

Physician-Focused Payment Model Technical Advisory Committee

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

Presenters:

Previous Submitter

- [Marie P. Bresnahan, MPH](#) – Director of Training, Policy, and Administration, Viral Hepatitis Program (VHP), New York City Department of Health and Mental Hygiene – ([Previous Submitter](#) - *Multi-provider, bundled episode-of-care payment model for treatment of chronic hepatitis C virus (HCV) using care coordination by employed physicians in hospital outpatient clinics proposal*)
- [Bruce R. Schackman, PhD](#) – Saul P. Steinberg Distinguished Professor and Executive Vice Chair, Department of Population Health Sciences, Weill Cornell Medicine

Subject Matter Experts

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

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

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Project INSPIRE: Payment Model for Treatment of Chronic Hepatitis C Virus (HCV) Using Care Coordination in Hospital Outpatient Clinics

PTAC Public Meeting - Listening Session 3: Best Practices for Incentivizing Improved Outcomes for Patients with Serious Illnesses or Complex Chronic Conditions
June 11, 2024

Marie P. Bresnahan, MPH

Director of Training, Policy, and Administration, Viral Hepatitis Program
Bureau of Hepatitis, HIV, and Sexually Transmitted Infections
New York City Department of Health and Mental Hygiene

Project INSPIRE: Overview

- Centers for Medicare and Medicaid Services, Health Care Innovation Award; focused on population health (2014–2017), designed to implement a care coordination model for treatment of the hepatitis C virus (HCV) for high-needs patients with multi-morbidity in New York City.
- Project INSPIRE-NYC: **I**nnovate and **N**etwork to **S**top Hepatitis C and **P**revent complications via **I**ntegrating care, **R**esponding to needs and **E**ngaging patients and providers.
- Submitted proposal to PTAC (Multi-provider, bundled episode-of-care payment model for treatment of chronic HCV) which was deliberated on during the Committee's December 18, 2017 public meeting.

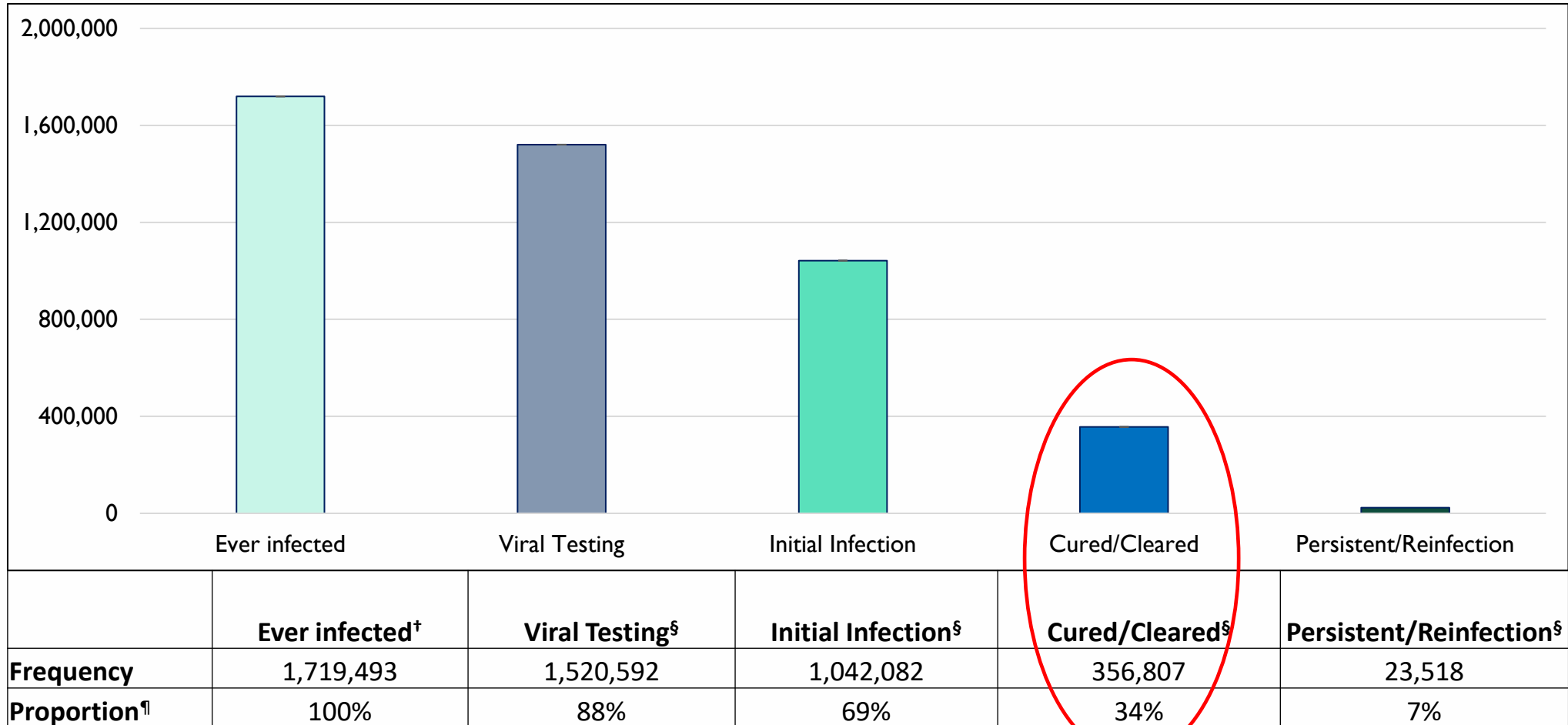
Characteristics of the Target Patient Population

- When project was developed, 75% of persons with chronic HCV infection were born between 1945 and 1964; this aging population is more likely to have additional chronic illnesses that can complicate or be complicated by HCV infection.
- Due to opioid epidemic, HCV currently affects multiple generations, with infections highest among two age groups: 25–45 and 55–70 years.
- An estimated 40% of persons living with HCV have comorbidities, including behavioral health problems, substance use, and chronic diseases such as HIV infection, diabetes, and kidney disease.
- Persons with a history of injection drug use, many of whom commonly have numerous co-morbidities, are at the greatest risk for HCV infection.

Current State of Hepatitis C

- Hepatitis C remains a leading bloodborne infection in the U.S.
- Despite the availability of direct-acting antivirals, incidence has tripled, due to unsafe injection practices associated with the opioid crisis.
- Incidence and mortality associated with cirrhosis due to hepatitis C has risen steadily from 1990-2019.
- The treatments are significantly less expensive than when they were first available, and many health insurance barriers (such as prior authorization requirements) have been removed.
- Simplified treatment algorithms are moving to a “test and treat” model and treatment is being provided in jails, prisons, homeless shelters and substance use treatment programs as well as in primary care setting.

