have seen palliative care, that changes to about 35 percent. If they weren't seen by palliative care, but someone entered a goals of care conversation documentation, the change in code status was 42 percent. And if palliative care was involved and palliative probably did that goals of care conversation, it was 63 percent.

Next slide.

We worry that patients will recoil from these goals of care conversations, but here's some data from a single hospital within the Providence system. This is Press Ganey data that shows that people who have goals of care conversations, at least in this hospital, had a higher Press Ganey score on multiple salient categories of satisfaction.

I want you to note that all of these goals of care conversations were conducted by non-palliative care clinicians. We washed the palliative care goals of care conversations from this data before analyzing it. So, people didn't recoil. They actually felt better for having it. And notice that these are 10 percent or more changes in or differences in Press Ganey, which are pretty large in Press Ganey terms.

Next slide.

Similarly to advance care planning and goals of care conversations, we can normalize early concurrent palliative care simply by introducing it to patients as saying, "Our palliative care team is here to provide you and your family with an extra layer of support." This is kind of the "team of teams" approach that General Stanley McChrystal wrote about in his book.

Next slide.

When you look at the impact of early palliative care on salient outcomes, -- again, this is actual data from the Providence system -- we saw that, when palliative care sees a hospitalized patient within the first Medicare day, before the second midnight, in each of these years they had less days in the hospital than palliative care patients seen initially after that second midnight.

Now, this is financially remarkable in terms of bed-days saved, but it's also a health outcome, because it's harder to fall in the hospital if you've been home for three or four days, harder to develop delirium, less likely to develop C. diff. or other hospital-acquired infections.

Next slide.

So, what are doctors for as we develop new models? Well, here's the list from the problem-oriented approach or problem-bound approach of medicine that we went over.

Next slide.

But doctors can also be for assisting patients with shared decision-making and treatment decisions, accompanying them through the difficulties of illness and disability, improving their well-being, not just their symptoms, and preserving and fostering people's opportunity to grow individually and together through the end of life.

I have two more slides. Next slide.

I would suggest to the Committee that there already is a satisfying model of physician practice that exists in our experience. It's called concierge medicine. Now, I know this has lots of problems and will challenge us as we look at adopting it, but what's important here is that patients love having a concierge physician, and concierge physicians are happy. And that Quadruple Aim goal of clinician satisfaction and joy at work is best accomplished through this model.

Next slide.

If I had more time, I would talk about some models that we have worked with or interventions and innovations that we have worked with, and some that are coming.

Personalizing the electronic health record, so that it is less solely problem-based and incorporates SDOH[9] and quality of life indices, and shows people's thumbnail photos.

I think AI is going to make a huge change in patient-reporting outcome measures, or I like to call them "patient-reported information," feeding forward to patients from an interview with an AI avatar rather than the PROMIS[10] surveys information salient to their health, but also their well-being, and feeding that forward on dashboards. So, at the point of contact with a physician, they can be addressed as priorities.

Next slide.

Thank you very much for the opportunity to present today.

CO-CHAIR HARDIN: Thank you so much for another essential presentation. Looking forward to asking the questions.

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[9] Social determinants of health

[10] Patient-Reported Outcomes Measurement Information System

Next, we have Dr. Betty Ferrell, who is Director and Professor in the Division of Nursing Research and Education, Department of Population Sciences, at City of Hope.

Welcome, Betty. Please go ahead.

DR. FERRELL: Great. Thank you so much. It's an honor to be included in such an important topic today.

And I'll be talking about some of the challenges in, specifically, the workforce to provide all of this wonderful care that we've been talking about this morning.

Next.

So, I think it's really important to acknowledge that nurses are pivotal to the workforce to accomplish anything that we hope to do in the area of serious illness care. So, nurses are really the predominant professional in health care across all health care settings and in all patient populations.

And nursing care is central to patient and family understanding of their illness; how they manage distressing symptoms; how they transition between health care systems; and they are present across all settings at the time of death.

And so, I think my conclusion that I will present to you at the beginning of this presentation is, if you want to create a better health care system, that will be impossible to do without centrally involving nurses as the key component of the workforce.

Next.

Also, I'd mention that advanced practice nurses are seriously underutilized in serious illness care and have untapped potential to manage patients with serious complex illness.

There are many models now of nurse practitioners that are serving in rural communities and underserved populations and really improving serious illness care.

Next.

We also know this is the Future of Nursing Report that was reissued recently charting the course for 2020 to 2030. And that report, published by the National Academies, concluded that nurses are vital in providing initial assessment of needs of diverse populations; care during disease-focused care; transition to palliative care; initiating hospice; managing urgent needs; supporting family caregivers; providing telehealth; and care at the end of life.

Next.

So, what are the best practices in complex care in serious illness? You know, often I'm asked, "Well, how do you define palliative care? What's the best definition of palliative care?" And there are many definitions -- the World Health Organization, the National Consensus Project.

But this is the definition that I always share. "Quality palliative care is the kind of care that you would want if you or someone you care about is seriously ill. Patient-centered care in complex serious illness attends to physical, psychological, social, and spiritual needs."

So, essentially, everything Dr. Byock just said about what would truly patient-focused care look like, if we want to deliver that care to patients, then that means we need to train clinicians in how to provide it. But again, if you remember nothing else today, remember the first sentence here: "Quality palliative care is the kind of care that you would want if you or someone you care about is seriously ill."

Next.

So, best practices include: assessing the person and their family's needs; assessing symptoms and quality-of-life concerns; a clear understanding of the goals of care; early integration of palliative care; early referral to hospice; and access to support for symptoms and changing needs.

And obviously, again, emphasizing changing needs. When you're newly diagnosed with heart failure or pulmonary disease or cancer, needs change over the months or years ahead. And so, we need systems that are responsive to those changes.

Next.

So, there's a lot of attention now in the literature and in our professional organizations to what is being called "the generalist-specialist model." And essentially, what this refers to, it's wonderful, wonderful that we have a palliative care service; that we have palliative care specialists.

But, for example, I work in a hospital, a cancer hospital, 250 inpatients a day, about 700 outpatients a day. That's about -- what? -- 900 patients a day in my cancer hospital. And we have a palliative care team which is outstanding, but how many patients today will they really see? You know, maybe 30 patients. And so, what about the care of the other 900?

So, the bottom line is that in all settings of serious illness, absolutely, we need our specialists. What's more important is a generalist-specialist model. Shouldn't we expect that every clinician in my hospital, a cancer hospital, knows how to provide very excellent palliative care? Shouldn't everyone in my organization be functioning at a high level of symptom management and quality-of-life attention?

So, I wanted to just share with you an example. This is a grant that I serve as the PI[11] on. It's funded by the National Cancer Institute through an R25 training grant. And it's called "Preparing Oncology Advanced Practice Nurses as Generalists in Palliative Care."

And so, basically, what we've done is to recruit nurses around the country who are advanced practice nurses working in cancer care. So, this might be nurses working in a breast clinic or giving chemotherapy or working on a

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[11] Principal investigator

hematology ward. So, these are not palliative care nurses. They're oncology advanced practice nurses. And we bring them to this training program and, basically, give them the palliative care knowledge to infuse into their oncology practice. And so, in the first funding through this NCI grant, we trained 430 oncology advanced practice nurses from all over the country.

And this is just one little piece of the follow-up date:

At 12 months, we follow up to look at documented changes in practice. So, not just did they like the course or did they learn from the course, but did it impact their practice?

And so, we evaluated things like: were these oncology advanced practice nurses more involved with things like family meetings; communicating with the oncologist about the patient goals and with the patients about their goals of care; referring families for bereavement support and supporting the other clinical staff and end-of-life care?

So, this paper was published in the Journal of Palliative Medicine.

But the important thing is, if we want the patient care, we need to train clinicians to provide it. And there's a very good evidence base now that, when we train clinicians, we can impact patient care.

Next.

Also, I just want to again emphasize that good palliative care applies to every setting of care. So, two years ago, I had the privilege of chairing the National Academies of Medicine report on "Improving Care in Nursing Homes." And the report was issued in 2022.

And again, we need to remember that it's not just patients in acute care settings, but patients in home care, in nursing homes, every place that a patient, a person with a serious illness can be.

Next slide.

So, this is just one slide from that report in the nursing home. It's that, if we want to improve care in nursing homes, it begins with the workforce -- with competitive wages and benefits, staff scheduling, and expertise. For example, having a social worker in each nursing home, empowerment of Certified Nursing Assistants, education and training, and good data collection and research.

Next.

I think, also, very critical, as I mentioned, because nursing is the largest part of the workforce across every population in every setting of care, we need good training of clinicians to provide that quality care in serious illness.

Next.

So, over the last 24 years, I've been the principal investigator of a project called ELNEC, the End-of-Life Nursing Education Consortium. And ELNEC is a partnership where I work, the City of Hope, and the American Association of Colleges of Nursing.

And this has been a tremendous partnership. Because to have the leading nursing education organization in the country, the American Association of Colleges of Nursing [AACN], really places a value and reinforces palliative care as an essential part of nursing practice. It has made all the difference in the world of the changes, the remarkable changes, we've seen in recent years.

Next? So, what do we teach if we wanted to train nurses, what would we teach them to provide better serious illness care?

Well, we use the national guidelines

for palliative care. And so, these are the domains. This is what the national organizations have all come to agreement about what is quality care in serious illness.

It is a general overview of what is palliative care. How do the goals of your care change?

It's pain management. It's symptom management. It's the many ethical issues that are confronted on a daily basis, by clinicians.

It's cultural and spiritual care. Good communication. Loss, grief, and bereavement care for patients and families.

And it is care that is focused on the final hours.

So we've taken the national guidelines, what constitutes quality care, and then we've now created curricula for how do we teach this. How do we enhance the skills of the clinician?

Next. So, the ELNEC project as I mentioned, is a partnership with the AACN. It started in the year 2000 with funding by the Robert Wood Johnson Foundation.

Our first course was held in the year 2001, and this year January 2024 marked our 300th

ELNEC trainer course.

So, a tremendous opportunity over these years to do a lot of training around the country, and around the world.

Next. ELNEC is a train-the-trainer course. So from the beginning, we realized there's over three million registered nurses in the country. The only way to really impact care is to create a train the trainer.

So when people come to us, they’re not only learning the content themselves, but they're going home prepared to teach others.

So, as of this point in time, we have over 47,000 ELNEC trainers. People who have been trained through our courses to not only improve their own practice, but to train others.

These ELNEC trainers have returned to their institutions and settings, and now trained over 1.5 million clinicians across disciplines, presented in every U.S. state and D.C.

In addition, we also have online training completed through Relias Learning. And one of our most important accomplishments is we have now integrated palliative care for nursing education.

So, we've created an entire curriculum

for undergraduate nursing; an entire curriculum for graduate nursing.

As of today, we have -- now, these numbers are a little dated, but we have over 1,200 undergraduate nursing programs in the country now teaching nurses about palliative care, and over 400 graduate schools. Again, preparing our advanced practitioners in how to provide this serious illness care.

We are getting close to 100,000 students who have completed all the modules, and tested in this content. And those numbers are growing rapidly. And our curriculum has been taught in 114 countries and translated into 12 languages.

Next. Also, I think something that's really important is there's common thread. So for example, whether you have heart failure or lung disease, or cancer, dyspnea is important.

And, regardless if you're in a nursing home or home care, an in-patient hospice or an acute care setting, you have some common needs. But I also want to really emphasize that there are, is also variation across patient population and setting.

And for this reason, we have created

several different curricula. We have a core curriculum, which is our sort of generic, all serious illness.

But we also have an entire curriculum for geriatric care, which includes teaching of unlicensed staff.

Pediatrics, which now also focuses on neonatal and even perinatal care.

The critical care setting where issues are very different in serious illness. ELNEC for advanced practice nurses, ELNEC oncology, and an entire communication curriculum.

And then as I mentioned, we also now have training for undergraduate and graduates. And most of these courses are also available online, as well as in-person training.

Next. So, I think just the bottom line is that the nursing workforce is essential in transforming serious illness care. And if the goal is to improve care of patients, it has to begin with patient -- with nursing.

Thank you.

CO-CHAIR HARDIN: Thank you so much, Dr. Ferrell. Another essential presentation. Really interesting from all four of you.

So next, we're going to open up the

discussion to our Committee members. So at this time, if PTAC members will flip your name tent up or raise your hand in Zoom, Jay, if you have questions for our guests.

And it's difficult for me to see the room so Angelo, if you could help me see the tents that are up, I'd greatly appreciate it.

CO-CHAIR SINOPOLI: I can do that.

Terry?

DR. MILLS: Sure, thanks. Great presentations.

The PTAC focuses a lot on measurement in metrics, and reducing caregiver burden, that sort of thing.

So, interested in knowing your advice and what the literature says about what are the approaches to performance measurement in this space, that would be most appropriate to help guide the development of total cost of care models, involving palliative and hospice care?

DR. FERRELL: I could start kind of putting on my researcher hat with the clinical needs. And I would just say that we're really fortunate in our field of palliative care, because we do have a strong national guidelines that define what are those important dimensions.

And so, we know that symptom management is a very high priority for patients and families. Are we managing dyspnea? Are we getting the pain under control? Is nausea controlled?

And so, I would say that there's been a great deal of work in quality measurement of the key outcomes of palliative care.

And so, if we look back at each of those domains, pain management, symptom management, are there goals of care conversations? Do we have advance directives?

That there's been a lot of work and so there are good, good outcome measures. Groups like the American Academy of Hospice and Health Medicine have done a lot of great work, like the project Measuring What Matters.

And so, we do have good outcome measures, and we are able to capture the things that are most important to patients and families.

DR. MERKELZ: I'll also comment regarding burden. Families, absolutely symptoms are incredibly important.

Families are incredibly burdened by polypharmacy, and trying to understand a medication regimen.

It's almost we take for granted so often when we, as clinicians and physicians, prescribe medications and give the prescription to the family and the patient, the failure that takes place after that point.

And very often we get a patient that ends up getting labeled as non-compliant. But it's not a matter of non-compliance, it's they don't understand the importance of how to take medications.

There's no one validating that a system is in place. Every home I go into, usually what I find is the bucket or the shoebox of medications.

And the patient literally goes pill bottle by pill bottle to decide if this is the pill they're supposed to take right now.

Or they fill up these medication containers, which is a great next step, but every time I look into it because nobody's ever validated that they're correct, you'll find well, Tuesday has five medications and Wednesday has seven. And Thursday has two of the same medications.

This occurs time and time again. And I just did another visit the other day where I walked in the home, and the patient's in AFib with rapid ventricular response at 180 beats per minute.

It was 11:30, she had a rough night. She hadn't taken her morning medications yet. She hadn't taken her diltiazem yet.

Nobody ever told her the importance of taking her medications on her schedule.

So, a lot of care burden stress comes from a lack of standardization and measures to, for clinicians to look at what needs to be measured, that patients understand the medications they need to take.

That we validate that they’re following their treatment regimen. That we validate they're following restrictions and precautions. That they have a system in place to take those medications. That they know what to monitor, and most importantly, they know how to respond when variances occur. When we train families and caregivers in this, stress can go down greatly.

CO-CHAIR HARDIN: Thank you.

And, Ira, please go ahead.

DR. BYOCK: I agree with what's just been said. I would also caution the Committee away from an overemphasis on outcomes. Most of us have been trained in a Donabedian model of structure process outcome. And sometimes we have under emphasized and process.

The process of goal alignment requires iterative goals of care conversations. As people's condition changes, their priorities may change.

And that in and of itself, is a quality measure. Have these conversations happened in a timely fashion, iteratively as things change?

I also want to emphasize the importance of structure. These days we have hospice programs in which there may be one physician for 100, to even 300 patients.

That's not an adequate structure for a good program. Nurses need, as Dr. Ferrell was mentioning, nurses have to be staffed well enough so that there's not one hospice nurse for 15 to 20 seriously ill patients.

That's a prescription for burning out the nurse, and for leaving unmet needs on patients and families.

So while yes, we need outcome measures, please don't forget the structures and the processes needed to deliver high-quality, value-based care.

CO-CHAIR HARDIN: Key points. Natalie, please go ahead.

DR. ERNECOFF: Thank you. I'll agree with everything everyone else said and just briefly add to Dr. Byock's presentation, that people want to have these goals of care conversations. And they want this ongoing communication. They want to know what their prognosis is.

And so, yesterday we heard about the AAHPM[12]'s feeling heard and understood measure. And I think those types of measures of what does the care experience look like; are people having their needs met, is essential as well.

And also couldn't agree more strongly about Dr. Byock's structure point, as well. Is the infrastructure in place? Do we have the resources that we actually need to make, meet the needs?

CO-CHAIR HARDIN: Great points. Jay, please go ahead.

DR. FELDSTEIN: Yes, my question is basically for the group. And that we know that

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[12] American Academy of Hospice and Palliative Medicine

minority populations and issues with health equity get exacerbated a lot of times in end-of-life care. And palliative care.

So, I was just curious as to each of you how you're addressing that in your organizations.

DR. FERRELL: I can start. In our training projects, we try to give a great deal of attention to social determinants of health, and a lot of attention to culture and diversity in our training.

And I think it really -- it has to be integrated in everything that we do. And so, it begins with the initial assessment of the patient. What are some of the barriers of patients that don't trust the health care system, and have good reason not to trust the health care system?

Or, and are afraid to communicate their needs. It happens when we get to pain and symptom management in terms of people who live in neighborhoods that don't have access to the medications that they need to relieve their symptoms.

