

Physician-Focused Payment Model Technical Advisory Committee

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

Panelists:

Subject Matter Experts

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

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Matthew Wayne, MD, CMD
Chief Medical Officer, Communicare

Matthew S. Wayne MD, CMD



- Chief Medical Officer, CommuniCare Family of Companies and Personalized Health Partners (PHP)
- CommuniCare operates 130 skilled nursing facilities in 7 states
- PHP is CommuniCare's medical practice, and includes 12 full time Primary Care physicians, a Psychiatrist, a Physiatrist and over 100 Nurse Practitioners
- 25% of the patients we serve are in a TCOC model (ISNP and High Needs ACO Reach)
- I am board certified in Internal Medicine and Geriatric Medicine
- I have been a Chief Medical Officer for 15 plus years, 9 with CommuniCare
- I have also been CMO for New Health Collaborative (NHC), a successful MSSP ACO in Akron, Ohio

Key Takeaways



- Everything we do is based on creating a connection or relationship with our patients
- Once this is established, we seek to define goals of care or what matters most to our patients
- We embrace best practices in chronic disease management
- We focus on timeliness of care, seeking to be there for our patients when they need us as opposed to when it is convenient for us

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David Gellis, MD, MBA

Vice President and National Medical Director,
Medicare Population Health Programs
One Medical Senior Health



David Gellis, MD, MBA

- VP and National Medical Director, Medicare Population Health Programs at One Medical (2013-2024)
- **One Medical Seniors**
 - Nationally scaled care model built around senior-focused clinics (48 practices, 8 states, 50k+ lives) operating under global capitated risk (MA and ACO REACH)
 - Founded as Iora Health, acquired by One Medical and now part of Amazon Health Services.
 - Care model embeds population health in robust practice care teams while deploying home-based and hybrid virtual programs for most complex/high need patients.
 - Joined GPDC/ACO REACH model in 2021 as New Entrant. Today 15k risk lives and a top performer on quality and cost-savings.



Key Takeaways

- Global risk contracts support investments in high-touch care, integrated behavioral health, and health equity promotion but require:
 - Program stability, predictability and multiyear time horizons
 - Benchmarks that reflect true acuity and allow savings to be reinvested (vs rapid ratcheting)
 - Quality metrics appropriate for a complex population
- ACO REACH provides helpful structures to align incentives across stakeholders (patients, PCPs, specialists, facilities), but CMS should strengthen those levers.
- AI/ML* technologies have increasing utility in supporting care for complex patients, especially in identification, stratification and synthesizing complexity.

*AI/ML – Artificial Intelligence / Machine Learning

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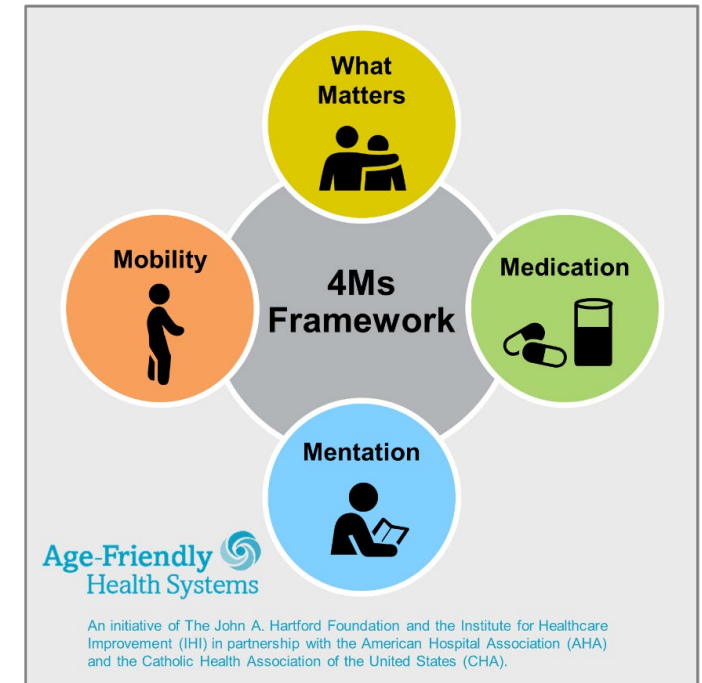
*Sr. Program Consultant at The John A. Hartford Foundation –
Age-Friendly Health Systems and Diagnostic Excellence for Older Adults*

- Fellowship-trained Geriatrician, Past President: Am Geriatrics Society and American Medical Directors Assoc. for Post-acute and LTC Medicine
- Clinical experience – Office and Hospital Practice, Post Acute and LTC, Home Health, Hospice, and Program of All-Inclusive Care for the Elderly (PACE)
- Large health system leadership – focused on risk stratification and care management of high risk, high needs older adults
- 15+ years in health policy work to improve systems and models of care for older adults.
- Immediate Past President and CEO – Special Needs Plan Alliance, a national association of Medicare Advantage Special Needs Plans focused on improving care for adults with complex needs
- Career focused on addressing complex needs for older adults across providers, settings, and payors

Care for persons with serious illness and complex needs has become FAR TOO COMPLEX!