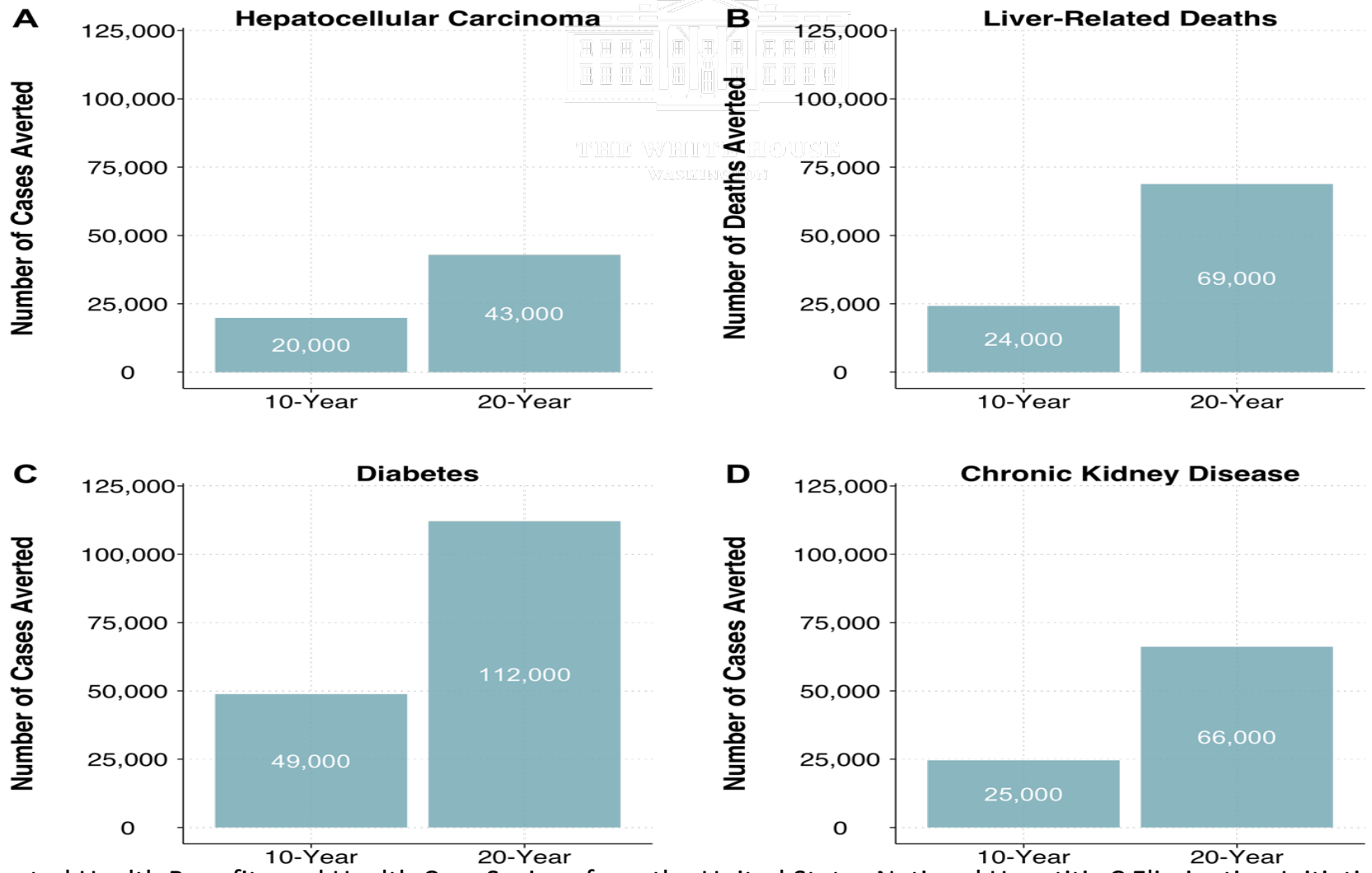
Hepatitis C Virus Clearance Cascade Using National Laboratory Data: United States, 2013-2022



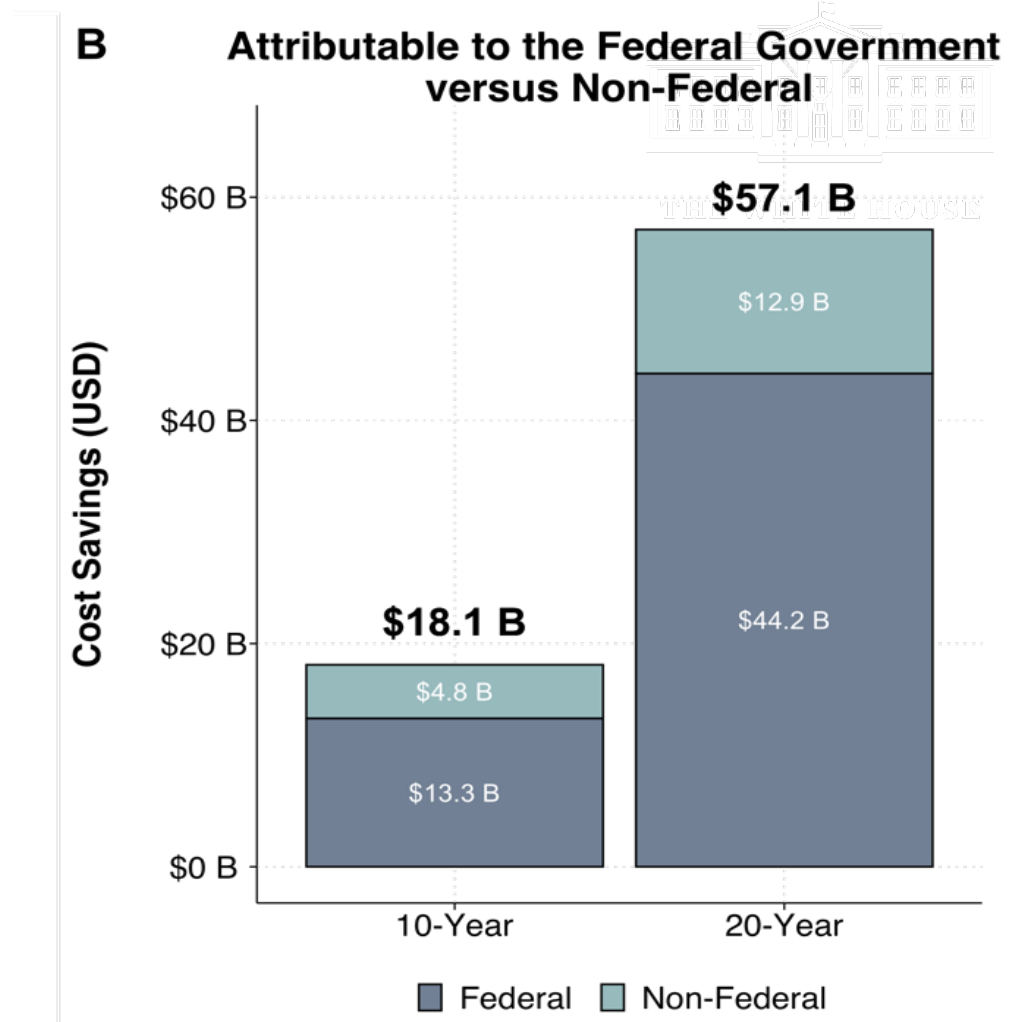
Notes: * Data from Quest Diagnostics during period: January 1, 2013 - December 31, 2022. † Ever Infected was assessed during the baseline period: January 1, 2013 – December 31, 2021. § Viral Testing, Initial Infection, Cured/Cleared, and Persistent/Reinfection were assessed during the follow-up period: January 1, 2013 – December 31, 2022. ¶ Denotes conditional proportion using denominator from previous column.

Source: CDC, MMWR June 30, 2023

Hepatitis C-Related Complications Averted



10-year and 20-Year Cost Savings of Hepatitis C Elimination



Chhatwal, J. et al. **Projected Health Benefits and Health Care Savings from the United States National Hepatitis C Elimination Initiative** Natl Bureau of Econ Research, April 2023.

Project INSPIRE: Overall Goals

- Provide treatment for HCV to Medicaid and Medicare patients that included comprehensive social determinants of health (SDH) assessments, integrated Behavioral Health services and medical care.
- Demonstrate better health outcomes for participants including:
 - Cured of HCV infection
 - Better able to manage other co-morbidities including HIV and substance use disorder (SUD)
- Demonstrate cost savings:
 - Decrease emergency room visits and inpatient hospitalizations
 - Avoid end stage liver disease, liver cancer and other complications

What's missing?

- **Primary care providers** who are comfortable treating HCV using simplified algorithms.
- **Care coordination**, which has been found to reduce barriers to care and improve patient outcomes, particularly for hard-to-engage and hard-to-treat populations.
- **Care teams that include people with lived experience and those able to support patients** through the process of screening, treatment and cure.
- **Payment models** to support care coordinators and peer specialists to increase the number of hepatitis C patients treated and cured.
 - We previously explored the use of Complex Care Management (CCM codes) and found that these codes were not widely used and that CCM payments were insufficient to fully reimburse the costs of this model.

Project INSPIRE: Key Components

Tele-mentoring:

- Allowed **non-specialist providers** to receive training in hepatitis C care via conference call and webinar by one or more specialists (e.g., hepatologists or gastroenterologists).
- Created knowledge networks where clinical guidance and case studies could be discussed.

Care Coordination:

- **Non-licensed care coordinators** delivered health promotion and coaching, health insurance advocacy, medication adherence support, alcohol and substance use counseling, and appointment reminders.
- **Peer specialists**, with lived experience (e.g., HIV, hepatitis C, substance use disorder) conducted outreach and provided support.

Reimbursement Model for Hepatitis C Treatment Care Coordination

- A potential payment model was calculated for 3 phases:
 - enrollment to treatment initiation,
 - treatment initiation to treatment completion, and
 - bonus payment for laboratory evidence of successful treatment outcome (sustained viral response).