It is a part of our failure to do good cultural assessments, and to understand important individual beliefs and practices.

Whether that be spiritual practices, or cultural factors that are influencing the experience of illness. And so, we have to take every aspect of serious illness care and really pause to say, this is not one size fits all.

But I think it really starts with the things you've heard about today. If we don't start our interaction with the seriously ill person by saying who are you, what do I need to know about you, who is your family? Is faith or spirituality important to you?

Then if we don't know the patient from the beginning, and Harvey Chochinov is a great psychiatrist and colleague in palliative care.

And he demonstrated with an initial assessment that at the end of that initial encounter, he asks the question, what do I need to know about you to provide the best care for you?

And so, I think this is not like here's the tool that will do this. It's more as Dr. Byock just said, it's the process by which we get to know the patient is the way that we will make sure that we are listening to and responding to, diversity.

DR. MERKELZ: I think the process by which we go about getting to know the patient though, does, does need fundamentally to be communicated. And trained.

Because when I first started doing this work and looking at the substantive outcome care, when I looked at what the nurses and the clinicians provided when they went into the individual patient's home, and what they would document, there's on the line of all the forms, there was reason for visit.

And what they would document was SNV, which stood for skilled nursing visit. They put the reason they were there in the patient's home, but not what the patient needed.

So, we had to give specific training and guidance to help identify what matters most to the patient, and how to ask and address the greatest concern.

So I agree, you need to get to the root of what's important to the patient. But I think our clinicians really need frontline training, and really specific actions and tools to drive their performance.

Otherwise, I am left with workforces, the thousands of clinicians all doing their level of care. And that type of variability is my biggest enemy towards quality.

The best I can do to try to standardize the approach to have meaningful communication, to have meaningful discussions, I think is in the best interest of the patient and the provider.

CO-CHAIR HARDIN: Natalie, or Ira, would you like to comment?

DR. BYOCK: Can I just say, I went, the very earliest portion of my brief presentation I talked about the problem-oriented medical record.

And it's a great tool. I mean, it was a really remarkable transformative tool in medical communication. And in conveying plans of care to other clinicians.

But it does focus us on the medical problems soaping our notes. And I can remember very carefully, very clearly as a young medical student and then young family doc, that it made me feel like the things that were personally important to the patients were fluff.

That my job was to deal with the medical problems. And I think we really, if we're going to transform the way care is delivered, including for people with very diverse cultures and priorities in their own lives, we really have to change the way that lens of the medical model, and make it more porous to the real priorities of the lived experience of patients. And their families.

DR. ERNECOFF: I can answer the question from a slightly different perspective. I agree with everything we've heard so far.

From the research and implementation side, we include members of the communities we work with on our research teams.

We involve them in development of the clinical programs structurally. And we try as hard as we can to be mindful of what are the structural barriers people might be coming up against.

I do most of my work in hospice and end-stage kidney disease right now. And a big part of this concurrent care work is getting access to those dialysis clinics for people who live in rural areas, and are too seriously ill for their families to drive them.

So we need ambulance transport. And so, how does that look different than it does in urban settings?

And we involve members of those communities both intensively as part of our research processes.

We do a lot of qualitative work, a lot of engagement work. And as members of our research team. So they're checking everything that we're doing along the way.

CO-CHAIR HARDIN: Well, thank you.

Walter, please go ahead.

DR. LIN: I wanted to thank our panelists for just some really thought provoking, and interesting perspectives.

My question actually stems from the kind of evidence that our panelists have presented, showing the effectiveness of palliative care in the seriously ill, and patients with chronic complex condition population to both improve quality, and decrease cost.

You know, I think the evidence is very compelling, and it leads me to observe that I think in this population of patients in particular, there is a great underutilization of palliative care services.

And I have to think that's probably because of the way palliative care is paid for.

I mean, I think all of us here on PTAC probably believe the old saying that care follows finance.

And that's why we all serve here, is because we think we can influence care through payment policy.

And so, my question to the experts on the panel is, what recommendations would you make to the Secretary of Health and Human Services, around payment policy in this population of patients, to better utilize palliative care?

DR. BYOCK: Can I respond and jump in?

Your question is pertinent, and changes in payment policy are necessary. I would simply emphasize however, that we also need improvements in accounting practices.

Because palliative care is often seen through the lens of a P&L sheet, a profit and loss sheet.

And on a profit and loss sheet, it always loses money. Right, it doesn't charge enough for, to cover the personnel cost, particularly.

But when you actually bring accounting into the 21st century and look at palliative care, concurrent palliative care's impact on total costs of care, it reliably reduces total costs of care.

In every study I've been part of and program development I've been part of, every paper I've read, it reduces total costs of care, mostly by reducing the area under the curve of days in the hospital.

So if you can meet people's needs without requiring them to come into an acute care facility, you will reduce total costs of care.

But even in sophisticated, integrated health systems, the CFO[13] and the C-suite often goes to the palliative care team and says, you're just not covering your own costs.

That's really bringing 20th century P and L sheet accounting to a 21st century reality. It's inaccurate.

DR. LIN: Yes, actually, Ira, thank you for that. I meant to say, I think palliative care like you were just saying is very, it's very easy to show a return on palliative care services under a total cost of care environment.

But right now, it's largely compensated under a fee-for-service environment. And so, what can we do now to change that?

To change the underutilization of

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[13] Chief financial officer

palliative care under fee-for-service, knowing that under total cost of care, it's very easy to show a return?

DR. BYOCK: Can I just follow up and say, you have to link it to a larger cost center, right?

And what I over my years of work in this realm, including I spent a decade with the Robert Wood Johnson Foundation, building concurrent care models.

We looked at which entity bears financial risk for this patient's total cost of care, even if it's in a defined period of time.

And then link those two so that the risk-bearing cost center sees the benefit of the losses, if you will, or the lack of meeting its expenses that the palliative care cost center will realize.

CO-CHAIR HARDIN: Other presenters? Dr. Merkelz?

DR. MERKELZ: Increasing reimbursement that clinicians receive. Increasing reimbursement for home visit. Increasing reimbursement for home-based level of care.

Giving clinicians meaningful models

of meaningful outcomes that can be supported in the home environment, that makes patients successful.

Providing reimbursement for this type of activity results in tremendous returns on total cost of care.

And it gives the clinician and the patient meaningful outcomes. When we gave substantive outcome model training to our clinicians, and they go into the home practicing with these outcomes, their mind set has a shift.

They said this is why I became a nurse. This is why I became a therapist. This is why I do what I do.

When we move away from outdated performance metrics and misaligned incentives, it leaves clinicians doing minimal documentation and moving on to their next patient.

When we give them meaningful outcomes to work from, they really feel empowered in the care that they are providing.

And it engages a workforce to enter this workforce. To enter into the home-based care sector. Enter into the post-acute care environment, where we can really make differences in patients' lives.

DR. ERNECOFF: From a hospice perspective specifically, I think it's also important to consider the cost of treatment to meet the needs of people receiving hospice now.

Forty years after the hospice benefit started, people are living much sicker for much longer. And their needs are much more acute.

And reimbursement hasn't changed much. And the population of people who are getting hospice is not only sicker, but much more diverse.

It covers many more diagnoses where perhaps marginally more expensive therapies can help meet their needs in a way that's reasonable, and time limited, and comfort-oriented.

And so, providing, the CMMI model tests are currently getting at some of these things. We've looked at these things in MCCM, VBID. Some of the disease-specific models, and kidney disease, and cancer.

But the population's really changing, and the hospice payment model hasn't.

CO-CHAIR HARDIN: Did you want to add anything, Betty?

DR. FERRELL: I think I would just say I agree with all of these comments. They're so important.

And I would just say that going back to concurrent care, I think still remains a key issue.

So, my research and my primary population is the oncology population. And for the last several years, I've actually focused a lot of my studies on patients on clinical trials.

And so, it's a perfect example of we now have third and fourth-line cancer drugs, and that are exceedingly expensive.

And we have all of these clinical trials and yet there's so many disincentives of patients.

Because people with cancer, they, the mindset is what's next, what's next? There's no end point.

And so, what we have, and we have very strong data. I led a study funded by NCI, almost 500 cancer patients, demonstrating that these are patients on clinical trials that are getting only disease-focused therapy, and they are not getting a well-designed system of patient-focused care.

And so, 70 percent were coming into urgent care and ERs with symptoms out of control. They didn't have advance directives. They were dying in the hospital.

And, with poor patient outcomes, as well as spending a tremendous amount of money. And so we really, we need all the things that you've just mentioned in terms of better reimbursement, better models of care.

But we have to move beyond this dichotomy of either you're getting care for your disease, or you're getting palliative care to provide, to reduce your suffering, and address your quality of life.

CO-CHAIR HARDIN: Jen, please go ahead.

DR. WILER: I, too, want to give gratitude to the panel for a really thought-provoking conversation.

I'm going to go a level deeper with my question, riffing off of Walter's question. And when thinking about payment to incent excellent evidence-based care, which you all have been describing well, we think about two levers.

One around maybe direct payment, and then another around incentives or penalties. And that's where my question is going to come from.

Many Americans die in the hospital setting. One of the quality measures to evaluate in-patient care, is the mortality metric.

A numerator over denominator where I think you know, when the hospice benefit is evoked, that takes that person out of an in-patient settings denominator.

That's created some interesting national conversation, including in the lay press, around leveraging that benefit.

We focused on this mortality metric, maybe creating a perverse incentive. And that metric is one that cascades into many, many Medicare programs, and value-based purchasing.

It's used in Leapfrog to evaluate programs, hospitals, and health systems. And it's used then secondarily in the U.S. News and World Report.

So, my first question for you all is, thinking about quality metrics, and incentives and disincentives, what your thought is around the mortality metric because it's so heavily weighted in a number of programs.

And is it one that incents us to have these conversations, again and maybe a perverse way when it is evidence-based? That's one question.

And then, my other question is going

to be around is there some again perverse incentive to not have these conversations in the in-patient setting, when we have such challenges in the post-acute and home space in getting care?

And it pays more to have a person in the inpatient space getting care delivered, than transitioning them, and not having a place to deliver home-based hospice care.

So again, getting deeper into payment, any thoughts on the current structure? And again, back to Walter's question, what are some other opportunities if we're not in a total cost of care space, that payment policy might be able to improve our performance and payment for both palliative care and hospice care?

DR. BYOCK: I'll jump in. I don't have that much to say on this. I don't, I've never found the mortality scores to be particularly helpful.

I do think for certain procedurally oriented disciplines, cardiac surgery, for instance, the O to E, the observed to expected outcomes, are more valuable from my perspective.

I do think we continue to avoid the, kind of the obvious of disincentivizing, or if you will, penalizing clinicians or systems that do not do what every, there’s a strong consensus need to be done, like having a goals of care conversation or an advanced directive on file.

We let this go forward and as if, well, that's just the way things are and we're unable to impact it.

Dr. Ferrell just mentioned funded studies of cancer care, in which a large number of those patients are receiving what I would humbly conclude are substandard health care because they haven't had those conversations.

They don't have a crisis plan. They don't have an advanced directive on chart.

We tolerate this and it's, and it perpetuates itself, because we keep funding new models that are allowed to go forward with key components of quality and patient care lacking.

DR. MERKELZ: It's certainly a very complex area. And my focus, and my expertise is really in bedside care, and looking at patient needs and patient outcomes.

It is a misaligned system. It certainly impacts the ability of us to provide care.

I think frequently on how the over regulatory, and misaligned regulatory environment that exists currently within the hospice space.

When we know that the Medicare hospice benefit saves the health care system billions of dollars.

We know even on the very long length of stay patients, they actually have 11 percent reduction in cost compared to other beneficiaries.

So we know even the long length of stay hospice patient, is a cost-saving service to our patients.

Yet the hospices are penalized and reviewed for long length of stay patients.

Well, from the clinician standpoint, we've been caring for these patients in their communities.

They've separated from their specialists and their health care system. And we've been providing total care for the individual patient.

They're now, they've advanced in age. They've advanced in disability. And because of supportive care that we know is saving the health care system money, is causing the patient to have potentially a prolonged life, we have to now discharge them.

And integrate them back into the system. And that type of fragmented care really doesn't align with the services that are being provided.

It's a complex issue, and I think an overzealous regulatory environment that's not aligned with what we know is the outcomes from the Medicare hospice benefit, really needs to be squared.

DR. ERNECOFF: From a patient-centered perspective, there's more and more work that dying in a hospital is not inherently a sign of poor quality end of life for people, nor discordant with their goals.

Especially if they're part of this group of people who are very acutely seriously ill, near the end of life.

And I worry about symptom management particularly for people who are discharging home with hospice, and uncontrolled symptoms. Especially given the difficulty of accessing inpatient hospices, where those symptoms can be managed.

And so, as we think about incentives in this space, I think that that, too, how we think about getting people into hospice at all costs, maybe it isn't the best approach either.

But thinking about how we can provide comfort-focused care in hospice settings, cost not withstanding, is also meaningful and takes some, really some caregiver burden, as well.

CO-CHAIR HARDIN: Okay, Betty, did you want to add?

DR. FERRELL: Yes, I would just echo kind of building on Natalie's comment just now. When we really talk about cost of care, and who's able to stay at home, it has a lot to do with family caregivers.

And so, in my, I do a lot of work with family caregiving over all the years. And we kind of jokingly say, sadly say, oh, who's the primary caregiver of the patient? Oh, yes, it's somebody who's older and sicker than the patient, right?

Is who is taking care of the end-stage heart failure, cancer, pulmonary disease? It's the family caregiver who looks slightly worse than the patient.

And so, the lack of, and there are so many social factors. How many people's children live three states away?

And so, and care is very complex. And so, we just have not built very patient-centered models that recognize.

And I agree completely, the lack of inpatient options for people at the end of life. And there are people who die poorly at home because their one very overwhelmed caregiver has been doing this for 24 hours a day.

And so, there is a, I mean, I live in Los Angeles. It is so difficult when you have a very difficult social situation, to find an inpatient option for someone to make sure their last days of life are good.

And so, you can't understate the family caregiving issues and social issues that are really a part of the quality question here.

CO-CHAIR HARDIN: Thank you.

Larry, please go ahead.

DR. KOSINSKI: Well, one of the things that I love about being on this Committee is I get educated. And this session was education for me.

And something stuck with me earlier in the comment where 20th century P and L finances are being used on 21st century issues.

And I got thinking, are we trying to

retrofit a 20th century care model into a 21st century problem, as well?

And so, my question is since you're so, I heard over and over again, that symptom control is critical. And that that is the major focus.

Have any of you worked with any tech-enabled patient engagement symptom management entities, in a way of decreasing your own P and L?

DR. BYOCK: I don't think it's symptom management is the key focus. I do think that symptom management is good medical care. Basic, good medical care.

I think the key focus is goal alignment. Is decisional support, as the IOM said in the crossing the quality chasm.

And there are some tech-enabled solutions coming forward that help with goal alignment, and making sure that patients are routinely assessed about their symptoms, their sources of distress, their major concerns.

And that the health care team can then address those key priorities for patients in the context of their households, and families.

Symptom management is absolutely

requisite. But I think the transformative focus is on goal alignment.

DR. ERNECOFF: We are definitely seeing creative models of remote symptom monitoring, to your question directly.

Whether it's app-based bring your device, for example. I know programs like that that are led by nurse practitioners' remote monitoring and can help with triage.

And various patient education for guidance if you have this level of symptom, do this, call your home health nurse. If you have this level of symptom, go to the emergency department.

So, we are seeing some of that in practice.

DR. MERKELZ: And we are leveraging predictive analytics to try to gauge, when is the right time to interface and increase our interaction with the patient?

So as we're seeing patients that are on a trajectory of a higher risk of mortality, we can engage and increase the frequency of our visits and appropriately utilize resources.

DR. ERNECOFF: I think that's where AI and electronic health records might get very interesting.

As prognostic prediction or systematically identifying people who have repeat acute encounters, and is it time to start maybe being more purposeful about those roles of care conversations. Or change in care plans.

DR. BYOCK: I agree.

CO-CHAIR HARDIN: Betty, did you want to add a comment?

DR. FERRELL: No, I just agree with all of these thoughts.

CO-CHAIR HARDIN: Wonderful. We appreciate all of you joining us today. Each presentation was essential in helping us to understand more about this issue, and really look at next space development in this area.

We want to thank you so much for taking the time to be with us today, and you are welcome to join for the rest of the day where we have multiple additional presentations.

But at this time we have a short break until 11:00 a.m. Eastern. So please join us then. We have a very special presentation with a CMS panel discussion planned.

So, we'll see you back at 11:00 a.m.

(Whereupon, the above-entitled matter

went off the record at 10:41 a.m. and resumed at 11:00 a.m.)

***   CMS Panel Discussion**

CO-CHAIR SINOPOLI: Welcome back. At this time I'm excited to welcome staff from CMS Innovation Center, or CMMI, who will share updates on the CMMI serious illness portfolio.

First, we'd like to welcome Dr. Susannah Bernheim, Chief Quality Officer and Acting Chief Medical Officer, and Dr. Jacob Quinton, Medical Officer of the Patient Care Models Group, to share introductions for this panel discussion.

Welcome, Susan and Jake.

DR. BERNHEIM: Hello. I was going to say -- I guess it's still good morning. Good morning. It's really nice to sit up here with all of you as I got to do last time. It has been an amazing first day and a little of conversations and really a pleasure to be here with all of you.