Essential Elements for Care Design

- Targeting (risk ID) and stratification for high risk/high needs
- Value-based payment models that account for whole-person care
- Integration of function, social needs, social support and behavioral health into all assessments: *“Individuals with serious illness are not the sum of their diagnoses”*
- *Meaningful* team-based care
- Meaningful measures that drive outcomes that matter to the individual
- Person-driven goal-oriented care
- Focus on 4Ms care



For related work, this graphic may be used in its entirety without requesting permission. Graphic files and guidance at ihi.org/AgeFriendly

Mate K, Fulmer T, Pelton L, Berman A, Bonner A, Huang W, Zhang J., Evidence for the 4Ms: Interactions and Outcomes across the Care Continuum. J Aging Health. 2021 Aug-Sep;33(7-8):469-481. doi: 10.1177/0898264321991658. Epub 2021 Feb 8. PMID: 33555233; PMCID: PMC8236661.

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Olivia Rogers, RN, MBA

Vice President and Chief Nursing Officer
Visiting Nurse Association of Texas

Olivia Rogers, RN, BSN, CHPN, MBA VP, Chief Nursing Officer



90-year-old Organization:

- Texas Hospice provider since 1984 - Medicare Hospice Pilot Program participant (Avg. Census Hospice 320 in 16 counties, rural and urban)
- Dallas Co. Meals on Wheels provider - serving 8,000 home-delivered meals/day
- Large Community Health Worker program to address SDOH needs in underserved community
- Participant – CMMI’s Medicare Care Choices Model (MCCM) - test community-based supportive palliative care services from hospice providers (*Exemplary provider per MCCM)
- Current provider of Supportive Palliative Care (Avg. Census 120, 16 counties, many rural)
- Participant – ACO REACH & Supportive Palliative Care with Wellmed Medicare Advantage



Value of Hospice and Community-Based Palliative Care

Late Admissions to Hospice or Other Appropriate Serious Illness Care Leads to:

- Adverse impacts on patients & families and Medicare spending.
- Lack of quality of life and goals being met if pursuing futile treatment.
- Median LOS on Hospice is low, Avg. 17 days in 2021.
- Hospice saved Medicare \$3.5B (3.1%) for beneficiaries in the last year of life, compared to beneficiaries who did not utilize Hospice.

One Solution – MCCM* – Allow patients to choose palliative care in the home without foregoing disease-directed therapy!

*Among enrollees who died before the model ended, net expenditures decreased \$7,604 (13%) per MCCM enrollee between enrollment and death, compared to a matched comparison group.

- Inpatient admissions decreased by 26%.
- Outpatient emergency department visits and observation stays decreased by 12%.
- Aggressive treatment in the last 30 days of life decreased by 15%.
- Consider relaunching MCCM demonstration project.



Appendix

- www.cms.gov/priorities/innovation/data-and-reports/2023/mccm-fg-fifthannrpt
- <https://www.dallasnews.com/opinion/commentary/2024/04/27/hospice-option-for-young-adults/>
- <https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2023.pdf>
- <https://www.nhpco.org/wp-content/uploads/Value Hospice in Medicare.pdf>



CMMI & MCCM: Perspective of Chief Nursing Officer

- Through MCCM, hospice staff provided care that kept enrollees from seeking care in an emergency department and this prevented hospitalizations (Enrollees spent more time at home before death and were seen by an entire interdisciplinary team).
- MCCM hospices reported delivering high-quality services per CMS-defined metrics (pain managed, etc.). Care met Conditions of Participations of hospice in a fee for service model, including full interdisciplinary team.
- MCCM enrollees and caregivers reported high levels of satisfaction with shared decision making, receiving care consistent with their wishes, and quality of life.
- Consistent care team and 24-hour support led to improved engagement with patients and families and built trust, led to earlier hospice utilization.

GOAL: MCCM be relaunched with some minor changes to increase enrollment

- Remove requirement to provide home health aides to MCCM patients
- Increase fee for service to \$700-\$800 per patient per month (versus the \$400 per patient per month)
- Consider broadening admission criteria to other diagnoses, such as liver failure, any end stage respiratory disease. Etc.