TABLE 1	
Care Coordination Activities for Treatment Phases I, II, and III^a	
Phase I: Enrollment to Treatment Initiation	Phase II: Treatment Initiation to Treatment Completion
Variable costs	Variable costs
Accompaniment	Health promotion no. 4-7 modules
Health promotion no. 1-3 modules	Case conferencing with medical providers and multidisciplinary teams
Alcohol counseling	Treatment adherence
Case conferencing with medical providers and multidisciplinary teams	Discharge planning
Treatment readiness counseling	HCV medical care appointments and appointment reminders
Medication and pharmacy coordination	
HCV medical care appointments	
Referrals	
Prior authorization	
Lost to follow-up tracking	
Assessments	
Time-dependent costs	Time-dependent costs
Patient communication	Patient communication
Data entry	Data entry
Case conferencing with peers	Case conferencing with peers
Team meetings	Team meetings
Pharmacy team coordination meeting	Pharmacy team coordination meeting
Care coordination training	Care coordination training
Phase III: Bonus payment for SVR	
Tele-mentoring costs ^b	

Implications for Policy and Practice

- A multi-disciplinary team with Care Coordinators and Peer Specialists focused on curing HCV proved effective; a similar approach could potentially support those with complex chronic conditions to be able to complete a defined course of treatment for a specific condition in primary care settings.
- The payment model includes a bonus payment to support tele-mentoring that would not be reimbursed otherwise.
 - Tele-mentoring was found to be an effective mechanism for peer-to-peer learning and an effective way to engage primary care providers and other non-specialist clinical providers.
- Savings will accrue from caring for complex patients appropriately in non-specialist settings and avoiding down-stream medical costs from untreated HCV.

Thank you to the Project INSPIRE Partners

- Clinical Partners
 - Mount Sinai Medical Center
 - Montefiore Medical Center
- Payer Partners
 - HealthFirst
 - Select Health/VNSNY
- Payment Model Development
 - Weill Cornell Medical Center for Health Economics of Treatment Interventions for Substance Use Disorder, HCV, and HIV

Questions?

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

Jason H. Feuerman

President and Chief Executive Officer, LTC ACO

Lessons Learned About Approaches for Implementing Financial Incentives

Jason Feuerman
President and CEO
LTC ACO, LLC
June 11, 2024



- **Not having financial incentives will never change care outcomes regardless of the population**
- Having financial incentives that are identical for all populations does not work
- Financial incentives have to be meaningful to help the providers rationalize the additional time required to care properly for complex populations
- Financial incentives must be provided timely, timed to projected outcomes and NOT delayed due to the need for “perfect” scoring of changes in costs and outcomes

- **A properly designed program should be looking at the following key performance metrics:**
 - Emergency room utilization
 - Hospital admissions
 - Proper utilization of specialty care and services
 - Over/under utilization of services
- **Other key components should be focused on the following:**
 - Accurate and complete diagnosis coding (ICD-10s) for risk adjustment purposes
 - Key quality measures meaningful to the population being served is an imperative

- **Simplicity** – the program has got to be “simple” for providers to understand in order to get buy in and ultimately performance
- **Transparency** – the program must be grounded in data availability and transparency
- **Relevant Metrics** – ensure that the program being implemented addresses key metrics which are in some way controllable by the provider
- **Quality Measures** – ensure any program designed has quality “guard rails” in order to not just have a financial “motivated” program

- Under utilization of specialty care
- Under utilization of home and community-based services
- Deferment of services to reduce costs being measured under a value-based program
- Too much focus on patient complexity while overlooking other aspects of care and social determinants of health
- Perception that there is too much focus on the financial incentives and not on the total quality of care

- **What doesn't work:**
 - Not accounting for and properly recognizing the acuity in the population being served
 - Not providing timely payment for performance (i.e., not annually but quarterly)
 - Assuming that all providers will respond to financial incentives
 - Financial penalties
- **What does work:**
 - Payment as close to time of performance as possible
 - Risk adjusting for the population served
 - Providing regular performance data to providers
 - Proper provider education of providers to the incentives being offered

- Work with all providers to create value-based and quality driven performance incentives, especially for high cost complex patients that consume a disproportionate amount of cost and time
- Encourage CMS and state Medicaid programs to not only support but participate in the initiative beyond the current programs run by CMS and CMMI (i.e., Medicare Advantage, MSSP, etc.)
- Unless financial incentives become an inherent part of our provider reimbursement structure, changes to outcomes and performance will be greatly limited, constrained and unachievable

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Professor of Medicine and Director
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Division of Geriatric Medicine
The Johns Hopkins University School of Medicine

Best Practices for Incentivizing Improved Outcomes for Patients with Serious Illnesses or Complex Chronic Conditions in Population-Based-Total Cost of Care Models

Monitoring Quality, Patient Outcomes, Quality of Life Longitudinally Across Settings for Patients with Serious Illnesses or Complex Chronic Conditions – Data Sources and Measures

Bruce Leff, MD

Professor of Medicine

Johns Hopkins University School of Medicine

PTAC Meeting on Addressing the Needs of Patients with
Complex Chronic Conditions or Serious Illnesses

June 10, 2024

Let's Think About...

- Caveats in the context of how to monitor quality of care, patient outcomes, and quality of life in these patients and a question
- Learnings or insights from existing clinical / payment models that focus on the population of interest
- Associated issues

Caveats in the Context of How to Monitor Quality of Care, Patient Outcomes and Quality of Life for Patients with Complex Chronic Conditions or Serious Illness

The nature of these patients makes this a challenge

Caveat 1: Dangerous to Assume These Patients are Getting Care – Often an Invisible Population

Original Investigation | Health Informatics

Use of Latent Class Analysis and k-Means Clustering to Identify Complex Patient Profiles

- Analysis of 104,869 individuals (3.3% of KP population, age 18+)
- Kaiser Permanente Northern California members
- Care to population via employer-based, Medicare, Medicaid, CA exchange
- Representative population
- Identified most medically complex based on comorbidity and utilization and then sorted using LCA

Group (% of Total Pop)	% of Population	% Died	% Hospitalized	% >5 Primary Care Visits	% No Outpatient Visits
Highest acuity (10)	10	21	51	22	9
Older with CVD (17)	17	10	33	16	6
Frail Elderly (13)	13	24	34	7	27
Chronic Pain (13)	13	4	23	23	4
Active Cancer (8)	8	22	34	8	7
Psychiatric Illness (12)	12	3	24	18	8
Less Engaged (27)	28	6	18	9	13

Caveat 2: Heterogeneity is the Norm - Long Tails of Morbidity, Single-Disease Constructs Often Irrelevant for Care or Quality Assessments

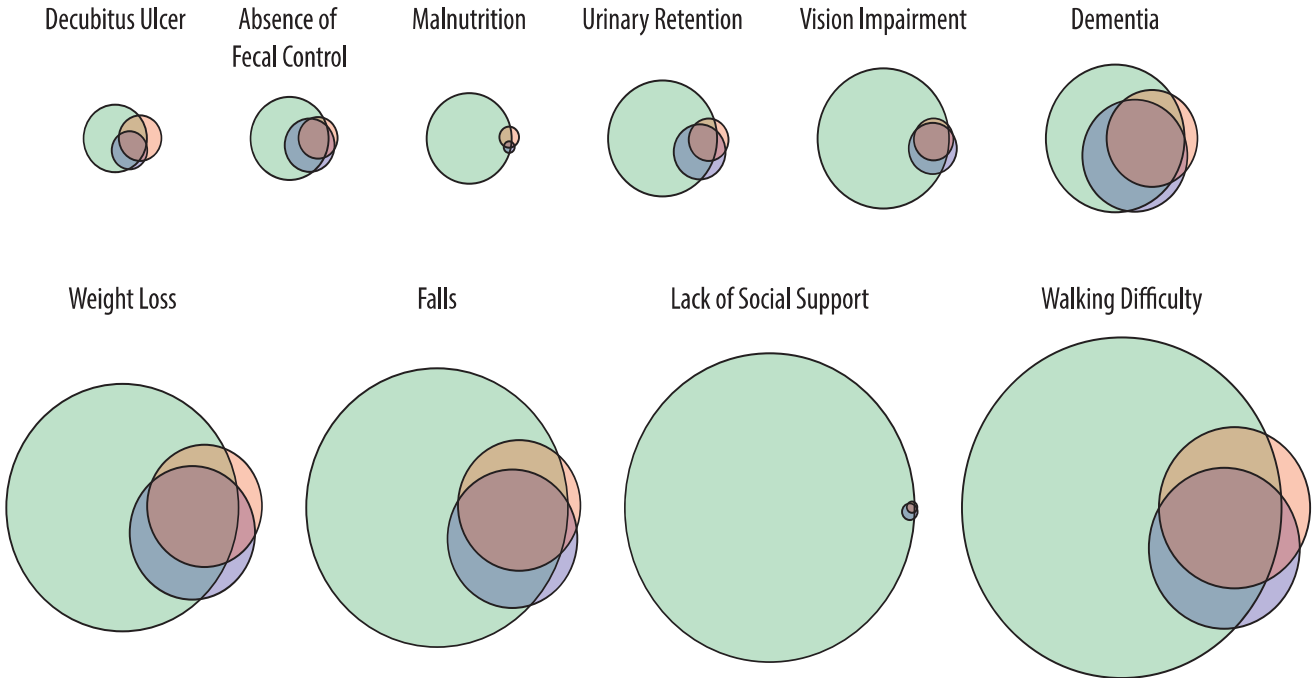
Medicaid-Only Adult Beneficiaries with Disabilities, Under Age 65