We have an amazing panel for you so I'm going to be very brief, Jake and I, in our introductions, but we're really happy and grateful that the Committee let us put together this discussion on some of what's been tested or is being tested in the CMS portfolio around payment models and demonstrations focused on seriously ill beneficiaries and those with complex chronic diseases.

This is going to give you a little bit of information on many different pieces, so I hope we'll have time to get through all of it. We're going to start by talking about three models that have existed and what we learned through the evaluation of those models, and then we're going to focus on three newer models that are either -- have been implemented or will be implemented shortly where we've taken some of the lessons learned and are thinking again about how best to design models to care for complex chronically ill patients.

One thing I want to say that will -- that sits in the background of all of this is that as all of you know, the Innovation Center was given the authority to test new payment and service delivery models, and if they are found to reduce spending and maintain quality or improve quality and maintain spending, they can be expanded. But there's actually also a lot of different ways that our models generate learning and get scaled even when they are not formally expanded. And you'll pick up on some of that here today. So I just wanted to note that.

In some cases we learn something and rather than scaling the model, we bring it into a new model. So the -- I'm going to get the name wrong, so I'm going to look at my notes for a second -- the ACO[14] Investment Model is a model that we tested and then was brought into the Medicare Shared Savings Program, renamed the Advanced Investment Payment Program. In other cases, we bring lessons learned from our models into successor models. So you'll see some examples here of that today.

And I think I'm actually going to keep it at that, let Jake go through a couple of these slides, but really our goal is just to give you some of the grounding in the work we've done in this area and the lessons that we have learned and continue to learn to try to build strong payment and service delivery models for this population.

DR. QUINTON: Thank you so much, Susannah.

And just two more quick slides to get us started. Sticking with the goals of the panel

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[14] Accountable Care Organization

discussion slide, our panels been given the nearly impossible task of describing multiple years of work in between three and five minutes, so I'm just -- we're just going to give a quick snapshot today, and I won't delay getting to the experts any more than we have to.

This series of models we're hoping is going to give you a both evaluation portfolio view and implementation portfolio view and a chronology of how the serious illness portfolio at CMMI has progressed over the last decade.

So those are the goals of the discussion as described.

So, next slide, please. Our order of operations. We're going to start with the models that have been implemented and have evaluation findings: the Medicare Care Choices Model, IAH[15], and VBID Hospice. We're also going to be moving to the models that are announced or in operation. And starting with ACO REACH[16] High-Needs. We have one virtual presenter for that. And then Kidney Care Choices, and concluding with a model about to begin in GUIDE[17].

So really excited for this

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[15] Independence at Home
[16] Realizing Equity, Access, and Community Health
[17] Guiding an Improved Dementia Experience

presentation. We do know that this is a quick snapshot of a breadth of our portfolio, and we're looking forward to in-depth discussions in future.

Now one more slide as we get started. We wanted to frame this discussion around the timeline of our models that are being discussed. On the Y axis, we have the type of model, whether it be a congressionally-mandated demonstration or a CMMI Model; and whether it's been completed; it's in implementation or it's been recently announced. And of course the X axis is time.

Independence at Home as you know has been in existence since 2012 all the way through 2023. The darker gray is for the completed Medicare Care Choices Model, and for those models in implementation VBID Hospice, we're presenting evaluation findings to date. But then for those models in operation in orange: ACO REACH, Kidney Care Choices, and GUIDE, about to begin.

So just wanted to set the stage a little bit further and give you a timeline for our portfolio. We are thinking this is just about chronological and wanting to help you see the evolution of our CMMI Models to date.

And, Angelo, I'm happy to hand it over

to our first presenter, if that's okay.

So I will hand the mic first to, we are very close to each other. I will turn off my mic in just a -- to Suzanne Wensky. And please as you start your remarks, give a brief introduction so people know where you come from.

DR. WENSKY: Sure. Thank you. Suzanne Wensky. I am in the Research and Rapid Cycle Evaluation Group, one of the division directors, at CMMI. I'm going to be sharing with you our evaluation findings from the Medicare Care Choices Model.

This was a six-year model designed to test a new option for Medicare beneficiaries to receive treatment for terminal conditions along with supportive for -- from participating hospices. And this is in contrast to the Medicare hospice benefit in which patients must forego curative treatment for their terminal condition. To be eligible for MCCM, beneficiaries had to have cancer, COPD, congestive heart failure, or HIV/AIDS; have a life expectancy of six months or less; and also not be enrolled in the Medicare hospice benefit. And at six years, over 7,000 beneficiaries enrolled in the model.

Enrolled beneficiaries received

assessments and care plan development, care coordination, pain and symptom management, 24/7 access to a care team, and counseling.

Next slide, please. From the evaluation, we 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 also reduced Medicare expenditures by 30 percent mainly by decreasing hospitalizations and increasing hospice use earlier in the disease trajectory. Enrollees and caregivers had high levels of satisfaction with the care they received under the model; however, despite these favorable outcomes, CMS was unable to expand the model due to low model uptake and low market penetration which limited the generalizability of these results.

Next slide, please. So specifically only five participating hospices enrolled 46 percent of all MCCM beneficiaries, and 3 percent of all hospices nationwide participated in MCCM. 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 were 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.

Next slide, please. Of the hospices that were successful in enrolling beneficiaries providing high-quality care and reducing Medicare expenditures, they tended to implement a no-wrong-door referral policy, gained enrollees' trust, engaged enrollees and caregivers in ongoing education, and gave enrollees someone to call after hours.

Last slide, please. So although CMS did not expand MCCM, the model is a promising approach to transforming care delivery at the end of life, and palliative care and concurrent hospice care continue to be tested in other Innovation Center Models, such as ACO Reach and Kidney Care Choices Model.

With that I will turn it over to David Nyweide to talk about the evaluation results for the Independence at Home demonstration.

DR. NYWEIDE: Okay. Thank you,

Suzanne.

I'm also in the Research and Rapid Cycle Evaluation Group at CMMI. And Independence at Home. I want to stress from the outset that Independence at Home was a congressionally-authorized demonstration project, which means that CMS didn't have any control over its timeline or some of the key design and evaluation parameters of the demonstration. However, the Innovation Center was charged with implementing and evaluating Independence at Home, and there are some lessons to be learned.

The key goals of IAH were to reduce total spending and improve quality of care for high-need/high-cost patients who were seen by practices that specialized in home-based primary care, and in return those practices could earn incentive payments that worked a lot like shared savings in ACOs.

Now as you can see on this slide with the patient eligibility criteria, these were really sick patients. And the criterion I want to particularly draw your attention to is the last one, the hospital stay and the post-acute care.

Next slide, please. What we found was

that using event-defined eligibility was problematic for the demonstration and for the evaluation. And the reason is that if you start with a high-cost event like a hospital stay, what we know is that for most patients, they have a downward trajectory of spending after that event. And you can see that in the blue line in the graph.

At the same time, the way that the incentive payments were set up with the target expenditures, they had an upward trajectory from a national cost trend from the prior year. And so that divergence in those lines became an issue when the evaluation looked at the IAH patient spending and matched it up with a comparison group that was a group of patients who looked very similar but didn't receive home-based primary care, and found that in 2019, as an example, there was no difference in spending between those two groups, and yet CMS paid the practices $11 million in incentive payments despite not showing any reductions in programmatic spending.

Now we all know that setting target expenditures is difficult in any scenario. That's nothing new. And there were in fact three different methods used in IAH throughout the demo, but the problem with setting accurate target expenditures was compounded in IAH because there was a relatively small number of patients in each of these practices. And when you have small numbers of expensive patients, their spending tends to be more volatile. And so it becomes that much more difficult to hit your target expenditures accurately.

Okay. Next slide? So that issue of small numbers also is a problem for the evaluation. Throughout the demonstration, a medium practice had 400 to 500 patients in IAH. For the demonstration overall, that number hit a high water mark in year five with about 10,000 patients. And then it declined thereafter mainly because the practices switched to Innovation Center Models.

Now that attrition in practices in those patients was an even bigger problem for the evaluation because even from year one, the evaluation couldn't measure total spending at a practice level because the spending at that level was too unstable and unreliable. So it had to pool all the patients across the practices and measure performance in the demonstration at the demonstration level. And so it really could not -- like I said, the attrition in the patients just really compounded the problems.

If you go to the next slide, what we ended up finding as a result over the first eight years of the demonstration -- there's two more to be evaluated -- there were only two of those eight years that had statistically significant findings. Now it could be the case that those other six years also had reductions in spending if we had greater power in the demonstration. We just don't know for sure. It could be that the practices increased spending overall or it could be that there was no difference relative to the comparison group.

The main thing to keep in mind here: If you take a step back and you consider that the types of patients that were targets of the demonstration comprised about 4 percent of the Medicare population at large -- they're a very small segment -- and the practices in this demonstration, they targeted specifically these types of patients, and they had a difficult time reaching critical mass. If you want to design a model that looks a lot like IAH, you're going to have a hard time doing it if you use your accountable unit the size of a practice. You have to think larger.

Next slide? Lastly a word on quality. The practices in IAH were responsible for six quality measures. They could qualify for incentive payments if they met performance thresholds for any three of those six quality measures, and of course they also had to spend beneath their spending target. And as you can see here, most of them were successful with meeting the performance thresholds for the three claims-based measures.

They weren't as successful with the site-reported measures, and they may have been delivering the care associated with those measures, but we don't know because they didn't report it. But the point here is that they were able to meet their incentive payments by reporting -- or by meeting the performance threshold with the claims-based measures alone.

All right. To wrap up, next slide? Some final key points on design from IAH. First, avoid event-based patient eligibility. Two, you’ve got to consider the size of the participating entities in the accountable unit. Larger is better. And finally, if you're going to use participant-reported quality measures, make sure that you tie that to the incentive structure of the model.

And with that, I will turn it to my colleague Julia.

Go ahead.

DR. DRIESSEN: Great. Thank you.

I'm Julia Driessen, and I am the evaluation lead for the Center's Medicare Advantage Value-Based Insurance Design Model.

Next slide, please. So this model encompasses a number of components and has been in operation at the Center since 2017, but I'm specifically going to talk about the VBID Hospice component, which I know you heard about earlier and a little bit yesterday. It began in 2021 and was recently announced that it would be concluding at the end of this calendar year.

And essentially the thrust of this model is that it allows Medicare Advantage Organizations, or MAOs, to offer the Medicare hospice benefit as part of their benefit packages. And that is in contrast with what happens outside the model where regardless of whether a beneficiary is in a Medicare Advantage Plan or is in fee-for-service, when they elect hospice, that becomes the purview of traditional Medicare.

So for participating plans in the model in addition to the Medicare hospice benefit, they were also required to offer related services, including palliative care and transitional concurrent care. And they had a fair amount of flexibility, the plans did, in terms of how they stood up those offerings in the model. They also had the option to offer supplemental benefits related to hospice.

Another thing to note is that in terms of characteristics related to putting this into the Medicare Advantage setting, there was a phase-in of the network adequacy requirements as it pertained to hospice, but beneficiaries maintained their choice of hospice consistent with how it would have operated outside of the model.

In terms of participation, in 2021, the first year, we had nine MAOs enter 49 plans into VBID Hospice, and currently in 2024, we have 13 MAOs and 78 plans participating. The last two evaluation reports released for VBID in 2022 and 2023 included a separate evaluation of VBID Hospice, so looking at those first two years of

2021 and 2022.

Next slide, please. Okay. Now as I mentioned, there was a fair amount of flexibility in the model design in terms of how the model was operationalized. And so somewhat unsurprisingly we saw significant variation in how the MAOs sort of stood up the various components of the model. So that would include things like how they formed hospice networks, the criteria that they used for establishing their concurrent care programs, and also how they designed their palliative care models.

There's also evidence in the evaluation of sort of -- again, this is early, but of a bit of a learning curve where we saw newer plans in the model report more substantial challenges. And plans that had some experience in the model in that second year sort of reported that those challenges had attenuated or subsided.

Nonetheless, sort of things that came out as elements that both hospices providing care under the model and plans participating in the model continued to devote significant effort to included education of providers and patients about these new services to make sure they were delivered to the right people at the right time.

And then on the hospice side, there was sort of continual mention in the evaluation of the effort associated administratively in working with plans. And for in-network hospices, there were concerns about reimbursements.

Next slide, please. Moving onto an overview of the utilization and quality findings so far, in general, utilization of the component services of VBID Hospice was lower than MAOs expected.

Now to the right you can see a table with some basic statistics on the first two years of utilization under the model. In terms of impact, the evaluation did not identify an impact of the model on hospice enrollment or hospice utilization patterns as of 2022, but they did identify an association between VBID Hospice participation by a plan and a small increase in hospice care experience as captured by Hospice CAHPS[18].

In addition to the quantitative analyses in the evaluation, the evaluation also included interviews with plans participating in the model, hospices providing care under the model, and beneficiaries who received care under

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[18] Consumer Assessment of Healthcare Providers and Systems

the model. And so one thing to note sort of in this setting for this meeting is that many recipients of palliative care under the model were actually not familiar with the term or the services that it comprised, but for those who were aware, they reported positive experiences with this component.

Next step please? Or next slide. In terms of thinking about the design takeaways from VBID Hospice, I think it's relevant to kind of step back and think about sort of the full scope of what the model entailed. So it represented the first time that an entity other than traditional Medicare was offering the Medicare hospice benefit to Medicare enrollees.

So it involves substantially new collaborations or collaborations in new ways between plans and hospices, and it involves developing and rolling out new services like transitional concurrent care. So those both create opportunities for patients at the end of life, but also have their own attendant sort of learning curves and time taken that sort of troubleshoot and get to sort of a good place.

Another thing highlighted by this model is sort of the inherent tension and design between wanting to be sort of prescriptive about the kind of essence or priorities of a model while also offering enough flexibility that you're harnessing the fact that your participants often are closer to the ground and may actually have sort of closer knowledge around their specific enrollees' needs and preferences.

And then finally sort of going back to a number of the points that I made on the last slide, the notion here is that this was both a payment model and also sort of much more than a payment model. So I think it's important to understand the significant sort of operational lifts behind the scenes to make it appear seamless and coordinated on the front of the house. And so it was also important throughout this model for there to be sufficient support for participants to actually let them get to a sort of a sustainable steady state.

So those are my comments, and I think I'm passing the mic to Meghan virtually.

MS. ELRINGTON-CLAYTON: Thank you, Julia.

Hi, everyone. My name is Meghan Elrington-Clayton. I am the director of the Division of Financial Risk here at the Innovation

Center.

I just wanted to share with you about the ACO REACH Model, which is one of our initiatives to help address the needs of seriously ill patients within Accountable Care Organizations, or ACOs.

The high-needs population ACOs type and ACO REACH Model are 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 in order to test whether provider-led entities can replicate the successful clinical approaches of PACE[19] and similar models of care within a broader Medicare fee-for-service population.

These approaches focus on interdisciplinary teams that (audio interference) besides preventative care and meet regularly to update patient care plans in response to changes of functional and health status. In addition, these approaches aim to manage patients' care across all settings,

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[19] Program for All-Inclusive Care for the Elderly

facilitating smooth transitions between those settings and reducing rehospitalizations.

Next slide, please. Importantly the introduction of the high-needs ACO track is innovative because prior ACO models have largely been population-agnostic and focused more on experience and risk level. Certain pieces of historical or traditional ACO designs such as risk adjustment and population size have been less compatible with the dynamic and high-acuity profile of the sickest and costliest patients.

To make ACO models work for a high-needs population, we made four key design changes that I wanted to highlight. The first is to qualify for alignment, beneficiaries had to meet a minimum risk score threshold, have a post-acute utilization level or mobility/frailty status.

Second, due to their smaller panel sizes, the minimum number of beneficiaries required for high-needs ACOs is much smaller than other ACO types, increasing to only 1,250 beneficiaries in 2026.

Third, during the first four years of the model, the benchmarks for high-needs ACOs are based on regional expenditures rather than a dynamic blend with historical expenditures, as is the case for our standard ACOs. This enables greater benchmark stability as high-need ACOs gain experience under the model.

Fourth, we incorporated a new modified risk adjustment model, the CMS-HCC[20] concurrent risk adjustment model to better capture rapid changes in health status as patients become seriously ill. The model does this by using diagnoses from the current performance year, as opposed to the prior year under CMS-HCC prospective risk adjustment model using Medicare Advantage. It also weights acute conditions more heavily than chronic conditions and demographics.

Next slide, please. We have learned a lot about what high-needs ACOs are doing to provide high-quality care and how they are providing this care from talking with our high-needs ACOs, their providers, and their patients.

High-needs ACOs have prioritized investments in primary care capacity, practice level infrastructure, complex care management, and enhanced primary care, including behavioral health and extended hours. They have made greater use of primary care (audio interference) practice providers such as nurse practitioners

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[20] Hierarchical Condition Category

and physician's assistants. Also hospice use in some cases increased while other post-acute utilization was decreased consistent with their efforts to improve advanced illness management and timely palliative care. Home-based touch points have been central for several of the ACOs care model approach as well.

In addition, we found that high-needs ACOs are reaching more diverse populations than standard ACOs serving a greater percentage of dually eligible patients and patients that are from racial and ethnic minority groups.

You can learn more about the impact of high-needs ACOs in the second annual evaluation report for the ACO REACH Model, which we're expecting to release this summer. It will be the first report to provide evaluation results for high-needs ACOs due to their limited number and size.