Findings at a Glance

Medicare Care Choices Model

Fifth and Final Annual Evaluation Report (2016 – 2021)

MODEL OVERVIEW

The six-year Medicare Care Choices Model (MCCM) tested whether offering eligible fee-for-service Medicare beneficiaries the option to receive supportive and palliative care services through hospice providers without forgoing payment for the treatment of their terminal conditions (which is required to enroll in the Medicare hospice benefit) improved beneficiaries' quality of life and care, increased their satisfaction, and reduced Medicare expenditures.

PARTICIPANTS



CMS accepted 141 Medicare-certified hospices to participate in MCCM.

- Participating hospices tended to be larger than hospices nationally and were more often a nonprofit organization.
- Significant attrition occurred over time, partly because of low payments and challenges recruiting eligible beneficiaries. Only 89 hospices (63%) enrolled a beneficiary and only 44 (31%) participated for all six years.
- Enrollment was highly concentrated: just 5 hospices enrolled 46% of all MCCM enrollees, which limits generalizability.



7,263 Medicare beneficiaries enrolled in MCCM.

- All qualified for hospice and met other eligibility criteria, including having cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS.
- Less than 1% of eligible beneficiaries who lived in participating hospices' market areas enrolled. MCCM enrollees disproportionately had cancer, used more health care services, were non-Hispanic and White, were not dually eligible for Medicaid, and lived in non-rural areas.
- Lengths of enrollment varied widely, with a median of about 2 months. About 89% of enrollees died before the model ended.

FINDINGS



Enrollees received supportive and palliative care services through MCCM.

- Enrollees received 2.6 encounters per week with MCCM staff (on average among all model enrollees), provided mostly by clinically trained staff, often in person and at home.
- Through MCCM, hospice staff provided a range of services they identified as critical to keeping enrollees from seeking care in an emergency department and preventing hospitalizations.
- MCCM hospices reported delivering high-quality services per CMS-defined metrics, such as achieving high rates of comprehensive assessments and symptom screening and management for pain, shortness of breath, and emotional well-being among all model enrollees.
- Surveyed MCCM enrollees and caregivers reported high levels of satisfaction with shared decision making, receiving care consistent with their wishes, and quality of life.
- Interviewed hospice staff identified (1) implementing a "no wrong door" referral policy, (2) gaining enrollees' trust, (3) engaging enrollees in ongoing education, and (4) giving enrollees someone to call after hours as keys to their success.

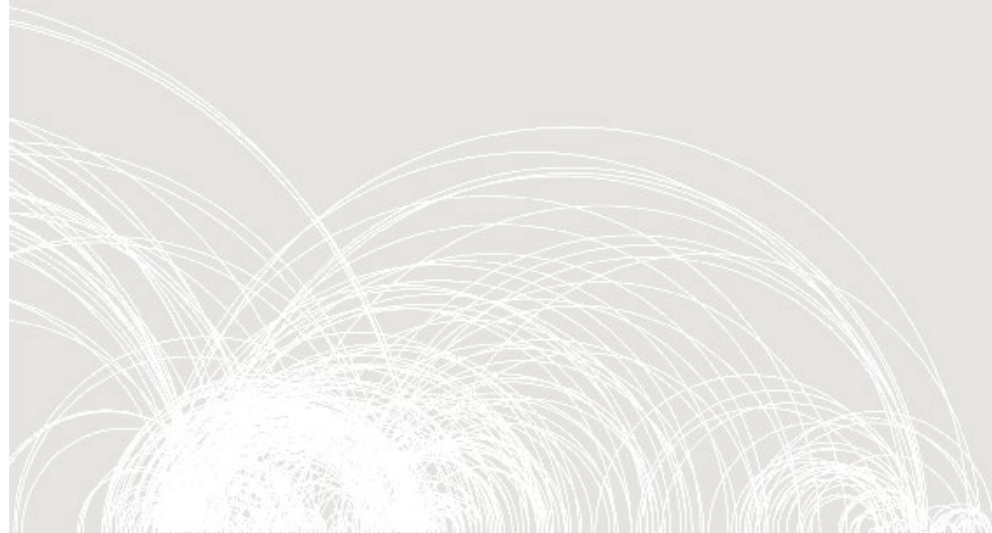
Commonly provided MCCM services

- Assessment of health and health-related social needs
- Care coordination and case management
- Round-the-clock access to health care professionals
- Person- and family-centered care planning
- Shared decision making
- Symptom management
- Education and counseling

FINAL REPORT
MARCH 2023

Value of Hospice in Medicare

Presented by:
NORC at the University of Chicago





NHPCO Facts and Figures 2023 EDITION

Published December 2023





I'm 32 and I'm dying

I've fought cancer for 13 years, and hospice care is the option I'm choosing now

Article by Taylor Roth, 2024



<https://www.dallasnews.com/opinion/commentary/2024/04/27/hospice-option-for-young-adults/>