Hypertension +													Pattern Prevalence, % ¹	Cumulative Prevalence, %	Annual Hospitalization Rate Per Capita	Per Capita Costs, excl. Long-term Care	% Total Annual Costs, excl. Long-term Care ²	Cumulative % of Total Annual Costs, excl. Long-term Care	% Total Annual Long-term Care Costs	Very High-Cost Prevalence, % ³	High-Cost Prevalence, % ⁴
Psychiatric disorders	Coronary heart disease	Diabetes	Asthma and/or chronic obstructive pulmonary disease	Back or spine disorders	Congestive heart failure	Drug and alcohol disorders	Chronic pain	Stroke	Dizziness	Chronic renal failure/end stage renal disease	Schizophrenia	Developmental disorders									
													6.91%	6.91%	0.07	\$3,680	1.87%	1.87%	2.46%	0.54%	2.98%
✓													5.61%	12.52%	0.11	\$7,244	2.99%	4.85%	3.71%	1.00%	9.22%
		✓											3.00%	15.52%	0.13	\$5,290	1.16%	6.02%	0.92%	0.82%	5.91%
✓		✓											2.42%	17.94%	0.17	\$8,811	1.57%	7.58%	1.52%	1.66%	15.12%
✓	✓												1.95%	19.89%	0.24	\$7,683	1.10%	8.69%	0.93%	1.56%	11.98%
✓				✓									1.90%	21.79%	0.10	\$6,415	0.90%	9.58%	0.44%	1.08%	8.68%
	✓												1.85%	23.64%	0.21	\$5,021	0.68%	10.26%	0.55%	1.02%	6.68%
✓				✓			✓						1.43%	25.07%	0.23	\$9,440	0.99%	11.25%	0.43%	3.10%	19.01%
✓											✓		1.37%	26.44%	0.36	\$13,504	1.36%	12.61%	2.00%	4.72%	28.10%
				✓									1.36%	27.81%	0.06	\$3,505	0.35%	12.96%	0.19%	0.35%	2.61%
✓			✓										1.29%	29.09%	0.22	\$8,786	0.83%	13.79%	0.73%	1.77%	16.43%
			✓										1.21%	30.30%	0.17	\$5,223	0.46%	14.26%	0.35%	1.13%	6.55%
✓	✓	✓											1.18%	31.48%	0.39	\$10,386	0.90%	15.16%	0.76%	3.07%	22.22%
✓	✓			✓									1.18%	32.66%	0.21	\$7,625	0.66%	15.82%	0.33%	1.18%	12.91%
	✓	✓											1.14%	33.81%	0.34	\$7,971	0.67%	16.49%	0.41%	2.36%	13.18%
✓							✓						1.11%	34.92%	0.33	\$10,812	0.88%	17.37%	0.79%	4.58%	17.97%

- KEY**
- Index condition with no comorbidity in identified conditions.
 - Patterns with the top three highest total annual costs.
 - Patterns with the top three highest annual hospitalization rates.
 - Patterns with the top three high cost prevalence rates.

¹ Prevalence of this pattern among beneficiaries with hypertension.
² \$7.6 billion, excluding Long-Term Care costs, was spent by Medicaid on 559,056 disabled Medicaid-only beneficiaries with hypertension. Results are presented for the top 16 out of 4,053 total patterns observed for people with hypertension.
³ The proportion of beneficiaries with this specific multimorbidity pattern who are represented among beneficiaries in the top 1st to 5th percentile of costs in the overall population of Medicaid-only adult beneficiaries with disabilities.
⁴ The proportion of beneficiaries with this specific multimorbidity pattern who are represented among beneficiaries in the top 5.01st to 20th percentile of costs in the overall population of Medicaid-only adult beneficiaries with disabilities.

Caveat 3: Critical Factors Highly Associated with Quality and Outcomes for This Population Not Captured in Claims or Structured EHR Data – Functional Status, Impactful Non-Disease Factors



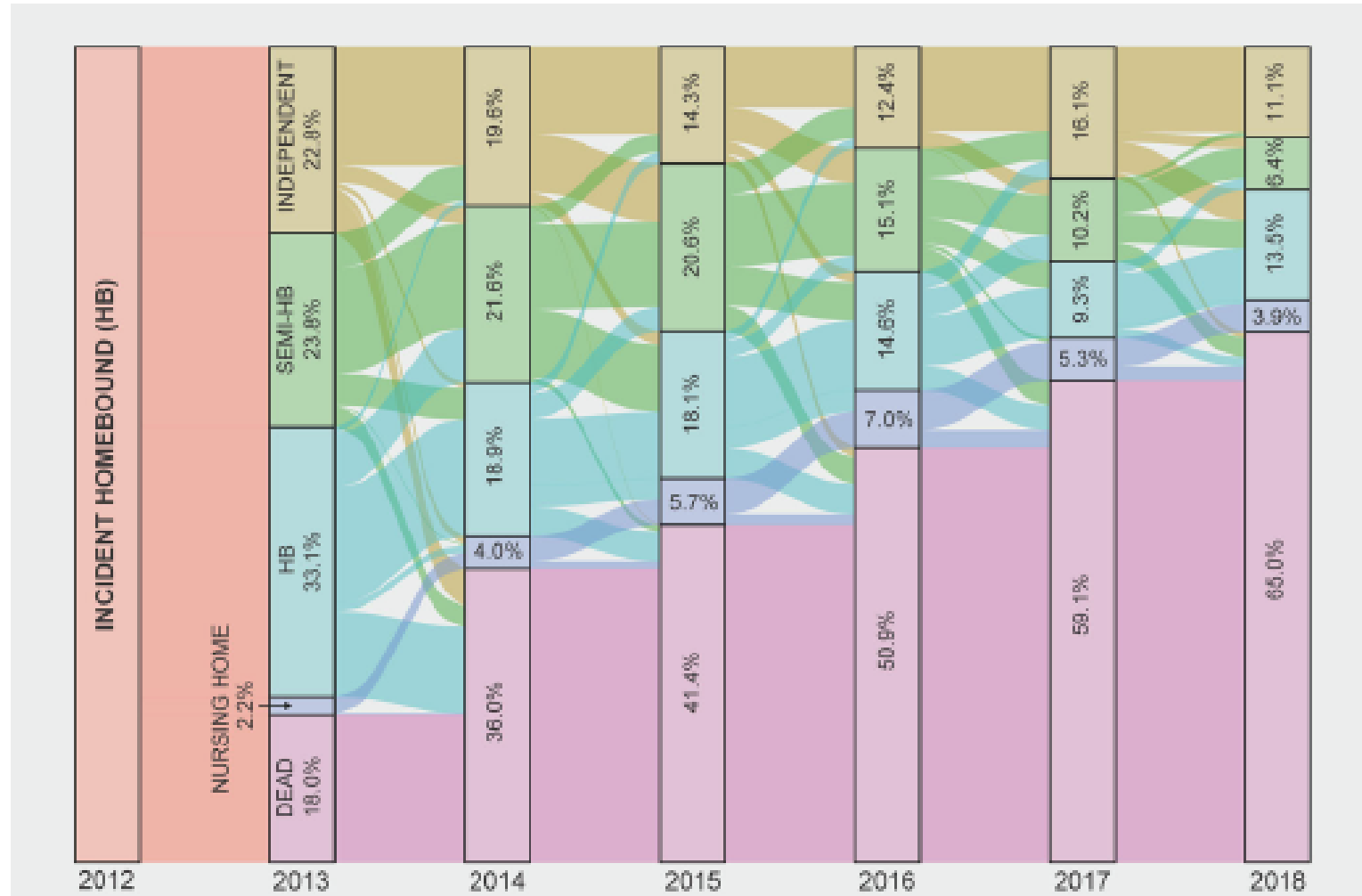
- 18K patients – claims and EHR data
- NLP on unstructured data
- Mean age 76
- Mean comorbidity count (only) 5.5
- Mean # notes / patient – 43
- Value of unstructured data –
 - Compare green to red+blue -
 - Decub ulcer 1.7x
 - **Lack of social support 455x**

Figure 3. Value of EHR free-text in identifying geriatric syndromes in addition to claims or structured EHR in the study population. Overlaps and sizes of circles are scaled to represent actual sizes or overlaps of underlying data used in study. In each of the Venn diagrams, the top right circle represents claims data (red), the bottom right circle represents structured EHR data (blue), and the left circle represents unstructured free-text EHR data (green) extracted using a natural language processing (NLP) approach. Diagrams are sorted based on absolute frequency of cases found from all data sources (including free-text) for each geriatric syndrome in study population (not sorted based on relative added value of free-text). The blue or red areas not encompassed by the green area indicate that a condition has been captured using encoded data but was not mentioned in the free-text as a clinical note.