Next slide, please. We've also learned a lot about the considerations in designing a model for ACOs serving this population. For one, it has been a challenge defining the high-needs eligibility criteria in a way that fully reflects these patients, as well as the panels served by providers who specialize in caring for them.

High-needs ACOs have found it challenging to grow and to achieve scale given the size of their patient panels and mortality rate. We can see that they are delivering care that is tailored to these populations, so the question is whether there is a way to make sure these patients still have access to that care while ensuring that it's a viable model.

The concurrent risk adjustment model has been tested for three years and has been well received by stakeholders. We are evaluating whether and how the concurrent risk adjustment model could be expanded for additional subpopulations and models in general.

And then in terms of generating shared savings compared to their benchmarks, high-needs ACOs tend to perform better than other ACO types, which is somewhat expected given the risk adjustment and benchmarking policy already designed to maximize their payment stability. However, we continue to explore whether the current incentive policy is appropriately balanced with net savings potentials for the model.

With that, I'll now turn it over to my

colleague Laura Missett to speak to Kidney Care Choices.

MS. MISSETT: Awesome. Thanks, Meghan.

I'm Laura Missett. I am the model lead for the Kidney Care Choices [KCC] Model and also was the model lead for the predecessor model, the Comprehensive ESRD[21] Care [CEC] Model. Going to talk to you a little bit about KCC today. You know, this is a very sick population, and we wanted to test KCC to see if that coordinated care ACO-type structure could work for kidney-specific population.

In this model, we are focusing on patients with chronic kidney disease stages 4 and 5, ESRD, and transplant. So we wanted to take the kidney care kind of from the whole spectrum. We aligned through the nephrologist in this model instead of the dialysis facility so we can catch those beneficiaries more upstream possibly before they get to ESRD or before they get a transplant.

We have two different risk options in this model. We have the CMS Kidney Care First [KCF] option, which is a nephrology-only option. So that is modeled after the Primary Care First

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[21] End-stage renal disease

Model where just nephrology practices can participate in that option. And that is a Medicare Home style model. They're paid by a performance-based adjustment based on different quality results.

And then there is the comprehensive Kidney Care Contracting option. That is our ACO-type structure, and we have different levels of risk for shared savings from the graduated level 1 option where it's all upside risk, all the way up to 100 percent risk for shared savings and losses.

We have three different innovative payments that we introduced with this model. So the first is the chronic kidney disease quarterly capitated payment. We've never had a capitated payment for this population before. And it was set at approximately three times of what a nephrologist would make normally in fee-for-service. This upfront payment is to account for things like technology and investments in the model, care coordinators, and things of that nature.

We also have the home dialysis true-up payment. This allows for home dialysis to not be dis-incentivized. It brings home dialysis up to the same level of payment as you would receive for in-center dialysis so it's no longer a disincentive for prescribing home dialysis.

And then finally we have the kidney transplant bonus. So this is a bonus on top of whatever you would normally be paid fee-for-service for a kidney transplant per beneficiary. It is paid in installments over three years to incentivize keeping that kidney transplant healthy for the duration of three years. And then you get that full $15,000 bonus. So that is also new in this model.

We have approximately 130 model participants. About 30 of those are KCF practices and the remaining 100 are KCEs, which are kidney contracting entities, which is just ACOs for kidneys.

So we are at the halfway point in our model almost exactly. We will be ending December 31st, 2026. What we have noticed so far is that for the first two years of our financial results, we do use a retrospective trend adjustment in this model, and the retrospective trend adjustment was a little larger than maybe anticipated by our entities. And we find that to be a little unsustainable for predictability in the model and transparency in the model because you're working towards one benchmark all year, and then it's not until after the year is over that you find out that that benchmark -- the actual expenditures were much higher or lower.

So we did incorporate risk corridors for the retrospective trend adjustment. They start in PY 2024, so they start in this year, to help protect from some extreme retrospective trend adjustments.

We saw with this model versus our predecessor model that there are more organizations, more care coordination organizations participating in the model than we saw. So it's not just dialysis facilities anymore in this model. It's also bringing in new investments into the market. And we see a lot of -- a lot more participants entering. The CEC model for comparison had 37 ACOS, and we have about 100 ACOs in 10 different organizations. So there's wide participation, and people are excited about the model.

Some of the challenges that we've had in the kidney models is difficulty in benchmarking. We're using this retrospective trend adjustment in this model. We used a reference population which also had its own issues in the predecessor model. And like some of my other colleagues were saying, it's a small numbers problem. So it's a small population, it's difficult to meet the beneficiary level that's required to evaluate the model. We work with OAC[22] to come up with these estimates of how many beneficiaries each entity needs to be able to evaluate the model correctly, and sometimes people don't meet that. So smaller entities can't participate as well.

We also run into carving out certain procedures and medications and devices in this model. Particularly we don't ding the entities for transplant costs. So we do take transplant costs out of the equation. We want to incentivize transplantation. And we're also looking at some of the TDAPA[23] and TPNIES[24] medications and devices that are in the market and if we should take them out of the benchmark or not or incentivize their use or not.

We do have issues with overlapping beneficiaries with other models, and we think that once you have a late-stage kidney disease

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[22] Office of the Actuary

[23] Transitional Drug Add-on Payment Adjustment

[24] Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies

diagnosis, that you're better suited for the kidney model. And there was a little bit of research to support that with the CEC model evaluation results.

And another thing we have trouble with is accounting for quality of life and intangibles. For example, what's the price of someone getting to continue to work while they're on dialysis because they're dialyzing at home or at night, and what are those quality of life increases of staying off of dialysis in general? So it's hard to account for things like that in the model.

We also have a couple of benefit enhancements for this population, the concurrent care benefit enhancement that allows you to continue dialysis if you're in hospice. That has been really popular. We don't have the exact -- the claims data yet. We're trying to get that, but we do have anecdotal evidence that people are using this, people like this benefit, as well as the Kidney Care Education benefit allowing more patients to get that benefit and additional medical staff to administer that benefit.

So, all right. I think that is all for kidneys. We do have our first evaluation results will probably be released at the end of the summer, so please look out for those and send us any questions. Thank you.

MS. SAFFER: Thanks, Laura.

I am Tonya Saffer, and I'm pleased to join you guys today. I'm going to be talking about the Guiding an Improved Dementia Experience Model. My division, I'm the Division Director for the Division of Healthcare Payment Models, and our division focuses on improving the quality of lives and care for people with chronic and serious illnesses.

A couple of the models mentioned here today: Independence at Home and the Medicare Care Choices Model, were led out of our division. And now I am pleased to talk about a model that we are launching very, very soon here, July 1, the Guiding an Improved Dementia Experience, which we call GUIDE.

Next slide? So as I said, July 1 we're tracking to launch this model, and we'll test whether a comprehensive package of care coordination and care management, caregiver support and education, and respite services can achieve three primary objectives.

The first to improve patient living

with dementia or the person living with dementia's quality of life, reduce caregiver strain, and reduce or delay long-term nursing home placement. The GUIDE Model requires that these services be delivered by an interdisciplinary care team that is at least made up of a clinician with dementia experience and expertise, as well as a care navigator.

Next slide? So Medicare beneficiaries, oop, I think sorry, we may have jumped ahead too quickly, there we go, eligible beneficiaries. Thank you! [laughter]. Medicare beneficiaries must be fee-for-service enrolled, community dwelling, and not enrolled in hospice or a PACE program to be aligned to the GUIDE Model. They do not need to have a prior diagnosis of dementia to be eligible for GUIDE as we recognize there is a great amount of under-diagnosis of dementia, particularly in underserved areas, and we also know that there is a great deal of missed diagnosis.

So instead, GUIDE dementia care programs will be required to use one of two validated publicly-available tools to assess someone for whether they have mild, moderate, or severe dementia. And then scores for these assessments will be used to determine the level of -- that level of severity, and they'll be placed into model tiers.

Now we can go to the care delivery requirements. As I mentioned, the comprehensive assessment is the first step in a person living with dementia's path in the GUIDE Model. The person living with dementia will also be asked to identify a primary caregiver. They will still be able to participate even if they don't have a primary caregiver. That caregiver though will be assessed for stress and strain. And the eight domains on this slide encompass that package of care coordination, care management, and caregiver support services that the dementia care programs under the GUIDE Model must deliver or partner to deliver.

One of the unique features of this model is the availability of the respite services to help caregivers take a temporary break from their caregiving duties. This is the first time the Medicare Program will pay for those services, and our goal is to see whether it helps move the needle on reducing that strain for caregivers and reducing nursing home placement. We will also attempt to collect data on caregivers who are enrolled in Medicare fee-for-service to assess the impact that respite might have on the caregiver's health and their use of health care services.

Next slide, I'll talk about the payment methodology. GUIDE is not a shared savings or a capitated model. Instead, dementia care programs will receive a monthly dementia care management payment, which we refer to as the 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 that mild, moderate, or severe status and whether they have a primary caregiver, and the strain of that caregiver resulting in those different tiers for payment.

That tiered DCMP will then be adjusted based on the performance of a set of metrics used in the model and also adjusted -- a budget neutrality adjustment based on health equity. So we call that the health equity adjustment. And to qualify for that adjustment, that will be applied based on the percentage points of -- or sorry, the percentage of patients that are dually eligible and living in a high area of deprivation index. So that adjustment will either be plus or minus depending on whether or not the dementia care program in GUIDE is serving a high number of underserved beneficiaries.

So the dementia care programs will be able to bill as well for the GUIDE respite services. And that's annually. There's a cap of up to $2,500 per year per person living with dementia and that have a caregiver and are in the moderate or severe payment tiers. The GUIDE Model requires that all dementia care programs offer in-home respite, but they may also offer respite services in an adult day health center or an overnight facility.

In addition, to support new dementia care programs in underserved areas, we have provided a payment, or we will be providing a payment, one-time infrastructure payment for those that meet those qualifications.

And my last slide on overlaps. So as we mentioned, it is not -- GUIDE is not a shared savings or capitated model and instead was designed with the intention to be complementary to other models. And that includes primary care models. So as a result, GUIDE clinicians and patients may also be participating in GUIDE, as well as another CMMI model or the Shared Savings

Program.

That's my quick overview. There are many resources on GUIDE on the CMS Innovation website's GUIDE page. And I'll turn it back over to Susannah.

DR. QUINTON: Thank you so much. I'll be Susannah's stand-in. I am thrilled that we have concluded a little bit early and have plenty of time for question -- Q&A and for this tour de force of CMMI model presentations.

You heard three unique models that have -- through the evaluation findings and heard some central challenges in terms of our ability to evaluate models based on small numbers, challenges with enrollment, and other benefit design issues that may be leading to variability for implementation.

You also heard how we're trying to address this with our new ACO REACH Model and in changes to the risk adjustment methodology, provider/patient eligibility criteria, and also within KCC, what's happening with the concurrent care. When we say benefit enhancement, that's internal speak for specific waivers to CMMI model authority. And then we are so excited for what's about to roll out in GUIDE.

So with that brief summary, really excited for your questions, really looking forward to the discussion. And thank you again so much for the opportunity to present.

CO-CHAIR SINOPOLI: Thank you. Thanks to all the team. And I will just say congratulations to you all. Sounds like a lot of hard work. And you're fulfilling the vision of CMMI to innovate and try new models of care and then bringing them forward and testing them. And appreciate you sharing all that with us today.

And so I'm going to ask the PTAC members if they have questions to flip up their name cards and we can -- Chinni, I think you're first.

DR. PULLURU: Thank you everyone for the presentation. That was incredible.

This is a more general question, but one of the things we heard this time and in past public meetings was the timeline that these models have and the fact that they get cut at a certain timeline, because then it forces systems not to be able to invest for the long term and actually create sustainable infrastructures.

So my question to you is how would you -- how can that change or how would you think about that? Because the investment is significant in order to be able to make this work.

DR. BERNHEIM: I'll start with a quick answer since it's a general question, but then any of our panel should feel free to weigh in.

I think it's a really important question, and I'll actually say I think it's an even more important question as we start to work in spaces where -- like our Making Care Primary Model or some of our Medicaid models where we're working with providers who don't have a lot of experience in value-based care so they need some ramp-up time. And what you'll see is that we've actually extended the length of a lot of the models now.

How long is GUIDE going to run for?

MS. SAFFER: I was going to take that. It's going to run for eight years.

DR. BERNHEIM: Yes. So, Tonya, if you want to add anything else -- but I think there's two pieces to that: One is what does it take for us to support with infrastructure payments and other things, providers, to get ready to really succeed in value-based care? And then also how do we help sustain what happens either through successor models, expansion, or just setting folks up for success in that? So we're thinking about both sides, right? How to get them on board, how to have the models be a little longer and what the other ones are.

But do you want to speak specifically to that in GUIDE just because it's a great example?

MS. SAFFER: Yeah, so GUIDE, as I said, will run for eight years. And one of the reasons we did that is because we understood that there may be a long trajectory, particularly for the dementia population, in reaching sort of end-of-life or long-term nursing home placement, which is a core objective of the model, is to delay that placement. So we realized we may not see that early on under a typical five-year timeline. So we have been thinking about that in our models, and it's playing out in GUIDE. So, yeah.

CO-CHAIR SINOPOLI: Perfect. Walter?

DR. LIN: Thank you for sharing all that information. That was really wonderful.

The impetus for this whole public meeting is kind of the observation that Medicare spending is highly skewed. Five percent of Medicare beneficiaries, those who are seriously ill with complex chronic conditions, account for over 40 percent of Medicare spending.

And I think inherent in that observation is a common challenge that I heard across multiple models, which is the issue with small numbers, right? I think 5 percent. How do you design care models that only address 5 percent of the population or 10 percent of the population?

And so I think one kind of answer to that would be you find concentrations of dense patient populations within certain practices: oncology, kidney disease, maybe nursing homes for example of these seriously ill patients who are densely located, and you find practices that will focus on that to better incentivize their care.

I guess another kind of thought I had was are there thoughts of encouraging providers to focus on this population of patients? So what I'm hearing is kind of these models will encourage voluntary enrollment of practices that are kind of doing some of this, but not really encouraging them to focus more of their efforts and attention on this rather than kind of easier fee-for-service patients.

DR. BERNHEIM: I'm just going to make

sure I heard the question, and then I welcome any of my colleagues to jump in.

I think what you're saying is would we or have we thought about sort of creating an incentive to be a specialist in the care of complex chronically ill patients? I don't think we've done that directly. I mean, I think we've more tapped into, as you said, places where there's concentrated need.

And I think the other thing you see as you look at sort of the early evaluation findings into ACO REACH is how do we bring some of the concepts we're trying to build on into these broader care models, right? So an ACO has a much broader population, but we can build some of those kinds of needs into that.

But I don't know if anybody else wants to add to that.

DR. QUINTON: I'll try quickly just with -- and was waiting for the mic. So just to say as a long-time observer of this Committee the -- one of the recurrent things we hear is sort of creating the patient structures that the clinical care are following. At least I've heard that said today and in previous conversations.

And I think from a CMMI perspective --

and I want to at least take an opportunity to make sure that David and Meghan have an opportunity to speak on IAH and ACO REACH -- but we would think that some of the work that's been done to facilitate both the integration of these -- integration within an ACO construct and then also the establishment of the high-needs track within ACO REACH would encourage more clinicians to like choose to care for these populations. At least that would be my observation as an individual clinician.

And I think David in particular can speak to some of the challenges in terms of having this be a unique model for this defined population.

I will say one maybe under-the-hood feature of GUIDE that I think is particularly interesting is the proportion of the patient population that has dementia and that kind of dementia specialist that was included in some early conversations around GUIDE. So certainly I would welcome Tonya's comments as well.

MS. SAFFER: I don't know that I have anything more profound to say, but I would say that we were pretty broad in who could qualify as a dementia -- and we say a clinician with dementia expertise, right? So we expect to see palliative care providers. We expect to see geriatricians. We expect to see primary care, generally internists caring for this population.

And really what that expertise was based on is a number of factors: Have they cared for a certain percentage of their population with dementia before? Have they -- do they have clinical training in dementia? So there were a number of ways to qualify for that which broadens the pool of the types of clinicians that can participate in care for patients in this model.

I would love to hear David. He's going to go -- I'm like, okay, talk more about IAH because he and I have had lots of conversations about the struggles of caring for these high-needs populations.

DR. NYWEIDE: Well, the only thing I'll add is that IAH was specifically targeted toward practices that delivered home-based primary care. That was the solution to treating and caring for patients with high needs and high costs.

An ACO high-needs type of ACO wasn't that prescriptive. It said it allowed providers who wanted to treat and care for patients in any number of care delivery mechanisms. It allowed them in. There were a number of IAH practices that transitioned to ACO REACH for similar reasons. They thought it was more flexible and it provided an opportunity to care for a broader set of patients. So that's what I would add.

CO-CHAIR SINOPOLI: Alright, Lee? Okay. Lindsay?

DR. BOTSFORD: Yeah, thank you, Angelo. Two questions: One, I think specific on the VBID Hospice and then one maybe a follow-on to that.

I think the first one is you pointed out that the utilization of the services was less than intended, expected, or whatever word you want to use there. My curiosity was around how would a patient or beneficiary or a primary care provider know that that MAO was participating in it?

So I guess one question is if we're thinking about making consumers in general, our patients, our providers aware of all of these, all of these different programs, how would they have known that they had this extra benefit available to them?