- Claims – red
- Structure EHR – blue
- Unstructured EHR – green

Caveat 4: The Status of these Patients is Not Static and is Associated with (Very) High Mortality

FIGURE 1 Homebound status 6 years after first report of homebound status (2013–2018).
 Source: National Health and Aging Trends Study, 2012–2018, $N = 267$. Independent: leaves home >1x/week without difficulty or receiving help; semi-HB (Homebound): community dwelling and leaves home >x/week but reports either difficulty and/or receiving help with leaving home; HB (homebound): community dwelling and leaves home never or rarely (1x/week); NH (nursing home): resides in a nursing home. All proportions adjusted to account for complex survey design and sampling approach

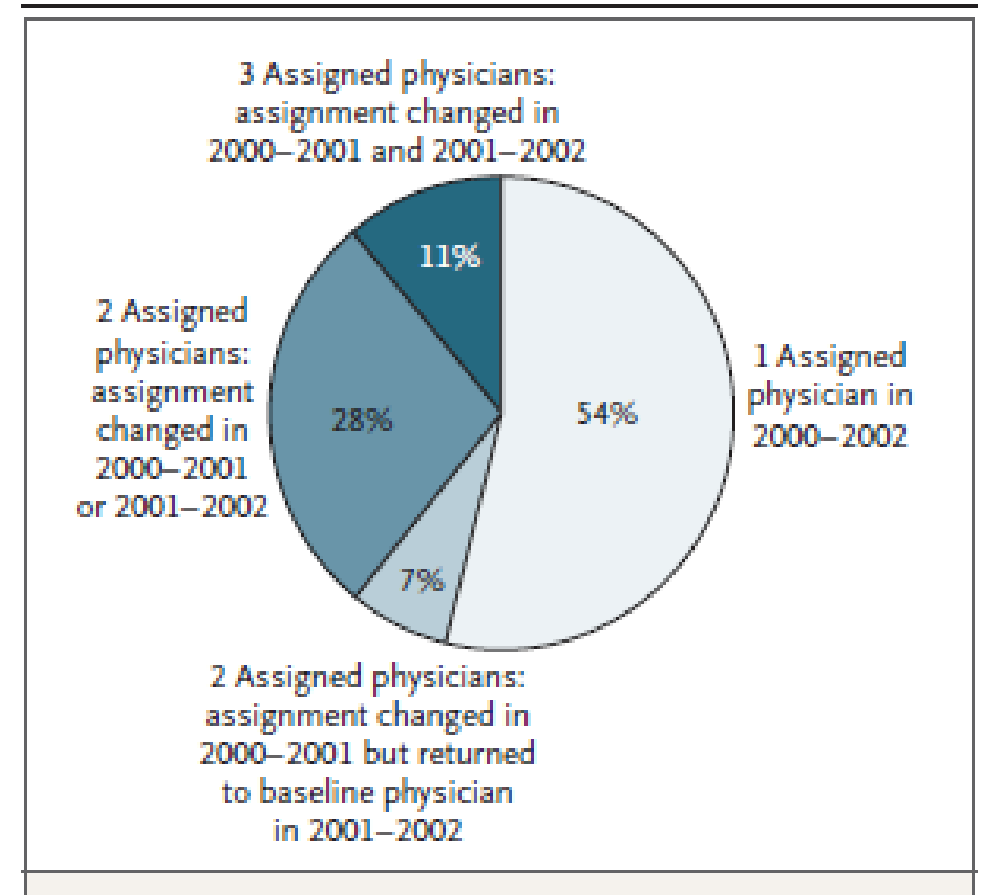


Caveat 5: Care Provision is Not Centralized Making Attribution a Challenge

Medicare Claims 2000-2002 1.79 M Beneficiaries

	Median # MDs	Median # PCPs	Median # Specialists
All	7	2	5
> 7 Chronic Conditions	11	3	8

For 33% of beneficiaries, 33% assigned MD changed from 1 year to the next



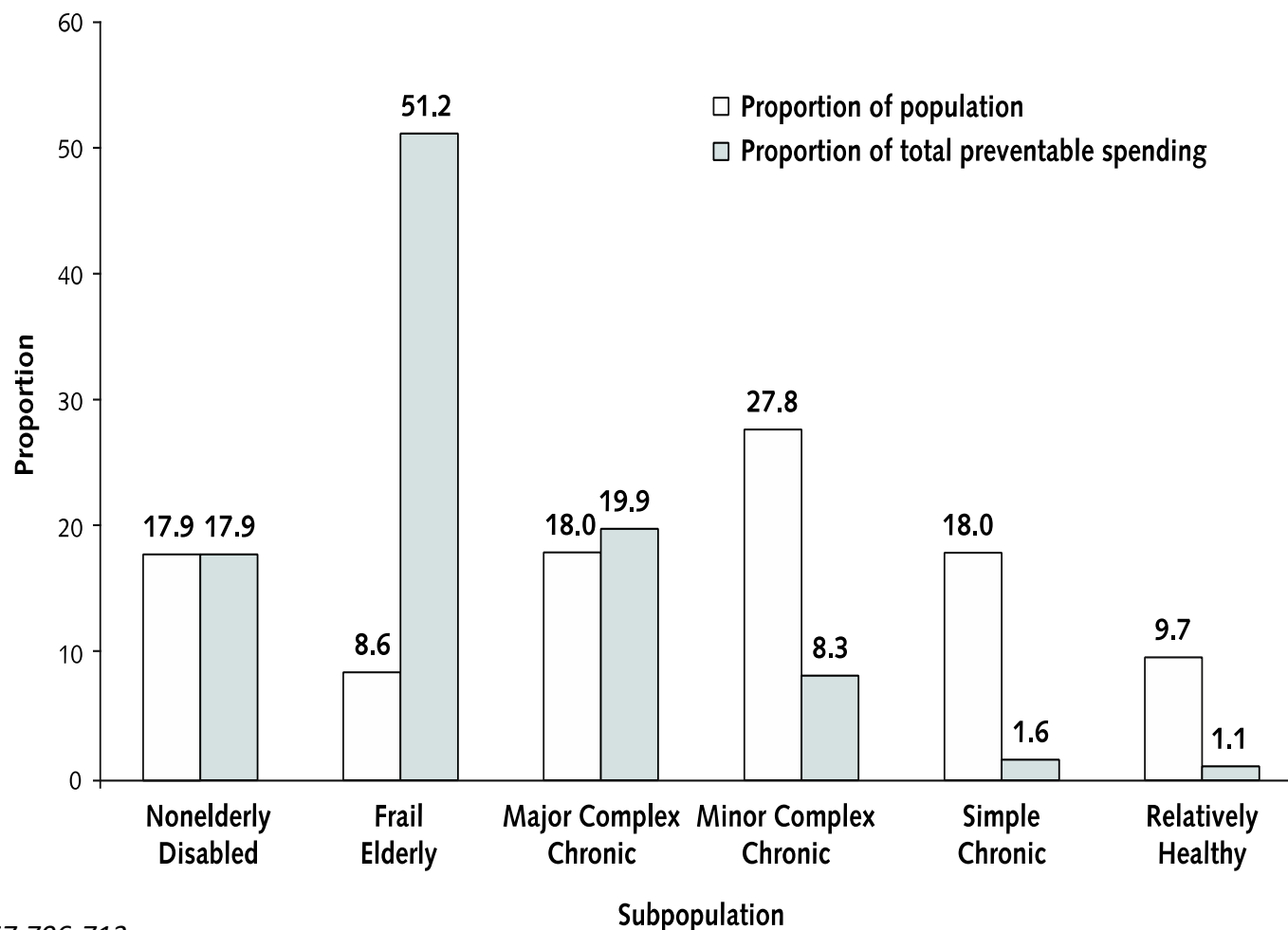
Question - Is Top 5% of SPENDING the Right Target? What is the North Star of this Effort?