And then I think maybe the broad

follow-on in general is there are so many things and some with some very specific benefits for the beneficiary as well. As you look at the GUIDE with the caregiver respite services, I mean, that's huge. You think about the VBID and the ability to access things you can't. To what extent are the models considering how patients or beneficiaries know to seek out providers that are participating in these models and kind of shine a light on new things that are available to them?

DR. DRIESSEN: Great. I'm happy to go first and talk about the VBID experience. And I think I had a bullet point sort of that was 1,000 words sort of on your exact question, which is I think on the ground this notion for MAOs of how you educate the sort of vast network of providers given that there are so many entry points to the potential conversations related to palliative care, related to TCC[25] and hospice was particularly challenging, sort of one of those things that I think folks anticipated but then the full magnitude really came out when it really was at go-live.

So that was certainly a place I think where participants and sort of the team on this

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[25] Transitional Concurrent Care

side of the house are still kind of working to troubleshoot and improve because there is just such a vast array of how folks end up at the kind of right place and have that information and getting there.

And there's also I think an awareness on the part of participants that they were very clear with us about the particular position they're in as a plan and wanting to sort of stay somewhat comfortably arm's length from a decision that really is more about the provider and the patient. So there's also sort of intentionally trying to be two degrees away and kind of capture the broad network of the ways folks may end up having that conversation.

So that’s, it's more of a recognition of the challenges than the sort of solutions that we figured out, but it is a place where at the frontier we're working on.

DR. BOTSFORD: So to clarify, it was fully on the MAO to decide if and how much they chose to popularize to their beneficiary that this benefit existed?

DR. DRIESSEN: Well, to some extent. So there was certainly a floor, right? So it was part of sort of the notice of coverage and other things in the sense that -- with the way other parts of the benefit are, but in terms of how it was disseminated, participants did engage in I think relatively intensive across-the-board kind of education efforts. It just it -- that was one of those ways in which it did vary how they went about doing that and even sort of how they changed that over the course of the model.

MS. SAFFER: And I can add for GUIDE because I think we're doing something unique where we are trying and testing whether sending letters to beneficiaries directly that -- alerting them of the GUIDE Model and listing participating dementia care programs that are in their service area will actually improve uptake and connection to those programs. So that's something that's unique about the model that we are trying out.

And I think the other -- which is normal in all of our models is that we do a lot of robust learning and education with the participants. We have a whole group within the Innovation Center that their responsibility is for developing learning plans for providers and helping with even peer-to-peer-based education. And so one of the topics in our model -- and I know that this has been the case in other models, is peer-to-peer what works? What's working in terms of outreach and education and drawing more people in to these programs? And I think on the ground, as Julia pointed out, the providers who are close to the patients or close to each other know the situation might have the best solutions to pose to one another.

CO-CHAIR SINOPOLI: All right. Great. Thank you. Appreciate all eight of you being here today and just sharing all this great information. And so, we're going to take a break now from 12:00 to 1:00, and we'll be back at 1:00, Eastern Time. Ask everybody else to join us back at that time. Thank you.

(Whereupon, the above-entitled matter went off the record at 11:58 a.m. and resumed at 1:03 p.m.)

CO-CHAIR SINOPOLI: Welcome back. I'm Angelo Sinopoli, one of the Co-Chairs of PTAC. We've invited four guest experts who have unique perspectives to share on best practices forincentivizing improved outcomes for patients with complex chronic diseases or serious illness in total cost of care models.

You can find their full biographies in

the slides posted on the ASPE PTAC website along with other materials for today's meetings.

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

I will now turn it over to Committee member Terry Mills to introduce our presenters and to facilitate this listening session.

Terry?

DR. MILLS: Thanks so much, Angelo.

Excited about this session, some exciting experts to present to us about best practices incentivizing improved outcomes for these patients with complex chronic conditions.

I'm excited to hear about their experience and recommendations.

We're going to start with Marie Bresnahan.

I'll ask each person, in turn, just to introduce themselves briefly. And then, give us your presentation.

So, Marie, please take it away.

MS. BRESNAHAN: Thank you so much.

Good afternoon, my name is Marie Bresnahan. I'm the Director of Training, Policy, and Administration in the Viral Hepatitis Program at the New York City Health Department.

I'm joined here today by Dr. Bruce Schackman, a distinguished professor in the Department of Population Health Sciences at Weill Cornell Medical Center.

And let me start by describing Project INSPIRE.

Next slide, please. Project INSPIRE was funded by CMS as a three-year Health Care Innovation Award designed to implement a care coordination model for treatment of the Hep C virus, or HCV, for high-need patients in New York City.

This model was designed to move care for Hepatitis C out of specialty clinics, primarily infectious disease and gastroenterology, and into primary care.

For this project, we worked with clinics located in East Harlem and the Bronx which were affiliated with Mount Sinai Medical Center and Montefiore Medical Center.

We developed a multi-provider bundled episode of care payment model which was designed to move treatment for Hep C into primary care and provide care coordination and support to patients through treatment to cure.

This was presented to the PTAC back in 2017. So, I want to describe a little bit more about the target population.

Next slide, please. When our project was developed, the majority of people with chronic Hepatitis C had been infected in the 1960s and '70s. They were baby boomers born between 1945 and 1964.

The demographics of people infected with Hepatitis changed as many more young people began injecting drugs because of the opioid epidemic.

And now, we see high rates of Hepatitis C infections among two groups, ages 25 to 45 and 55 to 70 years.

An estimated 40 percent of people living with Hepatitis C have comorbidities including behavioral health issues, substance use, and chronic diseases such as HIV, diabetes, and kidney disease.

As many of you probably know, people with history of injection drug use most commonly -- that is the greatest risk factor for Hepatitis C, injection drug use.

So, I'd like to describe a little bit

more about the current state of Hepatitis C on the next slide where you will see that Hepatitis C remains a leading blood-borne infection in the United States.

And despite the availability of direct acting antivirals, incidence for Hepatitis C has tripled due to unsafe injection practices associated with the opioid crisis. Incidence in mortality associated with cirrhosis due to Hepatitis C has risen steadily since 1990.

And the treatments now for Hepatitis C are significantly less expensive than when they were first available.

And many of the health insurance barriers such as prior authorization requirements have been removed.

So, the major medical societies such as AASLD[26] have developed a simplified treatment algorithm, and much of the treatment for Hepatitis C is moving to a test and treat model.

And treatment is being provided in many places including jails, prisons, homeless shelters, substance use treatment programs, as well as in primary care.

So, despite these advances, the

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26 American Association for the Study of Liver Diseases

current care cascade using National Laboratory data shows, on the next slide, please, that overall, only 34 percent of people diagnosed with Hepatitis C have been cured.

This study used more than 1.7 million people nationwide diagnosed with Hepatitis C between 2013 and 2022, which represents the first 10 years when safe and highly effective cures for Hepatitis C became available.

Other data in this study found that only 1.4 adults under the age of 40 were cured.

Cure rates were highest among adults 60 and older with Medicare and commercial insurance.

And yet, still, less than half of those folks have been cured or were cured when this study was completed.

So, we're leaving people, many people, with Hepatitis C in this country behind nearly a decade after curative treatments have become available.

So, I'd like to credit Dr. Rachel Florence, Senior Advisor to the White House on the National Plan for Hepatitis Elimination, for this and the next two slides.

She recently presented these slides in

New York. And they clearly spell out the need to ramp up treatment for Hepatitis C to promote better health and economic outcomes.

On this slide, you'll see the National Bureau of Economic Research did projections and found that increasing treatment for Hepatitis would have clinical benefit, including reduction of Hepatitis C-related Hepatocellular Carcinoma you see in the top left chart there, liver related deaths on the top right, diabetes on the bottom left, and chronic kidney disease on the bottom right over 10- and 20-year projections.

And increasing treatment for Hepatitis C would have economic impact as well.

On the next slide, you'll see projections found that increasing treatment of Hepatitis C would result in $18.1 billion in cost savings over 10 years and $57.1 billion over 20 years.

So, let's get back to the work we did in New York City with our Health Care Innovation Award.

On the next slide, what you will see was designed to provide treatment for Hepatitis C to Medicaid and Medicare patients that included comprehensive social determinants of health assessments, integrated behavioral health services, and medical care.

Our work on Project INSPIRE was designed to demonstrate better health outcomes and demonstrate cost savings, which you can see on this slide.

So, although we were able to demonstrate success with our model, the current health care environment is still not well equipped to treat all of those with Hepatitis C who need it.

On the next slide, you'll see some of what we think is missing.

We need more primary care providers who are comfortable treating Hepatitis C using the simplified algorithms.

We need care coordination which was found to reduce barriers to care and improve patient outcomes, particularly for hard to reach and hard to treat populations.

We need care teams that include people with lived experience and those able to support patients through the process of screening, treatment, and cure.

And payment models that support this care coordination and the peer specialists that would help us increase the number of Hepatitis C patients treated and cured.

And thanks to recommendations from the PTAC, we've explored the use of complex care management codes previously and found that these codes were not widely used and that CCM[27] payments were insufficient to fully reimburse the costs of this model.

So, what worked on Project INSPIRE, on the next slide, was tele-mentoring which allowed non-specialist providers to receive training in Hepatitis C and created knowledge networks where clinical guidance and case studies could be discussed.

And care coordination through nonlicensed care coordinators delivered health promotion and coaching and other services to support patients through care to the cure.

Our model also included peer specialists with lived experience who conducted outreach and provided support.

Next slide?

On Project INSPIRE, we also looked at how to reimburse these services. And we found that a potential payment model calculated in

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[27] Chronic care management

three phases which would support the kind of care you see in this table on this slide for patients from enrollment to treatment initiation, from treatment initiation to treatment completion, and a bonus payment for getting patients to come back for laboratory evidence of successful outcome, also called sustained viral response to verify that they had been cured.

In conclusion, on the next slide, we've outlined what we think are some implications for policy and practice, that a multi-disciplinary team with care coordinators and peer specialists focused on curing Hep C proved effective.

And a similar approach could be used to support other complex chronic conditions.

That a payment model, including a bonus payment to support the tele-mentoring that would not have been otherwise reimbursed.

So tele-mentoring requires some funding to support the time that a specialist spends with the primary care providers to teach them about how to treat Hep C patients.

And that savings will accrue for caring for complex patients appropriately in non-specialist settings, avoiding -- and avoiding the downstream medical costs from untreated Hepatitis C.

So, on our last slide, I just want to thank my many colleagues at the New York City Health Department and our partners who worked with us on Project INSPIRE.

The next slide, please -- outlines our clinical partners at Mount Sinai Medical Center and Montefiore.

We also had payer partners from HealthFirst and Select Health, the Visiting Nurse Service of New York, as well as my colleague and his partners here at Weill Cornell Medical Center for Health -- the Center for Health Economics and Treatment Interventions for Substance Use Disorder, Hep C and HIV.

So, Weill Cornell worked with us throughout Project INSPIRE to help us develop the payment model.

And the last slide just has our names and contact information. We are available for questions.

DR. MILLS: Thank you so much for that great explanation of your project.

Appreciate your presentation, Marie Bresnahan.

Dr. Schackman, I apologize for leaving you off of the initial introduction.

Let's proceed one with Jason Feuerman, President and CEO of LTC ACO.

MR. FEUERMAN: Hi, good afternoon.

Thank you for having me and the privilege to present to the PTAC Committee.

Just to give you some background really quickly, I come at this from dealing with the Medicare -- very high-risk Medicare Advantage patients over the last 20 years plus, over the last 10 years working not only with the bundled payment system that came out of CMMI, but operating the largest and most nationwide Accountable Care Organization through the Medicare Shared Savings Program.

And so, a lot of what I'm here to share are thoughts, are opinions, or things that we've learned through both being a payer and working within the fee-for-service world.

So, next slide, please. So, I think this first bullet is extremely important. Not having financial incentives will never change the outcomes regardless of the population.

You know, physicians work in a productivity model, and they must be incented to help drive down costs and rewarded for driving down those costs or things just won't change.

Financial incentives should not be identical for all populations. So, whether you're dealing with a high-risk dual eligible population or you're dealing with a high-risk nursing home population, or we're talking about disease-specific complexities, having one financial incentive program for a group like that doesn't necessarily work.

It really should be targeted so you can be assured you're getting to the right providers who are dealing with the intended population.

Financial incentives, obviously, must be meaningful.

You know, the number one feedback we get from -- or we've gotten from providers is, you know, if it's not meaningful, I just don't have the time nor the staff to bear the cost of taking that additional time for complex populations.

So, it's extremely important that they're meaningful.

And whether that's coming out of the payer world or as CMMI and CMS are coming up with and refining different models, financial incentives, I believe, must be an integral part of that and make them meaningful enough that providers are willing to take that extra time to care for these patients the way they need to be cared for.

And then, finally, and really, extremely important, is financial incentives must be provided in a timely manner. And that's time to the projected outcome.

So, as we think about some of the programs, for instance, that have come out of CMMI and CMS, specifically, Medicare Shared Savings Program, and other population-based programs, those shared savings do not get paid to the participants until about 9 to 10 months after the end of the calendar year.

So, it's very difficult without some creativity within the program to really align the effort and projected outcomes with the payments.

And so, to get a provider's attention, they need to be more closely related.

So, next slide?

So, a properly designed program really needs to focus in on -- and I just gave a few examples here, but and they’re really, the high-cost entry points into our health care system.

And so, what we looked to measure is the use of emergency room versus an urgent care setting or the proper specialists or primary care provider.

Obviously, for a high-risk population that's highly compromised, going through the emergency room, will more than likely, turn into a hospital admission.

So, that should be measured.

Proper utilization of specialty services is also something that needs to be zeroed in on, especially as we think about the last presenter talking about Hepatitis C.

If they're not with the right provider, they're probably not going to get the care that's going to yield the best outcome.

And then, we need to be looking at over and, more importantly, I'll talk about this a little later, but underutilization of services.

Other key components should, because so many folks think that, you know, they're dealing with a high-risk population, CMS does have a way, not a perfect way, but CMS does have a way to adjust for the acuity of a population and that's generated by ensuring that there's accurate and complete ICD[28]-10 coding for risk adjustment purposes.

And this is called the HCC Program. It's imbedded in the Medicare Advantage Program.

It's imbedded in the Medicare Shared Savings Program, as well as many states have adopted it for their Medicaid programs as well.

And then, an important guardrail that needs to be in there is that quality measures need to be meaningful to service as an imperative, kind of a guardrail to ensure the efficacy of this -- of a model.

Next slide, please. So, I think very quickly, components of a program – a well-designed program really needs to be simple so that providers understand it and people can explain it to them and it can be implemented.

Number two, transparency is extremely important. And too many programs, whether that's coming out of the fee-for-service world or coming out of the payer world, data transparency either intended or unintended, it creates a rub between the payer and the provider, also works to discount the results you get from the program.

Relevant metrics is an important piece

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[28] International Classification of Diseases

of the program, obviously. And that's why, when we think back to the first or second slide, I indicated that you can't have one reimbursement -- or one incentive program for a multitude of disease states and populations. They should be very specific and relevant.

And then, I spoke earlier about the quality measures so that a provider isn't so focused on just the financial aspect which, while important, if it's not guarded well with quality, it will lose its efficacy and it'll lose its ability to be adopted in a greater sense.

Next slide?

And so, as we think about developing models, there's always going to be unintended consequences.

Providers are thinking, well, if I'm being provided to give better care or incented to provide better care, and in a total cost-based environment, then, really, I want to do as much possibly as a provider to contain costs.

And that can be a real detriment to a program, and one that is, obviously, very unintended.

So, we look at underutilization of specialty care. So, if you've got dialysis patients and they’re not being -- under that situation, it's probably a better one because they are being seen by a nephrologist, but, you know, the diabetic who isn't being seen by an endocrinologist, being treated specifically by a primary care provider that may not specialize in diabetic patients could be very risky.

The underutilization of home and community-based services is another area.

A lot of these folks are susceptible to non-medical issues that create medical issues that send them back to the hospital.

And so, there are plenty of home and community-based services out there that should be leveraged.

The deferment of services to reduce costs being measured under a value-based program can't be overlooked.

You know, it's not good enough to say we'll put off that EKG, for instance, for another few months for the sake of saving money. And meanwhile, the person's in heart failure and costs the system a hundred times more money than the cost of the EKG.

And then, too much focus on a patient complexity while overlooking aspects of care and social determinants of health.

And that's really kind of ties into the second bullet. It's extremely important that all the right components of the health care delivery system, whether that's clinical or non-clinical, is properly leveraged.

And then, again, getting back to quality, if there's a perception out there that this is all financially driven without quality outcomes being measured and being rewarded as well, or penalized because of the lack of quality care, providers can get disenfranchised with the program.

And so, and I believe there's another slide.

So, in terms of lessons, works -- what doesn't work, and I hate to be negative and putting that first, but it's -- I think it's extremely important, what doesn't work is not accounting for and properly recognizing the acuity of the population being served.

And what I mean by that is, you've got -- you had these very serious populations out there that drain the health care system from a cost perspective and not really being able to properly recognize that acuity and accounting for it is something that could undermine the efficacy of the program.

Not providing timely payment for performance, not necessarily on an annual basis but maybe on a quarterly basis. We found that in the Medicare Advantage world to very beneficial.

We've even gone as far as implementing that under the Medicare Shared Savings Program in certain situations.

Assuming that all providers will respond to financial incentives. That doesn't hold true. There are plenty of providers that, either their business model doesn't allow for it, they don't have time for it, or they're just, for whatever reason, they're just not interested in responding to financial incentives.

And then, penalties, we saw this in the early introduction, particularly out West with Medicare Advantage with a lot of downstream risk where the providers themselves, if they didn't perform well, were giving money back to the Medicare Advantage Program.

And that's something that, after a while, just evaporates any value of a financially based incentive program.

So, what does work?

As I indicated, payment as close to the time of performance as possible.

Risk adjusting for the population served is very important, but it's one that should be looked at very closely to ensure that it's properly adjusting for the population and not just from a numerical perspective.

Providing regular data to -- regular performance data toproviders, I've always felt is one of the most critical things in making a program like this work.

You have really, in my opinion, waking up an ecosystem by giving -- by creating that transparency and giving providers information that they don't necessarily have on their patient population and their utilization services outside of their scope. And so, that's extremely important.

And then, proper education of providers to the incentive being offered. So, just rolling a program out there is something that could be troublesome for a program -- can you go back one slide yeah-- can be troublesome to certain providers.

So, being able to keep it simple so that the individual charged with speaking to the provider or providers can get their attention, can have a greater chance of getting the incentive program across and making it more effective and, thereby, not only containing costs, but getting better quality outcomes.

And then, finally, the next slide, conclusions, thank you.

Yes, it's working with all providers to create the value-based and quality-driven performance incentives, especially those for high-cost patients, obviously, that consume a disproportionate amount of cost and time.

So, in looking at programs, there is a theory that you don't want to necessarily just incent, say, a primary care provider, but work on incenting for a population, but work on incenting different providers along that specific continuum so that you're creating alignment within the -- within that delivery system.

The next bullet is encourage CMS and state Medicaid programs, not only to support, but participate, in the initiative beyond the current programs run by CMS and CMMI, including examples such as Medicare Advantage and Medicare Shared Savings Programs, you know, making that almost an integral part of participating in these programs.

Because it's one thing to incent and generate savings and share savings with the ACO itself, for instance, or with the Medicare Advantage Program itself.

But if it doesn't make its way down to the provider level in a timely manner, then it probably won't work and have the most desired outcome as expected.

And unless financial incentives become an inherent part of our provider reimbursement structure, which it really isn't today, which is unfortunate, changes to outcomes and performance will be greatly limited, constrained, and unachievable.

So, I think that goes without saying just the importance of these incentives to get out of that production-based environment, one that's more grounded on better outcomes, both for the system and, most importantly, for the patient or beneficiary.

And with that, I think that's the end of my presentation.

I want to thank you all.

DR. MILLS: Wonderful, thank you so much, Jason, for that insight.

We will come back with questions after

the end of all presentations.

We'll turn now to Dr. Bruce Leff, Professor of Medicine and Director of the Center for Transformative Geriatric Research at Johns Hopkins.

Bruce, take it away.

DR. LEFF: Coming off of mute.

Thanks very much. It's a pleasure to be here and, I think my comments will resonate with both Jason and Marie's comments.

I've been asked to talk today as a geriatrician and health services researcher, someone who's been interested in quality of care, delivery of care, especially in home and community-based settings to talk about quality outcomes, across settings for folks with serious or complex chronic conditions, think about data sources and measures.

And if we go to the next slide, I just want to, first, present a few caveats.

I think you're aware of most of these, but just want to try and tee them up, perhaps, in a unique way, thinking about this population, see if there are any learnings or insights from existing clinical or payment models that could be of use to us.

And then, talk about some associated issues that I think it's important for the PTAC to be aware of.

So, next. So, some caveats on how to monitor quality patient outcomes and quality of life for these patients.

And just by starting off by saying the nature of these patients makes this a particular challenge and a few caveats.

So, starting with next slide, number one. It's, first of all, I think, really dangerous to assume that these patients are getting care. They are often an invisible population.

So, these are data from Kaiser Permanente. They are members, but not necessarily getting care through Kaiser.

They looked at their 100,000 or so most complex patients out of a population of several million, did some latent class analysis.

One of the classes they identified were the frail elderly in red.

And if you go all the way to the right hand column, you'll see that 27 percent of the most frail elderly, the most complex, had zero outpatient visits in the previous year, but still had among the highest mortality rate and the highest rate of hospitalizations in this entire analysis.

And next, caveat number two.

There's a tremendous amount of heterogeneity in the population.

So, these are actually Medicaid data, somewhat dated, but the principles apply.

The tales of morbidity are long and complex. Single disease constructs, there are some exceptions, but with rare exceptions are often irrelevant for care or quality assessment in this population.

And if you think about cost, we often talk about cost as if it's just one thing when you're targeting patients, but is it the cost for the illness? Is it a cost for the illness plus associated conditions? And there are many ways of slicing and dicing.

Next. Number three would be that many critical factors highly associated with quality and outcomes are not captured in claims or even structured electronic health record data.

Things like functional status, social constructs, going to back to what Jason said.

We did a study where we looked at

claims data, structured EHR[29] data, and in green, we actually did some natural language processing around text data in the records in over 18,000 patients.

So, if you compare the green, the text data to the blue or red structure data for some items, so, for instance, lack of social support.

You're more likely to -- you're 455 times more likely to find that information about a patient compared with structured data.

And next. So, the status of these patients is not static, and it's associated with very high mortality rates.

So, this is a study we did looking at incident homebound in that left hand column, folks who are not homebound in the previous year become homebound.

And then we looked to see what happens to them over the next six years. Sixty-six percent of them are dead within six years. But you'll see that status, in terms of homebound, can vary quite a bit over time.

You're homebound, maybe you're permanently homebound, but maybe you vary between various homebound states. So, thinking about

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[29] Electronic health record

that is important.

And five, care provision is not centralized. So, this makes attribution a significant problem.

These data are almost 20 years old, the New England Journal article.

And if you look at folks with more than seven chronic conditions, the median number of physicians seen is 11. Median PCPs, primary care physicians, median is three. And the median number of specialists is eight. A big challenge.

Next. So, a question for you all is, is the top 5 percent of spending the right target? What's really the North Star of this effort? Is it to keep spending down? Maximize quality? Finding patients with rising risk and keeping them from getting expensive?

I think if you just focus on spending thresholds, that's an error.

I think it's useful to keep in mind, you can only improve quality for patients who are getting poor quality care, which is probably most patients, quite honestly.

But you can only save money on patients who cost money and have preventable costs.

A lot of talk about 20 percent costing 80 percent. But not all of that is preventable.

And, next. So, to that point, this is a terrific study from Jose Figueroa and his group up at Harvard.

They did various slicing and dicing of the populations.

So, if you look at that second set of columns from the left, frail elderly are about 8.6 percent of the Medicare population, but constitute about 51 percent of preventable costs. Important.

And studies estimate that the preventable proportion of Medicare costs is on the order of 5 to 10 percent. It's not that 80 percent, but 5 to 10 percent of a big, big number is important and worth focusing on.

And, next. So, some learnings, are there learnings from other models?

Next. So, these are some data from the Independence at Home Demonstration from CMMI. I think this is probably the most underappreciated and probably the most successful CMMI demo.

This demo which focused on folks who are homebound receiving home-based primary care, interdisciplinary care had 10 times the savings of per year savings of ACOs and averaged about 9 percent savings per year.

It was a Shared Savings mechanism.

And actually achieved success not adhering to many of Jason's very excellent recommendations in terms of getting money to providers quickly. That was a big barrier and could have been more successful.

And next?

So, the Independence at Home quality metrics that were used were things like follow-up contacts within 48 hours of hospital admissions and ED[30] visits, med rec within 48 hours, all-cause hospital admissions, annual documentation of preferences.

And I think Diane will be talking to that.

I put the two in red in numbers five and six, hospital admissions for ambulatory-sensitive care conditions, and ED visits for ambulatory-sensitive care conditions.

I don't think those are particularly useful.

Next. I think it's useful to look at

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[30] Emergency department

the ACO REACH quality measure set which is actually pretty good.

They have some claims-based measures, all condition readmission risk standardized, all-cause unplanned admissions with multiple chronic conditions, a nice one, days at home for patients with complex chronic illness in the high-needs ACO only.

And then, timely follow-up after exacerbations of chronic conditions.

These feel more aligned with the care patients with serious illness and complex chronic conditions need, and also importantly includes a component of patient experience.

Next. So, you know, thinking about additional dimensions or constructs of quality to think about, I think these are all things worth, you know, putting on the white board.

They're often difficult to measure. But, you know, access to specialty care, provision of urgent care.

And a lot of qualitative work that we've done, provider competency is often a huge concern of patients, one that is really often not addressed.

There's literature on goal attainment

approaches to quality which may not quite be ready for prime time, but I think are worth thinking about.

Continuity of care and care fragmentation and care coordination measures also evolving.

And then, end-of-life care, hospice referral rates, death in preferred settings worth looking at, and long-term care placement.

And next. So, you know, I think it's useful to think about a core set, you know, something along the lines of ACO REACH.

But then, I think it's very useful to think about structure and process requirements for the kinds of care these folks receive.

So, interdisciplinary care team and structure very important here.

24/7 clinical responsiveness and not a phone tree that anyone, you know, that someone with an IQ of a 100, you need an IQ of 150 to get past. They need to be able to talk to people at 3:00 in the morning, with people who know them.

Principle of comprehensive assessment, monitoring care across settings, having concurrent palliative and disease-directed care, appropriately targeting patients and services, very critical to integrate medical and social supports for those populations.

Caregiver supports critical.

Having explicit financial incentives as Jason alluded to a few moments ago.

Very important to allow the entry of smaller practices, very important here. They can do this and they can save money, too.

And an ongoing, what I would real quality improvement.

And next? Coming towards the end.

So, what about quality improvement?

You know, there's really zero point in measuring and monitoring quality of care unless, on the practice side, there's some incentive and some ability to actually do process improvement.

I think -- I don't see that terribly often in my practice or in a lot of practices, and I coordinate a learning collaborative of over 90 home-based primary care practices from around the country.

This is, you know, not just check box, checking the box quality.

And next, a major culture issue in terms of this, I would submit that there is somewhat a facility-based care hegemony with little or no recognition for non-facility-based care.

So, in the context of quality, the recently implemented complex care codes, did not include home-based visit codes in there.

You know, those providers cannot access those codes.

We did some work a few years ago looking at the MIPS[31] measures. Fifty percent of MIPS measures applicable to this population do not include home-based visit codes in their denominators. That's just absolutely absurd.

Next. So, some key takeaways, I think it's my last slide. It's a very complicated population. Really need to clarify the North Star of this type of work. There are some signals from existing programs, I would say especially Independence at Home.

I think creating high-level requirements for key structures and processes and having a few key outcome measures is the way to go. I would keep away from disease-specific outcomes.

I agree with Jason on explicit financial incentives and methodologically

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[31] Merit-based Incentive Payment System

appropriate evaluation.

And the need to recognize non-facility settings for this kind of work because that's where a lot of the care happens.

And I think I'm done.

DR. MILLS: Outstanding, thank you so much, Bruce.

We will turn next to Diane Meier, Founder of the Center to Advance Palliative Care. Please take it away.

Diane, I believe you're on mute.

DR. MEIER: There we go, I'm unmuted now.

Thanks, thanks very much. And I appreciate the opportunity to present.

I was asked to speak about best practices for integrating and incentivizing palliative care and hospice in population-based total cost of care models.

Next slide, please. So, I just want to remind everybody what the definition, and this is a CMS definition, of palliative care is, it is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

It is delivered throughout the

continuum of an illness, which may be decades in length.

And involves addressing physical, intellectual, emotional, social, and spiritual needs.

And in this sign wave graphic you see underneath, from the point of diagnosis through many, many years of treatment, patients need and deserve simultaneous access to both palliative care focused on their quality of life, their function, their social needs, as well as best available disease-directed treatments at the same time.

And you note in the green arrow on the right, hospice really is not relevant until people are no longer benefitting from disease-directed therapies.

And let me point out to you that disease-directed therapies are both life prolonging and often they are palliative.

So, treatment of heart failure relieves symptoms.

Treatment of COPD relieves symptoms.

Dialysis relieves symptoms.

Cancer care improves quality of life.

There is no claim distinction between

quality of life-focused treatment and disease-directed therapies.

And disease-directed therapies are often helpful and effective, very long into a disease course.

Next slide, please. So, who are these patients? Similar to what Bruce said, they're hugely heterogeneous. They have more than six to eight simultaneous chronic conditions. They see a median of eight to 11 different physicians per patient per year. They have a high level of functional and cognitive impairment.

They have a high burden of symptom distress, not only pain, but many other symptoms as well. They undergo multiple transitions in settings. Their caregivers are exhausted and overwhelmed.

They end up using 911 to manage symptoms and caregiver exhaustion after 5:00 p.m. and on weekends because, really, there's no one else to call other than 911. If you call your doctor, you get a tape that says, if this is an emergency, hang up now and call 911.

And they're expensive because they are really sick. They are really complex. They need care from a lot of specialists and, as Bruce said, much of the spending is, in fact, not preventable.

Next slide, please. Just want to make the point to you that unpredictable, unplanned ED visits are largely due to a symptom.

Sometimes, they're due to falls or trauma, but a large number of them are due to pain, shortness of breath, dizziness, fatigue, inability to manage one's own activities of daily living.

And just between 2012 and 2019, there was a 100 percent increase in the number of patients with any diagnosis visiting an emergency department because of pain.

Next slide, please. This is a patient that I met 12 years ago and I'm still caring for. Her name is Debbie.

Next slide, please. You can see she is a hairdresser. We met her 12 years ago when she had been in the ED four times for pain crises related to the consequences of her bone marrow transplant for multiple myeloma.

When we met her, she was in disabling pain, had depression, functional impairment, inability to work.

She was the sole support of her

daughter and granddaughter.

Lots of suffering and family distress.

She had to call 911 many times for pain crises.

Was accused of being a drug seeker on more than one occasion by colleagues in the Emergency Department.

And finally, on the fourth ED visit, someone in the ED contacted palliative care.

We've been taking care of her side by side with her hematologist for the last 12 years.

Her pain is hard to control, but it is controlled. She has very complex pain syndromes.

She's been able to return to work.

She reaches us 24/7. There's a 24/7 palliative care phone number. Someone who can see her chart answers the phone.

She's -- basically, she sees hematology every six weeks. And we see her on the same day in a different building.

She gets a lot of support from our interdisciplinary team, especially our chaplain.

And she has not once been using 911 or in the ED since we met her. And she is not dying.

Next slide, please. So, lots of data, I won't exposure you to all of it, but the reason palliative care saves money is not because we are rationing, it is not because we are withholding needed care, it is because we are meeting the needs of a very complex, seriously ill, multi-morbid population in the community.

So, if we're managing symptoms, if we're paying attention to family needs, if we're communicating with all of the eight, nine, 10 other doctors, we're often the quarterback for these patients, costs go down.

Not because we're trying to reduce costs, but because we're trying to improve quality.

So, you can't get the cost reduction if you're not delivering the quality.

And next slide, please. And the structural requirements similar to what Bruce mentioned and payers can create structural requirements and should.

You have to have an interdisciplinary team that, at a minimum, includes somebody trained and certified who is a prescriber in palliative care and a clinician who can provide psychosocial and spiritual care, a social worker, a chaplain are essential to the care of these patients and their families.

The clinical team has to be reachable by phone 24/7. And that means reachable by phone within 15 to 20 minutes at the longest.

If a patient is at home and can't breathe and no one calls back, the family member's going to call 911.

So, timely responsiveness is essential.

Next slide, please. So, this is a publication from the organization that I work for, the Center to Advance Palliative Care, that identifies best practices for integrating palliative care into population models.

And it's the usual series of steps, systematic, proactive identification of the highest-risk people.

Care management assessment of those that are identified for symptoms, for functional needs, and for caregiver needs.

Communication with the other eight, nine, or 10 treating physicians about these issues or referral to specialty palliative care.

Specialty palliative care dosed. So, we still take care of Debbie 12 years later, even though she hasn't needed to come back to the hospital. And I think that's why she hasn't needed to come back to the hospital.

And, again, 24/7 meaningful response.

Next slide, please. So, these are the risk factors in my hospital, the Mount Sinai Health System, a multi-billion dollar system.

We do not routinely screen for these very high-risk patients and identify them, either on the outpatient side or on admission to the ED.

If -- they have to be lucky, I would say, to get seen and then, referred to a palliative care team who will follow them in the community. It's not systematized.

But it can be systematized, and I will tell you that United Healthcare, through its subsidiary, Optum and its subsidiary, Landmark, is doing a really good job at identifying Mount Sinai's highest-risk, highest-cost patients.

And they call us and say, they're taking care of our patient who they identified through their, basically, their machine learning. But health systems are not incentivized to do this.

Next slide, please. As everyone has said, explicit incentives are clearly necessary. We've been experimenting with value-based payment for over 10 years. They have not changed the behavior of clinicians.

So, we need two things. We need meaningful financial incentives that actually change behavior and explicit requirements, not -- we can't say, well, because of value-based payment, everyone's going to start paying attention to palliative care. That did not happen.

Next slide. Here's just a few examples of financial incentives working.

The example for hospitals, Elevance, which used to be Anthem, palliative care had a quality health improvement measure.

Network hospitals received an explicit financial bonus for having a palliative care policy, having standardized patient identification algorithms, having an interdisciplinary team.

They required at least two of the relevant disciplines in palliative care and mandatory annual all staff training. And those have both been sustained and been successful.