- **Is the goal to:**
 - Keep spending down?
 - Maximize quality of life or quality of care?
 - Find patients with rising risk and keep them from entering the top X% spend?
- Focusing on the spending level thresholds may be an error if the goal is to reduce the spend or to improve quality
- You can only improve quality for patients who receive poor **quality care that you can improve**
- You can only save money on patients who cost money and have **preventable** costs

Concentration of Potentially Preventable Spending Among High-Cost Medicare Subpopulations

An Observational Study

Jose F. Figueroa, MD, MPH; Karen E. Joynt Maddox, MD, MPH; Nancy Beaulieu, PhD; Robert C. Wild, MS, MPH; and Ashish K. Jha, MD, MPH

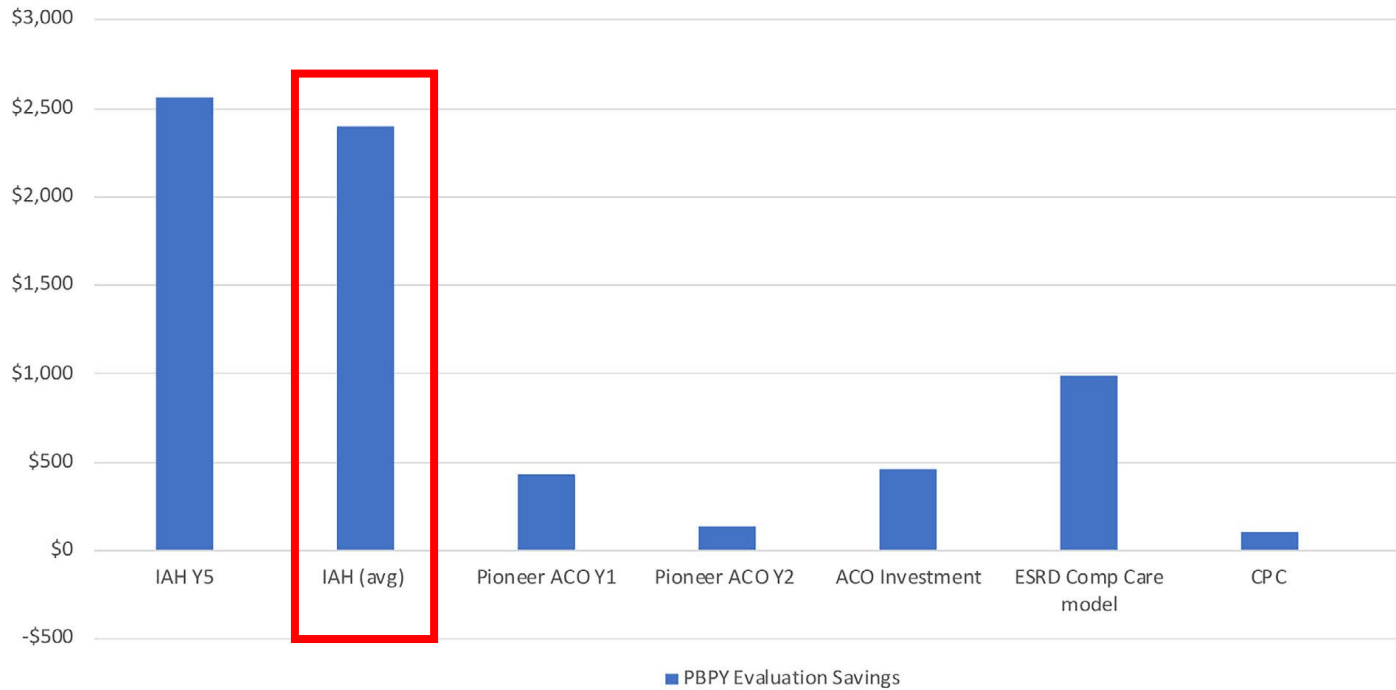


- High-cost and preventable costs are not the same thing
- Estimates that preventable costs in Medicare ~5-10%

Are There Learnings or Insights on How to Monitor Quality of Care, Patient Outcomes, and Quality of Life from Other Models of Care for Patients with Complex Chronic Illness or Serious Illness?

The underappreciated success of home-based primary care: Next steps for CMS' Independence at Home

Comparison of Per Beneficiary Per Year (PBPY) Evaluation Reported Savings for IAH and MedPAC Comparator CMMI Demonstrations



Name	Location	Bonus
Boston Medical Center	Boston, Mass.	\$0
Christiana Care Health Services	Wilmington, Del.	\$0
Cleveland Clinic Home Care Services, Medical Care at Home Program	Independence, Ohio	\$0
Doctors On Call, Comprehensive Geriatric Medicine	Brooklyn, N.Y.	\$0
National House Call Practitioners Group	Austin, Texas	\$0
Doctors Making Housecalls	Durham, N.C.	\$275,000
Physician Housecalls Program, North Shore Long Island Jewish Health Care	Westbury, N.Y.	\$542,000
RMED; Visiting Physicians Association	Jacksonville, Fla.	\$712,000
Visiting Physicians Association	Lansing, Mich.	\$1,000,000
Housecall Providers Inc.	Portland, Ore.	\$1,200,000
Visiting Physicians Association	Milwaukee, Wis.	\$1,400,000
Visiting Physicians Association	Dallas, Texas	\$1,700,000
Mid-Atlantic Consortium including Washington Hospital Center, University of Pennsylvania Health System, Virginia Commonwealth University	District of Columbia, Pennsylvania, Virginia	\$1,800,000
Visiting Physicians Association	Flint, Mich.	\$2,900,000

Independence at Home Quality Metrics

1. Follow-up contacts within 48 hours of hospital admissions, hospital discharges, and emergency department visits
2. Medication reconciliation in the home within 48 hours of hospital discharges and emergency department visits
3. All-cause hospital readmissions within 30 days
4. Annual documentation of patient preferences
5. Hospital admissions for ambulatory care-sensitive conditions
6. Emergency department visits for ambulatory care-sensitive conditions

ACO REACH Quality Measure Set

- Claims-based Measures
 - Risk-standardized, all condition readmission
 - All-cause unplanned admissions for patients with multiple chronic conditions
 - *Days at home for patients with complex, chronic patients (High Needs ACOs only)*
 - Timely follow-up after acute exacerbations of chronic conditions (standards and new entrants ACOs only)
- Patient Experience Survey
 - CAHPS survey

Additional Dimensions or Constructs of Quality to Consider – Not Quite Ready for Prime Time or Difficult to Measure

- Access to specialty care
- Provision of urgent care
- Provider competency
- Goal attainment approaches
- Continuity of care across sites by primary team
- Care fragmentation
- Care coordination
- End of life care – hospice referral rate, death in preferred setting
- Long term care placement

Structure and Process Requirements of High-Value Care for Patients with Serious Illnesses or Complex Chronic Conditions

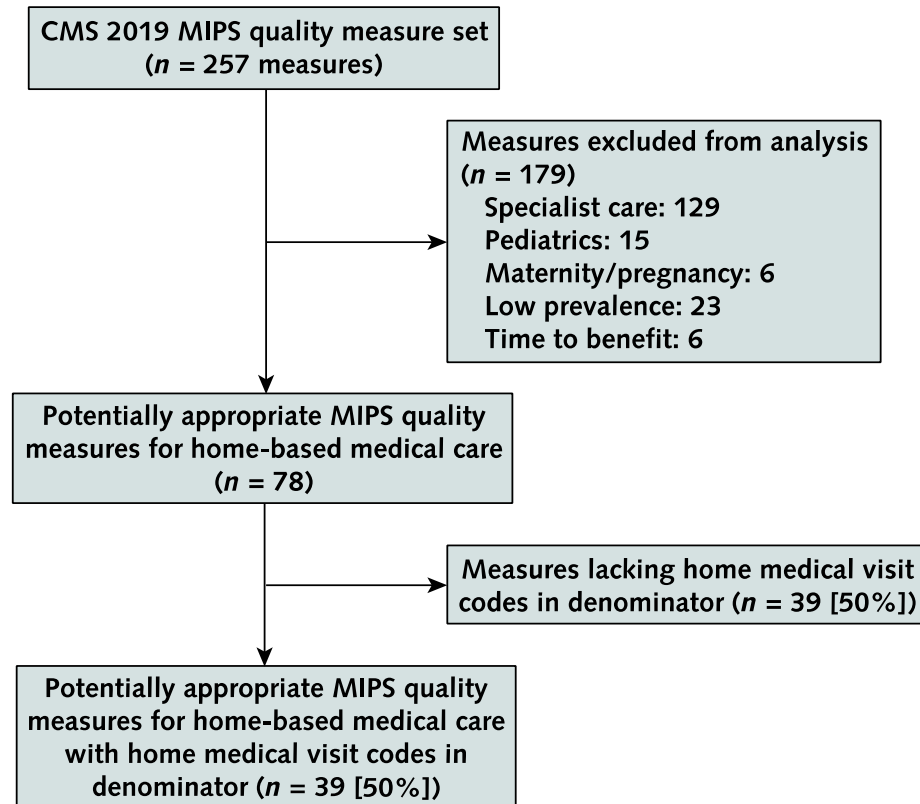
- Interdisciplinary team training and structure
- 24/7 clinical responsiveness – live local person **WHO KNOWS THEM**
- Comprehensive assessment
- Access across settings
- Concurrent palliative and disease-directed care
- Targeting of patients and services
- Integrated medical and social supports
- Caregiver support
- Competent clinicians
- Explicit financial incentives (and cash flow)
- Allow entry of smaller practices
- Ongoing REAL quality improvement

What About Quality Improvement?

- What is the point of measuring and monitoring quality of care if interest in doing the hard work of quality improvement is lacking?
- Need a mandate for real quality improvement, not just box checking quality

MAJOR Culture Issue – Facility-Based Care Hegemony with Little or No Recognition of Non-Facility-Based Care Setting

Figure. Eligibility status of CMS 2019 MIPS quality measures for use in home-based medical care.



- 50 % of CMS MIPS quality measures potentially applicable to patients receiving home-based medical care lack home visit codes in their denominators - excludes homebound from value-based care

Recently implemented complex care codes DID NOT INCLUDE home-based visit codes

Key Takeaways

- Very complicated population
- Must clarify the “north star” of this effort
- There are some signals from existing programs
- Create high-level requirements for key structure and processes of care
- Non-disease specific outcomes
- Explicit financial incentives
- Methodologically appropriate evaluation
- Regulators, payers, and the quality measurement industrial complex need to recognize that not all care happens in bricks and mortar facilities

***Listening Session 3: Best Practices for Incentivizing Improved
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Serious Illnesses in PB-TCOC Models***

Diane E. Meier, MD, FACP

Founder, Center to Advance Palliative Care

Best Practices for Integrating and Incentivizing Palliative Care and Hospice in Population-Based Models

Diane E. Meier, MD

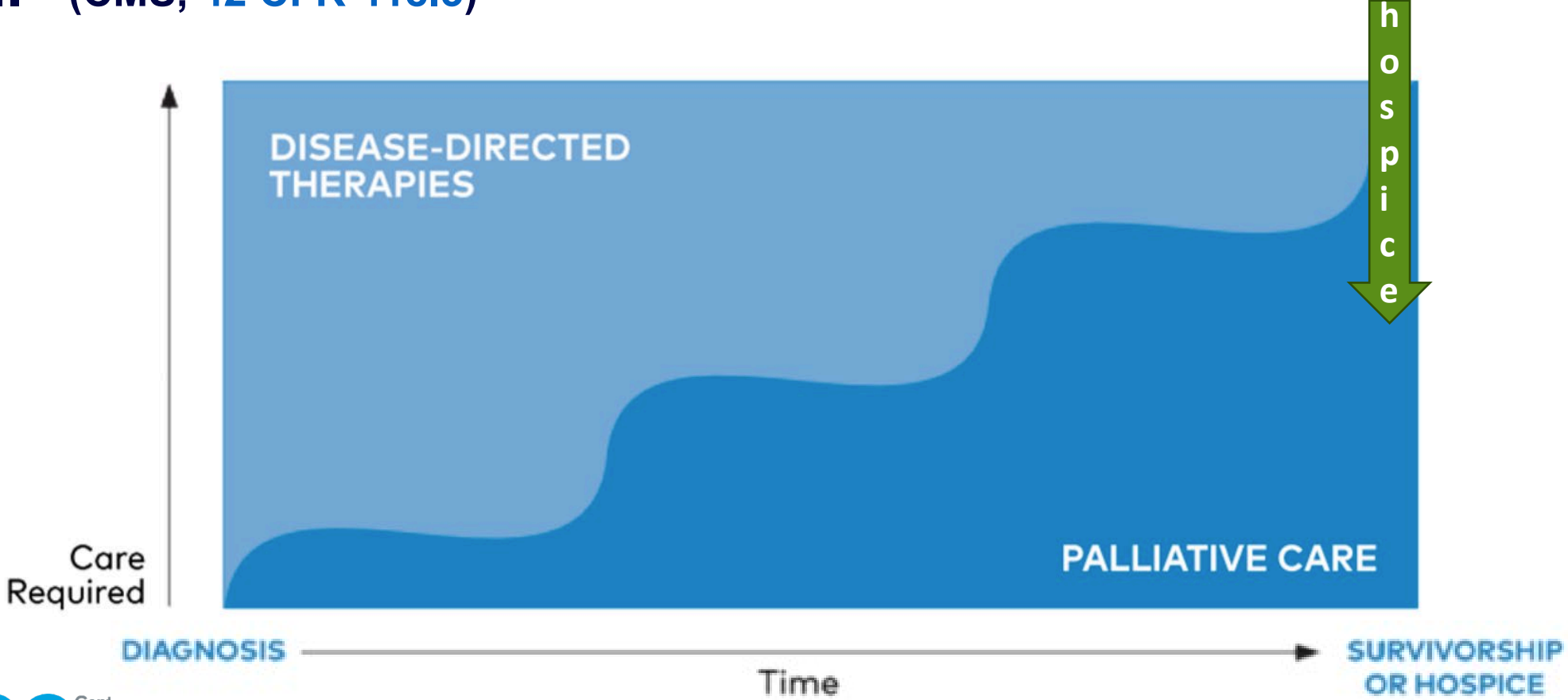
Icahn School of Medicine at Mount Sinai

June 2024

Center to
Advance
Palliative Care™

capc

CMS definition: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs ..." (CMS, 42 CFR 418.3)



Who are these patients?

- Heterogeneous
- Multiple serious chronic illnesses
- Median of 8-11 physicians **per patient**
- Functional and cognitive impairment
- Symptom distress
- Multiple transitions
- Caregiver exhaustion
- Use of ED to manage symptoms due to chronic illness (esp. after 5pm/weekends)
- Expensive because they are really sick and complex, need care from a lot of specialists: much of this spending is not preventable.

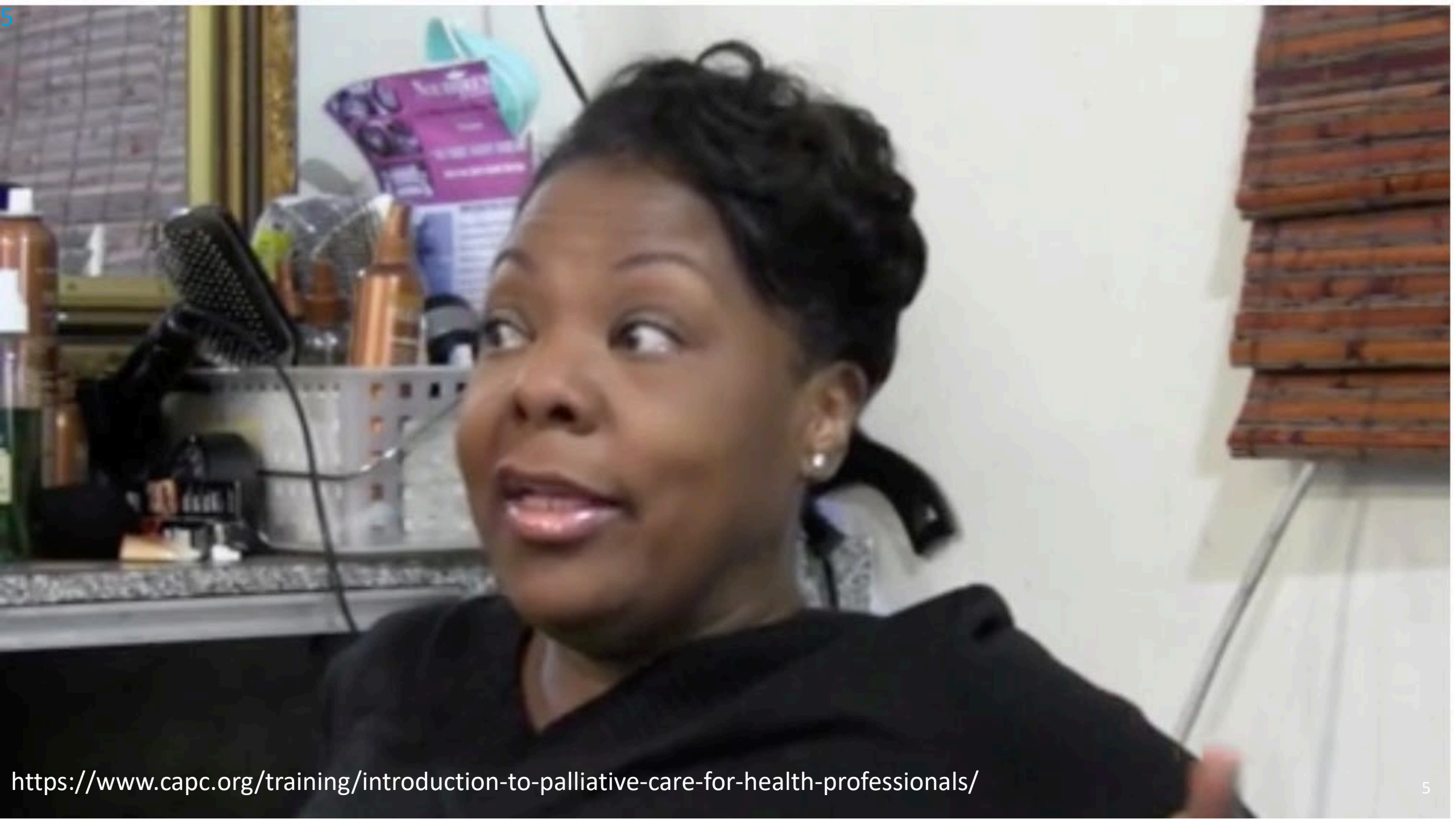
Untreated symptom distress drives preventable utilization

Cancer ED Visit Primary Diagnosis (Within the top 10 Diagnoses)	% of Total Visits	Median Reimbursement
Pain	27.2% (36.5%)	\$1,127
Dyspnea	6.2% (10.2%)	\$1,115
Dehydration	3.3% (6.5%)	\$1,160
Fatigue		\$544
All Other Preventable Distress		\$292-1,314

102% increase from 2012-2019 in the number of patients – with any illness – visiting an ED because of pain

(Tabriz, JAMA Open, 2022)
<https://ascopubs.org/doi/abs/10.1200/JCO.2010.34.2816>

Panattoni, J Oncol Pract, 2018



Debbie's quality of life changed with the addition of palliative care.

Before palliative care:

- Disabling pain due to chemotherapy side effects
- Depression, functional decline, inability to work, social isolation, and suffering
- Family distress
- Multiple 911 calls for pain crises, followed by three ED visits and 3 hospitalizations
- **Devastated by being accused of drug seeking by ED staff**

After palliative care:

- Pain controlled
- Resumed work, family role, and going to church
- 24/7 phone access to clinicians
- Ongoing relationship with our palliative care + hematology teams for >10 years
- Support from social worker, chaplain
- **No 911 calls or ED visits in 10+ years**

Not dying!



Palliative Care Improves Value

Quality improves

- Symptoms
- Quality of life
- Length of life
- Family satisfaction
- Family bereavement outcomes
- MD satisfaction



Costs reduced

- Hospital cost/day
- Hospital, ICU, ED LOS
- 30-day readmissions
- Hospitality mortality
- Labs, imaging, pharmaceuticals

Palliative Care: Structural Requirements to Ensure Quality, Reduce Cost

Required elements to achieve value:

1. Employ an **interdisciplinary team**

- Clinician licensed or certified to provide **psychosocial-spiritual care** (social worker, psychologist, counselor or chaplain)
- At least one **prescriber with training and certification in palliative care**

2. The clinical care team is available by phone **24/7**, has access to health records, and can make home visits when necessary

Best Practices for Integrating Palliative Care into Population Models

Serious Illness Strategies

<https://tinyurl.com/bddj4bzw>.

Driving Value in High-Need Populations



- Systematic, proactive identification of patients most in need via EHR
- Care manager assessment for symptom, functional, and caregiver burdens
- Communication with treating clinicians **or** connection to specialty palliative care, as warranted
- Specialty palliative care services “dosed” to patient and family need
- 24/7 meaningful clinical response

Require screening for palliative care needs

- Multimorbidity
- Functional impairment
- Cognitive impairment
- Symptom distress
- Caregiver burden
- Frailty
- SDOH (housing, food insecurity, poverty)
- Psychiatric co-morbidity
- Recurrent hospitalization/ED visits



High-need high-cost population

Explicit Incentives Necessary

- VBP models alone have not motivated most providers to ensure access to high-quality palliative care services
- **Additional payment and explicit requirements** are required to ensure timely integration of palliative care services, and achieve its quality-of-life and cost-avoidance impacts

Financial Incentives Work: Hospitals

Payer Example	Details	Impact
<p>Elevance Palliative Care QHIP Measure</p> <p>https://hospicenews.com/2024/03/06/the-most-disruptive-forces-shaping-palliative-care-in-2024/</p>	<p>Network hospitals receive financial bonus for: palliative care policy, patient identification process, interdisciplinary team, and all staff training</p>	<p>Proportion of network hospitals receiving the bonus has grown over time; palliative care teams have also grown</p>
<p>Highmark Quality Blue Palliative Care Measure</p> <p>https://bettercareplaybook.org/_blog/2020/8/driving-improvements-hospital-care-through-palliative-care-quality-incentives#:~:text=Highmark%20Quality%20Blue%20Hospital%20Program&text=The%20measure%20sets%20a%20target,within%20two%20weeks%20after%20discharge.</p>	<p>Network hospitals receive financial bonus if >50% of identified Highmark enrollees receive palliative care services in a 30-day episode</p>	<p>Proportion of enrollees receiving palliative care has grown over time</p>

Financial Incentives Work: Community

Payer Example	Details	Impact
<p>Cambia Regence BCBS https://www.regence.com/medicare/programs/health-support-services/palliative-care</p>	<p>Financial bonus for network primary care providers for goals conversations with identified enrollees, and for referral to palliative care services</p>	<p>Utilization of community palliative care services has grown over time</p>
<p>Highmark Health https://www.highmarkhealth.org/blog/future/Enhanced-Community-Care-Management-Bringing-Palliative-Care-into-the-Community.shtml</p>	<p>Financial incentive for PCPs if refer to Enhanced Community Care Management for identified high risk enrollees in risk models, provides phone and home-based care</p>	<p>Consistent reduction in TCOC</p>
<p>HealthFirst https://hf.org/healthcare-home/departments-services/hospice/palliative-care#what-does-outpatient-palliative-care-offer-me--</p>	<p>Network ACO received additional payment for a 90-day episode of home-based palliative care services, for identified enrollees</p>	<p>ACO achieved shared savings despite added palliative care spend</p>

Options for CMS/CMMI

1. **Require** hospitals/systems participating in population-based TCOC models to attest to having a palliative care policy, a patient ID process, an interdisciplinary palliative care team, and all-staff training – with spot audits to verify
2. **Require** TCOC model participants to report on the number and % of patients receiving specialty palliative care services
3. **Financially incentivize** through a **fixed palliative care care management fee and/or a quality incentive** for screening for and access to palliative care to ensure resource commitments
4. **Create a CPT G-code** for palliative care assessment to count who gets palliative care
5. **Use new NQF-endorsed Patient Reported Outcome Measures to incentivize quality:**
 - #3665 – Patients' Experience of Feeling Heard and Understood
 - #3666 – Patients' Experience of Receiving Desired Help for Pain

Best Practices for Integrating Hospice into Population Models

- Deliver hospice without terminating other services (“Concurrent or Transitional” hospice—major equity issue)
- Incentivize the treating clinician to continue to visit the patient: Successful PACE programs have done this
- 24/7 **meaningful** clinical response- incentivize timeliness of response to patient calls

Concurrent Hospice Models

Model and Population	Payment Approach	Outcomes
<p>Medicare Care Choices Model – selected Dx and hospice criteria met</p> <p>https://www.cms.gov/priorities/innovation/innovation-models/medicare-care-choices https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.14289</p>	<p>Monthly care management fee on top of all allowed Part A and B billing</p>	<p>14% less spending, longer hospice length-of-stay, and more days at home, better equity</p>
<p>VA Comprehensive End-of-Life Care Initiative – patients referred for hospice</p> <p>https://www.hsrd.research.va.gov/research/citations/PubBriefs/articles.cfm?RecordID=889</p>	<p>Included in VA budget</p>	<p>More likely to die on hospice and less likely to receive high-intensity care at end-of-life</p>
<p>UPMC Concurrent Hospice and Dialysis Program for patients</p> <p>https://pubmed.ncbi.nlm.nih.gov/36269338/</p>	<p>Negotiated payment between the hospice and the dialysis center</p>	<p>Longer hospice length of stay Most patients discontinued dialysis</p>

Bottom Line

1. Requirements
2. Financial incentives