Highmark in Pennsylvania, a Blue Cross Blue Shield plan, provides network hospitals a financial bonus if more than half of enrollees that Highmark identifies using its enrollees receive palliative care services during the 30-day episode. That's also been successful and sustained.

Next slide, please. Here's examples of financial incentives working in the community.

Cambia in four states in the Pacific Northwest, Blue Cross Blue Shield plan, provides a financial bonus for network primary care providers to have goals of care conversations with enrollees and for referral to palliative care services. So, they're explicitly paying extra for referring to palliative care and people who screen in.

Highmark, Blue Cross Blue Shield, provides a financial incentive for primary care providers if they refer to what's called Enhanced Community Care Management, which is really sort of like a cross between Independence at Home and home-based palliative care. And they get explicitly paid more if they identify high-risk enrollees and refer them. And this has shown a consistent reduction in total cost of care.

HealthFirst, which is our major Medicaid and duals managed care plan here in New York, network ACOs received additional payment from HealthFirst for a 90-day episode of home-based palliative care services for patients who screened in using the algorithm.

Next slide, please. So, these are the options. I think we're essentially a choir here or a broken record.

We need to require hospitals and systems participating in population-based models to attest to having a palliative care policy, a patient ID process, an interdisciplinary team, and all staff training.

Total cost of care model participants should be required to report regularly on the number and percent of high-risk patients receiving specialty palliative care.

We should financially incentivize the delivery of palliative care through a care management fee or a quality incentive without which hospitals and health systems will not provide the necessary resources to ensure palliative care capacity.

We need a CPT[32] G-code, because right now, we cannot count who is getting palliative care and who is not through coding.

And we should use patient-reported outcomes as quality measures. This is a very

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[32] Current Payment Terminology

sick and complex population.

Knowing that patients felt heard and understood by their team and receive the desired -- the help they desired for their pain are really relevant to this patient population. And these are both NQF[33] endorsed measures and have not yet been integrated into CMS programs.

Next slide, please. For hospice integration, I think we already know from the early work with the Medicare hospice integration model, hospice referral should not require terminating other services.

So, that's called concurrent or transitional hospice. And this is a major equity issue, particularly in vulnerable communities. And treating clinicians should be incentivized to continue to care for their patient.

One of the major barriers to referral to PACE, for example, was the early requirement that patients had to give up their prior relationships with clinicians, people, often, they've been seeing for years. And because of that requirement, many people refused to go into PACE.

Those PACE programs that got a waiver

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[33] National Quality Forum

and enabled patients to continue seeing their regular docs and incentivized that were much more successful. The same should be done in hospice.

Most of my colleagues, once the patient is referred to hospice, they never speak to them again. And that is a huge sense of abandonment and blow not only to the patient and family, but also to those clinicians.

And then, last, and again, and again, 24/7 meaningful clinical response that is incentivized.

Next slide, please. And these are three models of concurrent hospice care models.

First is the Medicare Care Choices Model which showed 14 percent lower spending, longer hospice length of stay, more days at home, and much better inclusion of under-represented groups.

The VA[34] Comprehensive End-of-Life Care Initiative, this was paid for through the VA budget.

These patients were much more likely to die on hospice and less likely to receive hospital and intensive care in the last several months of life.

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[34] Veterans Administration

And at University of Pittsburgh Medical Center in a concurrent hospice and dialysis program, this was actually an individually negotiated payment rate between the local hospice and the dialysis center and which enabled the hospice to pay for the dialysis, much longer hospice length of stay, much higher use of hospice.

And most patients, when experiencing life at home with hospice, made the decision to discontinue dialysis, not because they were forced to discontinue it, but because they were able to make that choice later.

Next slide, please. So, this is my last slide, reiterating what lots of people have said before. One is that you need to explicitly require that these models are there, are present, and that there's access to them, and that they meet quality standards. And financial incentives need to be real, meaningful, and timely.

Thank you.

DR. MILLS: Thank you so much, Diane. I greatly appreciate your all's experience and perspectives shared with us. I think we've now got right at 30 minutes for question and answer for the Committee members present to pose additional questions. I will look for a few questions that come up. Okay, let’s start with Walter.

DR. LIN: I wanted to go ahead and thank our panelists for just a really rich discussion. And in many ways I feel like this panel is one of the most important ones throughout our two-day meeting because PTAC is all about payment models and how payment models can better the delivery of care and improve outcomes.

And we're focused on this population of the top 5 percent, to Bruce's point, for the reason that they account for such a big share of Medicare spending. Over 40 percent of Medicare spending is from this population.

And I was actually a bit surprised to hear that only, according to the study that Bruce cited from Harvard, 10 to 15 percent of that spending is preventable. So two questions there. One, I'm curious if, Bruce, that's been your experience as well, and maybe Diane and others can speak to that.

But I'm also very curious to hear from Jason as well. What kind of savings are your practices in long-term care ACO achieving? Kind of, you know, you won't have to give us exact numbers, but just a general range. Is 10 to 15 percent preventable with kind of better clinical models, or is it greater, is it less?

MR. FEUERMAN: That's for me, right, Dr. Lin?

DR. LIN: Yeah, it's for actually the whole panel, but definitely you as well.

MR. FEUERMAN: Well, I'll go then. So we do, as you know, it's the adoption of the program, the adoption of the data. And once the clinician really grabs on and starts to not only question the data, but engage with the data, it does result in a reengagement type with the patient that does create a meaningful outcomes.

In general, in that 10 percent range, you know, plus or minus. But it is within that range, and it is meaningful for very high-cost patients.

DR. LEFF: Yeah, I would just add, Dr. Lin, you know, the notion of 5 to 10 percent preventable, that's for the overall, right? So, you know, a small proportion account for a lot of the cost, and a very high proportion of Medicare beneficiaries account for a very small proportion of the cost.

I think last time I looked at that, 50 percent of Medicare beneficiaries actually account for 5 percent or somewhere around that percent of the cost. So, you know, if you can implement -- you know, so it's kind of the Willie Sutton thing, right?

You know, why do you rob banks? It's because that's where the money is. If you can only save money, as I said, on people who cost money and who have preventable costs. So frail elderly is not the only place to find preventable costs, but it accounts for a big a big chunk of that.

And those are the kinds of patients that, you know, Diane and I care for every single day. I would say that even in that context, you know, there are clearly examples where people are doing good clinical practice to keep those costs down.

But I don't know that that's ubiquitous. And, you know, and I would say to the extent, you know, building on Jason's comment around having data to actually then do something with it, that ethic, that deep cultural DNA of taking data, doing something with it to improve care processes and reduce costs, I don't think that's deeply embedded throughout much of health care either.

I think it's still much a, you know, an eat what you kill kind of atmosphere. And because financial incentives are often not tightly linked to perform -- you know, to getting a performance bonus, you know, I think providers generally say, why bother if I'm going to get an extra, you know, .5 percent on my own income or whatever measure it is.

It's easier not to then change process. Why bother? And I think that's a big part of it. Sorry to be cynical, but that's -- I think that's the water we're swimming in to some extent.

DR. MEIER: It's also what our employers want us to do.

DR. LEFF: Exactly.

DR. MEIER: They want us to do throughput and billing. And our health systems are not incentivized to manage total cost of care. To the contrary, we're constantly being beaten about the head to see more patients faster.

You can't -- you can't do that with these patients. I mean, I spent an entire day yesterday getting a patient of mine who broke her ankle and refused to go to the ED because the ED is a nightmare. It was a full day of my effort to get her seen by an orthopedist and into the OR[35] today.

That's a very expensive cost. Most patients don't have doctors willing to do that or able to do that or stubborn enough to do that. You know, it was like a fight with the system all day long.

Those are those are the things that we're asking clinicians to do with zero reward. And of course, most don't do it because they have to get home to their families. They have 60 people in the waiting room. The financial incentives need to be completely flipped to change that.

We should be incentivizing care of these very complex, multimorbid patients by paying those doctors way more than we pay. Orthopedic surgeons.

DR. LEFF: I mean, it's another thing we haven't really talked about today. Sorry to talk over you, Diane, but we haven't talked about issues related to workforce in this space. So

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[35] Operating room

geriatrician, palliative medicine doctors, ain't too many of us, right?

Geriatrics is the one field you go into only to take a pay cut after your fellowship. So, you know, it's still astonishing to me, for instance, that special needs plans do not have a requirement for having geriatricians leading those programs. That to me is insane and absurd.

You know, you like having an oncology service not headed by an oncologist, like, you know, how would you do that? So, you know, we haven't really talked about the workforce issue, but these kinds of payment incentives, were they implemented, were they taken up could also have an effect -- the kind of effect on workforce that I think we need to have moving forward.

DR. MILLS: Anyone else want to add to that? Okay. I'm sorry. Go ahead.

DR. FELDSTEIN: Lee, I was trying to raise my hand. And I guess it didn't come up.

DR. MILLS: Go ahead, Jay.

DR. FELDSTEIN: I really appreciate the candor that is being expressed today. I almost feel like the health system itself needs palliative care. That's kind of where we are. And if you think about, you know, Bruce, to your point about the workforce, I mean, a lot of hospitals got rid of the geriatric fellowships because it cost them money.

So that's part of the issue. And if you look at the nature of palliative care and, you know, how do we get there is because your everyday general internist didn't want to spend the time taking care of these patients. That's the reality.

And it takes a special type of physician to go into geriatrics and palliative care who's willing to spend the time. And that's a systemic issue with our profession. And, you know, somehow we've got to get to that.

But, you know, how much is enough to change behavior? And I'll put that out to all of you, because part of the problem is if the system gets the reward, a lot of the times it doesn't make it down to the practicing physician. Like Diane, like you said, they just want more throughput. You know, so, you know, how do we work it in so that the provider gets the reward for the incentive?

DR. LEFF: Yeah, I would say it's not only an amount. I think also it's the milieu, you know, the work milieu. I think that, you know, if total cost of care models created a world where volume was less valued, and where quality improvement was part of part of the core DNA of practice, you know, you would keep physicians in the workforce longer. They would be able to spend more time. It's not just a dollar.

I don't think it's simply a dollar amount, although that's, that's important, no doubt. But I think if you ask many physicians who come to work each day and actually want to do good, want to do good each day, they would, you know, if you said here, here's an algorithm, if we improved your working conditions this much and raise your pay that much, would that be enough? And I think you would, you'd see both sides being, both sides of that equation being valued.

You know, no one comes to work wanting to be a crappy doctor. No one comes to work not wanting to try and do what Diane did yesterday with her lady with the ankle fracture. I think we all would like to be able to do that. And it's actually kind of a miracle that Diane even having spent all that time was successful in getting that person to the OR.

You know, I've spent days doing that kind of stuff and you know what, you fail because the system is just too unyielding. So, you know, my bet is that Jason has some analyses that could tell us whether that number is 5 percent, 10 percent, 15 percent, but it does need to be meaningful.

I think there are some clues from the Independence at Home Demonstration, as flawed as it was in terms of the money flow, I think there are some clues probably from, you know, a high-needs reach that will help people think about that as well.

And there are probably some clues from, you know, organizations like Kaiser and Landmark and Prospero where they're doing this in more of a capitated environment if they will share their data with you.

DR. LIN: I asked yesterday, they didn't.

DR. LEFF: You know, and that's not surprising either, but I think there are ways to get signals on that, but it's not simply dollars. I think it's a bit more-it’s potentially, and I think that that's actually a good thing cause, you know, it's not just the money, it's the system as well. It's delivery.

DR. MILLS: Wonderful. Thank you for

that, Jay and team. We'll pass it to Jennifer.

DR. WILER: I completely agree with Walter. This has been a very important discussion, and I have to, before I make my comments, acknowledge pediatricians and psychiatrists would say they're actually in that bucket also.

I think, gosh, there's so much to say, but I'm going to start with a comment around the business case is always harder. It's considered soft business case to our CFOs around cost mitigation versus revenue generation, and I think that plays out here a lot.

And I think the specific examples in the last presentation are very helpful about what currently exists around financial incentives for hospitals and communities in the private payer space.

But I'm actually come back to where we started and that's in the workforce question. There's clear evidence around what exceptional care looks like and your examples around financial incentives to try to nudge us to deliver that care is helpful.

But the long game of financial incentives is workforce expertise. We're talking about how do we create short-term incentives that meaningfully change care delivery where we've got a workforce gap. So can you talk through that? What does that look like in the next 12 to 36 months of meaningful incentives that can also change the system to deliver excellent care knowing that there's this workforce gap?

We can't have in my own practice -- we don't have enough palliative care doctors to do this tomorrow. So is there a primary care-based model where this is successful? Can you talk to us about how do we acknowledge that workforce gap and align that with financial incentives?

DR. LEFF: Jennifer, it's funny when you started the sentence 12 to 36, the next word I expected to come out of your mouth was years and not months so.

DR. WILER: In full disclosure, I am an emergency physician.

DR. LEFF: There you go. There you go. So I would agree that I think there are ways a few ways to look at workforce. Number one is to think about workforce in terms of worker bees and we need worker bees, and I'm a frontline worker bee in geriatric primary care and home-based primary care.

I think we also need to think about workforce in terms of leaders and leadership who can create systems and, you know, embed educational programs to bring along primary care physicians of all types, whether it's pediatricians or internal medicine docs or internal medicine, mid-level practitioners or geriatric mid-levels.

I think there are all sorts of ways to start to inject knowledge, attitudes, and skills that need to be brought to the bedside over the shorter term.

I do think also that, you know, were payment incentives under total cost of care implemented such that it actually motivated systems to move forward, those systems might start to value the kinds of leadership that pediatric leaders and geriatrician leaders and palliative medicine leaders could provide because we understand not, not exclusively, but we understand settings of care.

We understand how to think about functional status. We understand how to think about social determinants of health, I think in a slightly more enhanced way than some other specialties. And I think you then can create a leadership core that could help move systems forward.

And I think to your point about systems valuing revenue, just one example, we took our home-based primary care program. It was sitting in our academic division, losing a quarter million dollars a year, and we proposed to bring it into the system, over to the health system, where in theory, economic incentives would align.

That movement took, I would say about 80 meetings. And it wasn't until meeting number 30 that the lead, the financial folks who had an Excel sheet that evaluated any new thing, that Excel sheet did not have a row for projected savings on it. So that's like a little widget in the system that doesn't even think about saving.

So we finally got them to add that row. And they saw the potential value in the model. And then they finally took it on somewhat begrudgingly, I would say. But, you know, those are the kinds of like hardwired things within systems that actually prevent innovation, prevent this kind of development. And, and these are, you know -- it's not trivial. It's really not trivial.

DR. MEIER: We eliminated our home-based primary care practice.

DR. LEFF: And that was the premier home-based, academic home-based, primary care practice in the United States of America.

DR. MEIER: Right. Because they weren't, they couldn't use cost avoidance as a -- as an argument. And they were saving a lot of money, but they wanted that fee-for-service. They wanted those heads in beds.

DR. SCHACKMAN: So in terms of gaps in a very sort of tangible way in our, in our project, we relied on tele-mentoring to enhance the abilities of primary care physicians to basically do something new and different. And we were fortunate that there was a technology out there that was not being adapted that adopted, and this was a way to make that happen.

And there was no -- as we were putting the payment system together, there was no payment mechanism to cover basically the time of the provider in the tele-mentoring session rather than seeing a patient. So we calculated what that was, what that lost revenue was basically.

And then suggested that there were, there could be a quality bonus, which was allowed by the mechanism, or could be allowed by the mechanism, and that would be specifically targeted to fill that hole so that from the organization's point of view, the revenue was not truly lost.

And the providers were motivated to participate because they were -- their skills were enhanced and they were able to see patients they hadn't been able to see before and patients who were not going to leave primary care to go see a specialist.

So it's a -- it's a small example, right? It's very targeted, which is probably why it was successful because it was very focused on a specific outcome in a specific complication that these complex patients had. But also, you know, we tried to figure out a way to get it paid for so that it didn't look like a loss.

DR. MILLS: Wonderful. Thank you for that rich answer. I'm going to put myself into the queue and just, Bruce, you got me thinking this way, but I think it's an appropriate question that everyone will have perspectives on, which is pulling in strains of both lessons learned about what's worked in the literature and in your professional lives and in aspects of data sources and measures.

I'll ask you for a minute to cone down on identifying, so which of all these complex patients have preventable costs? You know, in full disclosure, until very recently I was also boarded in hospice and palliative care, and for my 20-year private practice career in rural Kansas, I did hospice and palliative home visits routinely as part of my practice, and I could identify them when they walked past me somewhere in Walmart and I said, that's a palliative care patient, right?

Unfortunately, similar to the definition of art, you can't build programs and metrics and incentives around, I know it when I see it. So if you will share your learnings about how you identify these patients, is it a set of characteristics, diagnoses, events in a claim feed, or some risk-predictive methodology that has seemed effective?

DR. LEFF: Yeah, I think it's a combination of things. You know, part of the issue is dealing with data that you can actually get your hands on, right? So claims tend to be the most easy to get at, and even those are not terribly easy to always get.

And recall my slide where, you know, a lot of folks are not getting -- you know, if you lack access to care, your experience may not be showing up in claims or maybe not be showing up fully in claims.

You know, in the example of Independence at Home, it was the presence of two or more of a specific set of, I think it was 11 or 12 chronic conditions that are particularly costly, and experiencing health service utilization in the form of a hospitalization, and having experienced an episode of skilled home health care or time in a skilled nursing facility.

And the key issue there was, you know, it's not just number of chronic illnesses, but functional status, cognitive status, are critical to this kind of conversation. If I have five chronic conditions, I might cost X. If I have five chronic conditions and functional impairment, I'm going to cost two to three times X.

And the challenge is we do not capture functional status well unless you are getting into a skilled home health care episode where a skilled home health care agency has to fill out the OASIS[36] assessment, which takes a few hours for a skilled home health agency to fill out, or if they get to a skilled nursing facility, and then the minimum data set questions need to be filled out so you actually get a signal on function.

So I think critical to this effort, and I think it was in a slide that ultimately had to be pulled out, you know, some mandate for a standard way to assess functional assessment and get it done on people is critical to understanding and identifying this population.

Independence at Home did not do badly. I think they did pretty well with that. There are also now claims-based ways to assess frailty, not perfect, but reasonable, and that is also something that can be used.

I can tell you we're just finishing our project with a large integrated payer provider with whom we were able to add questions on whether the person was homebound into their annual in-home wellness assessment.

The prevalence of people who are homebound is about 20 percent in the Medicare population. If you look at people who never get

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[36] Outcome and Assessment Information Set

out of their house and people who need help or assistance or have difficulty getting out of the house, being homebound is an extremely powerful indicator of utilization, mortality, and just lousy care experience.

So there are these other things, and, you know, the system has to decide how they're going to collect it. I don't think perfect needs to be the enemy of a reasonable signal, but how to incorporate that into payment and performance payment, it's complicated, but it has been sort of done before.

DR. MEIER: But I think the key point to remember is that this information is not in claims.

DR. LEFF: Exactly.

DR. MEIER: And we use claims. We use utilization and ICD-10 codes to identify the high-risk population. So we're looking for our glasses under the street light because the light is better when we dropped them at the back of the parking lot. So, you know, we do what's easy, not what's accurate, and so we're missing the boat.

And if we started to mandate recording of cognitive status and functional status and caregiver stress and home boundedness lives alone, even just knowing someone lives alone is a key variable. It's not anywhere in claims, and it's not in the electronic health record either. So all the key factors, many of which are social and behavioral, are invisible to the health system and to CMS.

DR. MILLS: Anyone else?

CO-CHAIR HARDIN: I'm just going to add an accent to that point, Lee.

DR. MILLS: Sure. We've got just a few minutes left.

CO-CHAIR HARDIN: I think that is so important. I remember talking with Jose Figueroa when he ran that data in 2017, and the integration of health-related social needs, and even the behavioral health diagnosis wasn't in that report. And in my work, I obviously have a biased opinion.

I spend a lot of time in that space. But I think your study with the NLP[37] pulling out the social support aspects and just the importance of that, it's another actionable area that we don't have line of sight into and maybe one of the most promising areas to look at next.

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[37] Natural language processing

DR. MEIER: Your data on the costliest 5 percent highlighted, you know, Area Deprivation Index as a major predictor. And, you know, we're just not picking that up in our algorithms.

DR. MILLS: Okay. We're down to just about two or three minutes, but I think it's just time for 45 seconds or so per person. What's the one final summary thought you would leave us with as we close down our listening panel for today?

MR. FEUERMAN: I'll jump in, Jason Feuerman, again. I think that these financial incentives need to be structured appropriately but also need to be more mandated by CMS so it does get into the hands of providers. Because to several other people's points today, a lot of times it doesn't, and they're the ones that are frontlines.

And we're never going to change the paradigm when we think about this from a health system perspective. You know, the CFO is never going to find the paid for. And in order to really bend this cost curve and bend the quality curve, the providers need to be incented.

And so I would urge some level of mandate. I don't know what that exactly looks like, but start having that discussion. And whether that's sitting in the Medicare Advantage or whether it's sitting in fee-for-service or both, it can bend the cost curve to this point.

DR. MILLS: Thank you.

Diane?

DR. MEIER: I agree. That was really my major point is, A, these services have to be required, and they have to meet quality standards. And if you want to get paid by Medicare, you must deliver these services.

You must demonstrate what fraction of the high-need population is receiving them, and they have to be financially incentivized in order for the institution to allocate the resources. So requirements.

DR. LEFF: I think the only thing that I would add to that is the notion of trying to figure out how to link what Jason and Diane just spoke to to real, true quality improvement, process improvement efforts, because the systems, when they hear requirements, will just check a box and try and collect the money.

So I don't know how to thread that needle, but really linking to true quality improvement. And as Jason was talking about and Diane about requirements, the thought that just flashed was, you know, look to the VA. The VA has done a lot with requirements around certain kinds of care delivery.

So their home-based primary care services, which they have at each of their medical centers, they have a mandated membership on their interdisciplinary team.

Their teams are the most robust of any teams you will see in the country, you know, including mental health, including chaplain services, including a whole bunch of things that most systems outside the VA cannot put on a team, but they mandate it, and they pay for it.

So, you know, there are models outside of, you know, VA practically invented geriatric health service delivery. There are some examples there.

DR. MILLS: Wonderful. Last one in closing.

DR. SCHACKMAN: Our thought is maybe a little bit more hopeful, that there are examples where targeted focused payments can make a difference and, you know, don't let the perfect be the enemy of the good and try to find some of these successes and design payments for those specific cases, and then maybe that will help build the momentum towards a bigger system change.

DR. MILLS: All right. Thank you so much for your rich perspectives and hard-learned real-world experience and advice. Appreciate it.

We're going to be turning now to a public comment period that you all are each certainly welcome to stay around and listen to. And at this time, I'll pitch it back to Dr. Wiler.

DR. LEFF: Sorry, I need to jump off. Take care.

*** Public Comment Period**

DR. WILER: So I'd like to thank all four of you for joining us this afternoon and for those of you who are able to stay, we welcome you to listen to as much of the meeting that we have remaining.

At this time, as Dr. Mills said, we'll have our public comment period. And if we don't have any public comments, we'll then move into Committee discussion. Now I'd like to see if we've had anyone sign up for public comments. It looks like we do not.

*** Committee Discussion**

So at this point, I'd like to move

into the comments from our Committee members. We will be discussing everything that we've learned today. As you know, PTAC will submit a report to the Secretary of HHS[38] with our comments and recommendations based on this public meeting.

Members, you have a document on potential topics for deliberation tucked into your binder to help guide the conversation.
If you have a comment or question, please flip your name tent up or raise your hand on Zoom. Who would like to start?

DR. MILLS: Well, such rich discussion. I took pages and pages of notes, but I have not had time to fully distill them to a cogent synthesis. But this will be a little bit stream of consciousness. So I really appreciated Jason's hard-won experience about what the nature of incentives must be to move the needle in the real world.

And that ties in a little bit with what we heard about encouraging us to have a CFO or a finance-driven panel to ensure that it connects all the dots in a complex system. But the list of characteristics for incentives, they

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[38] Health and Human Services

should be meaningful, timely, tied to appropriate performance metrics, quality.

Interestingly, quality is not really an inducement. Quality ought to be a guardrail or it’s an impairment. It's table stakes. But that high-quality expectation must be set out plainly and transparently.

He spoke to knowing that there's going to be consequences any time you incent something strongly. There are unintended consequences, and think that through carefully and mitigate in advance.

Spoke to careful applications in addition to an incentive and what incentives should be applied. There should be careful application of penalties. Essentially the flip side of an incentive, which is interesting.

And then spoke to risk adjustment and incenting providers along a continuum to get more engagement and more participation. So I thought that was a really nice list of things we've heard, frankly, over the last several years as we've been exploring these topics.

I'm particularly struck with Jason's comments about waking up an ecosystem. And that speaks in my experience dealing with individual physicians and data that essentially goes through the entire stages of grief, and it's not until you get to acceptance that the ecosystem wakes up, and they start engaging with data and start managing the process and so that was powerful.

We've heard refrains throughout this weekend that this complex chronic disease population essentially definitely bats above their weight. A small percentage yields a great amount of cost. And refrains that many programs or incentives are built around a single disease construct that don't really work for this population, just because they're outside the bounds of any single disease construct. And that was really powerful.

We heard pretty powerfully this afternoon that for this group of providers, and palliative care especially, they're begging for a mandate. I mean, they're asking that requirements be tied to programs to get paid. And that was really powerful.

And I wondered, you know, with all the data that we've seen in my personal reading, it seems like the data may be there, and maybe this is a -- we can ask for an ASPE research project, but there may be data supporting palliative care is actually the second domain in addition to primary care, where simply increasing the supply leads to improved quality and decreased costs.

And I think I sniffed that out a little bit. In which case a fundamental problem is that we're not identifying the patients. Again, everybody agrees you know it when you see it, but you can't build a program around that. And then they spoke to the challenges of there's really no, there's no code.

You can't use a specialty designator because there's not enough palliative care doctors or geriatricians. You miss a lot. There may be a cluster of -- you know, from the prior pilot, a cluster of some diagnoses plus an incident, like hospitalization, plus a certain cost threshold. I mean, maybe that can work, but that gets really complicated and leads to all kinds of reconciliation issues after the fact.

So it made me wonder if there's a path CMMI could explore about essentially -- you know, I never wanted to speak in favor of the proliferation of G codes, but maybe there's really an opportunity for a single G code incentive to start upstream with just identify these patients and there's an incentive for identifying them.

Because once you've identified them, then you can unlock more powerful things about dramatically lowering costs and improving outcomes. So that was a thought.

DR. WILER: Excellent. Thank you.

Lauran?

CO-CHAIR HARDIN: I know you'll be completely surprised but I'm going to lead with equity. So we heard a really strong theme about the importance of really paying attention to equity in this equation. Related to access, related to inclusion of people with lived experience and governance, patient-reported outcome measures as part of the equation for measuring quality and the opportunity, feeling heard and understood being a really key measure.

And then really thinking about the importance of building a system where people have choice in this transition. So building a system that has 24-7 access for urgent needs, the ability to call and get some management support, caregiver support, and that that 24-7 support is provided by someone who knows your story and has access to your complete record.

Along with that urgent response in

order to get stabilization and outcomes in this population, it's also important to have explicit and concurrent care and proactive anticipatory care, which is new competencies for many people to teach.

Not the way our system works now, which is we wait till there's a crisis and then we respond, but really to understand how to proactively address symptom management, disease management, and include health-related social needs and assessing for caregiver and social support needs as part of that equation.

The importance and opportunity to include peers and non-licensed providers with lived experience as part of this response offers promise and was brought up as part of this. And then really the importance of weaving concurrent care along with hospice and palliative care so people really have choice and can transition along the road with stabilization.

So I'll leave it there to leave my colleagues a little room to comment as well. Thank you.

DR. WILER: Wonderful. Thank you, Lauran.

Other member comments?

Walter.

DR. LIN: It's been just such a great couple days. And I first want to preface my comments by, again, thanking the ASPE staff, my fellow PCDT team members, PTAC members, and NORC for just organizing a really rich two days of discussing an extremely important topic. You know, we are talking about the disproportionate impact high-cost patients have on Medicare spending.

You know, the top 5 percent per capita spends 130,000 dollars a year. That's just mind boggling to me still. And the good news is that I think there's a lot that can be done to address this. There's a lot of opportunity to improve the care of this very small minority of patients. But it's going to take some focus and creativity in care model design.

I had mentioned in my PCDT presentation that there were a few overriding key objectives in caring for this population of patients. And I was happy to hear various experts validate those over the course of these past two days.

Those objectives include providing goals-concordant care. We heard a lot about the importance of goals of care discussions, advanced care planning discussions. You know, it's hard to provide goals-concordant care if the provider doesn't know what the goals of care are of the patient, as they state.

The whole area of measuring patient-reported outcome measures around symptom control, pain control, around understanding the goals of care, I think, was really insightful.

Another important objective that we have for this population of patients is delaying the progression of chronic disease. And we heard quite a bit about the importance of intensive primary care for this population of patients, not with just any primary care provider who may not be trained or have the inclination to care for complex chronic patients with serious illness, but those with expertise in this area. So activated PCPs, I think, was the term that was used to really try to somehow enable their care of this population through better payment models.

A third goal I had mentioned was to catch acute exacerbations early to enable outpatient treatment. And we heard both yesterday and today about the importance of availability, 24-7 availability to this patient.

I think Diane had said you have to have a good response in 15 minutes, a meaningful response in 15 minutes. Dr. Smith said yesterday the same thing. We have to have on-call meaningful response to encourage these patients to reach out again and again.

And then finally, I had said an important goal was to reduce treatment burden and focus on symptom relief. And we heard a ton about palliative care and hospice care and what that can do to not only improve quality of care, provide more goals in coordinate care, but also improve, also lower costs.

So I think it's all kind of coming together. I was actually -- I'm leaving these two days a bit more depressed in many ways, because I feel like it just highlighted how broken the fee-for-service system is in addressing the needs of the seriously ill and complex chronic condition patients that drive so much of medical spending.

Just speaking from my own experience, we have -- we're the largest independent group of providers in the greater St. Louis area focused on the care of seniors living in nursing homes and assisted living facilities, seriously ill, chronic complex.

We would love to hire a palliative care specialist into our practice, but I can't make the numbers work. The numbers just don't pencil out, right? It would for Medicare. I'm confident that the savings that the specialist would help generate would more than cover any cost. But as a practice, though, that just doesn't pencil out for us, because we are still in many ways under fee-for-service.

And so fee-for-service just really does not work in terms of payment, appropriate payment incentives for this population of patients. And so that is a bit disheartening, but I will end with hope.

I think the future is bright for palliative care as our system moves more and more toward a total cost of care environment, because it's easy to see how accountable entities can really generate a positive financial return on palliative care.

And more intensive care of the seriously ill, but it's just going to take some time to get there, so I'll leave it at that.

DR. WILER: Excellent. Thank you. Jay, any comments?

DR. FELDSTEIN: Well, I think Walter did such a great job. We'll let Walter have the last word today for the last two days. But just to reinforce what I think we heard from a lot of people.

We're getting to the point where, you know, and especially as we get move forward on the glide path, these payment models, if we really want to see the change to total cost of care, they're going to have to be mandated. And, you know, we'll give people long enough runway to face things in. But if they're going to want to continue to see Medicare patients, they're going to have to participate in programs.

And, you know, the incentives in the system are not aligned. That's why hospital CEOs got rid of the geriatric fellowships. They don't get paid for cost savings. They get paid for revenue generation and profit. And they weren't profit centers.

And they closed like half the geriatric fellowships in the country. And until we move to a total cost of care, when that's where they truly add their value, as well as taking great care of patients, we're not going to get the change we need.

And the other issue, and this gets to Lauran, you know, in terms of equity, there are areas in this country and in the city of Philadelphia where you can't get a home health care worker to visit somebody who's homebound because of the neighborhood they live in and it's not safe.

And that gets to a whole other systemic issue in terms of violence in society. But that's the reality. You can't -- you know, you can't get providers to go places because it's just not safe. So, you know, that just adds to the equity issue and the care issue.

So, you know, it's systemic, like Walter, like you, some days I get more depressed. But, you know, I think, you know, if you don't have hope, why get up in the morning? Right? So, you know, thanks, everybody, for their participation and attention. It was a great couple of days.

DR. WILER: Well said. Other Committee member comments?

Well, I'll add my own comments, which this time are brief. You all have done a wonderful job summarizing just a phenomenal day. I agree. Thank you so much, Walter, to you and the PCDT team, our NORC colleagues, and staff for putting together a phenomenal two days.

And you grounded us well in focusing on a specific complicated patient population that is heterogeneous. But I, too, am going to leave with a couple of comments around optimism.

I think we talk often on this Committee about identifying the ideal care model and then layering on top a payment model with incentives or disincentives to try to ensure that that ideal care is provided in addition to essential care being provided.

And what I learned over these two days is this is actually one area where there is a lot of excellent evidence that tells us expertise, longitudinal relationships with trust, for which we can better understand a person's goals and availability are the secret sauce to immediately decrease cost and improve quality. And there are ways with payment to make that possible that we haven't chosen to prioritize.

The other thing I heard is sometimes we talk about what are the potential low-lying fruit. And I'm hearing us have an opportunity because we're tripping over watermelons. And that's around mandating that certain activities occur, including collection of data elements that would have an immediate impact in us being able to identify patients. So, be that a mandatory assessment around functional status, we kept hearing over and over, and around, we heard conversations around being homebound or even living alone. And I love Freakonomics, and I think what I heard today are a couple of real pearls in that space where we could think about how that might be something that's incented or made mandatory.

With that, before closing, I'd like to check with our staff team to see if they have any clarifying questions for us. Audrey, no questions? All right.

* Closing Remarks

Again, I want to thank everyone for participating today, our expert presenters and panelists, my PTAC colleagues, and those listening in. We explored many different topics regarding addressing the needs of patients with complex chronic conditions or serious illness in population-based total cost of care models.

Again, a special thanks to my colleagues on PTAC. There was a lot of information that was packed into these two days, and I so appreciate your active participation and thoughtful comments.

We will continue to gather information on our theme through a request for input that's based on the topics that we discussed today. These will be posted on the ASPE PTAC website and sent out throughout the PTAC listserv where input to our questions can be offered by July 8th.

The Committee will work to issue a report to the Secretary with our recommendations from this public meeting.

*** Adjourn**

And with that, I get to do this for Angelo. Meeting is adjourned.

Thank you.

(Whereupon, the above-entitled matter went off the record at 2:52 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 06-11-24

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter