

**Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in
Population-Based Total Cost of Care (PB-TCOC) Models
Request for Input (RFI) Responses**

On June 11, 2024, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on addressing the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care (PB-TCOC) models and physician-focused payment models (PFPMs). PTAC has received six responses from the following stakeholders listed below:

1. [Center to Advance Palliative Care \(CAPC\)](#)
2. [Coalition to Transform Advanced Care \(C-TAC\)](#)
3. [American Academy of Hospice and Palliative Medicine \(AAHPM\)](#)
4. [American Nurses Association \(ANA\)](#)
5. [National Association of ACOs \(NAACOS\)](#)
6. [LTC ACO](#)

For additional information about PTAC's request, see PTAC's [solicitation of public input](#).



July 10, 2024

Lauran Hardin and Angelo Sinopoli
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
PTAC@hhs.gov

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**RE: Request for Input
Addressing the Needs of Patients with Serious Illness
In Population-Based Total Cost of Care Models**

Dear Ms. Hardin and Dr. Sinopoli:

Thank you for the opportunity to submit comments on meeting the needs of patients with complex chronic conditions and serious illnesses in population-based total cost of care (PB-TCOC) models.

The Center to Advance Palliative Care ([CAPC](http://capc.org)) is a national organization dedicated to ensuring that all persons living with serious illness have access to high quality, equitable care that addresses their symptoms and stresses, including access to specialty palliative care services. [Palliative care](#) specifically refers to specialized medical care for people living with a [serious illness](#), focused on improving quality of life for both the patient and caregiver. It is an *added* layer of support, working in partnership with other providers and can be provided along with curative treatment.

A strong and consistent evidence base shows that palliative [improves quality of life](#), [reduces caregiver and clinician burden](#), and in so doing, [avoids preventable spending](#) across all settings. Yet despite this evidence and the clear alignment of incentives, participants in existing population-based total cost of care models – particularly accountable care organizations (ACOs) – [underutilize](#) palliative care and other strategies aimed at improving care for beneficiaries with serious illness. In fact, one actuarial analysis estimated that ACOs could [save an additional \\$1,200 per beneficiary per year across their whole population](#) if improvements were made to the care of their seriously ill population.

Therefore, CAPC urges *explicit* attention to this population, and *specific* financial incentives – even requirements – within population-based models. Responses to the selected questions below expand this perspective.

[Characteristics of Patients with Complex Chronic Conditions and Serious Illnesses](#)

While there are several definitions of this population, CAPC relies on the [Commonwealth Fund estimate](#) of 12% of the US adult population being “high-need,” who are more likely to be:

- Older, female, and white;
- Less educated than other US adults; and
- Have low incomes and be publicly insured.

This profile suggests significant social needs as well as clinical needs, underscoring the need for a holistic approach and ‘an added layer of support’ within existing care delivery models.

Prospective Identification of the Population

CAPC has spent many years working with payers, ACOs, and others to proactively identify the population with serious illness who would benefit from palliative care, and found this [common two-factor approach](#):

1. Diagnosis of late-stage or end-stage illness, particularly metastatic cancer, heart failure, COPD with oxygen, chronic or end-stage kidney disease, and/or advanced dementia
AND
2. An additional indicator of unmet need, depending on the data sources available. Most commonly used are: recent hospitalization or emergency department visit; home health episode from community referral or repeated home health episodes; or durable medical equipment such as wheelchairs. Less commonly available but significant indicators are functional scores and indicators of unmet social needs.

Major Challenges to Care for the Population Living with Serious Illness

Even after the high-need population is identified, they often do not receive care for their holistic needs. This is underscored by the [mixed results from existing care coordination](#) models. However, what is missing in so many population management approaches is explicit attention to anticipatory guidance for patients and caregivers, alignment of care with patient goals, and appropriate management of pain and other symptoms.

This deficit cannot be easily addressed, since currently, many treating clinicians lack the knowledge of, and/or comfort with, [communication](#) and [pain and symptom management](#) in the face of serious illness. Compounding this challenge is the relative lack of palliative care specialists, currently numbering 2.12 certified physicians per 100,000 US population. Thus, not only do patients suffer needlessly when their treating clinicians inadequately address their communication and symptom management needs, but they also cannot reliably access assistance from specialists.

Therefore, **CAPC strongly recommends that total cost of care models include meaningful financial incentives for completion of skills training for non-palliative care clinicians AND for access to certified specialty palliative care teams and professionals.** This can be accomplished through:

- Participant application requirements, where organizations are unable to participate in the total cost of care model unless they demonstrate wide-scale training in communication and symptom management skills, along with inclusion of sufficient proportions of certified palliative care specialists. Hospital participating providers should similarly be required to demonstrate sufficient specialty palliative care capacity.
- Care model requirements that include assessment of symptom distress and of caregiver burden on a regular basis, at minimum for a defined population most likely to have complex chronic illness or serious illness. (Alternatively, participating organizations can be financially incentivized to complete these assessments on a specified population, through performance measures.)
- Benefit enhancements, such as a new care management fee for palliative care consultations. The additional payment is necessary to ensure sufficient resources for access across the population.

Because such requirements or incentives may encourage poor quality to meet the threshold, parameters on the types of training to be completed, and on the palliative care professionals included in the organization should be articulated.

Examples of Effective Care Models for Patients with Serious Illness

The basic care delivery approach that improves both quality of life and cost-effectiveness for this population is:



What has worked well for the first step are data systems and care managers that are trained to be “on the lookout” for patients with complex chronic illness and serious illnesses facing gaps in care, and flagging those patients for the treating team. In some cases, organizations use [patient-reported outcomes/symptom reporting](#) to alert clinicians. Clinicians with the knowledge and skills to meet the basic needs of patients and families then adjust care delivery to address the noted gaps.

For the patients whose palliative care needs are most complex, the palliative care team is consulted as step two. Palliative care specialists provide consultation or co-management with the treating team, clarifying patient goals and relieving stress and symptoms, such as at [Moffitt Cancer Center](#), [Sharp Healthcare](#), or [Mercy Health](#) (the latter adding in palliative care consultations to its top virtual complex care patients). Note that these consult/co-management approaches also address the issue of identifying patients in the top 6-10% of health care spending who are at risk of moving to the top 5%.

When the population with serious illness is proactively and regularly identified, there will be some with significant needs, who may be home-bound or whose caregivers are overwhelmed. For this population, ongoing care in the home through the addition of home-based palliative care is an [effective model of care](#). To manage resources, [some organizations](#) maintain strict admission and discharge criteria for their home-based services.

Best Practices in Performance Measurement

There are important structure and process measures that can be used to reinforce and incentivize attention to the population with serious illness as well as attention to effective specialty palliative care access and deployment. For example, in the private sector, both Elevance and Highmark [incentivize their hospital network](#) to deliver palliative care to the appropriate population through required identification processes and interdisciplinary palliative care teams, and claims-based measures of palliative care utilization, respectively. Other structure and process measures that align with high-quality care for this population include:

- the proportion of key clinicians who complete a required curriculum in core palliative care skills
- the proportion of a defined population who have completed symptom distress and caregiver burden assessments.

In terms of outcome measures, there are two measures stewarded by the American Academy of Hospice and Palliative Medicine that [assess patient experience during serious illness](#):

1. How much patients feel ‘heard and understood’

2. If patients got the help they wanted for their pain

While not yet validated broadly, these measures should be tested in population models for all patients with complex chronic illnesses and serious illnesses.

* * * * *

Thank you for the opportunity to submit these comments. Please do not hesitate to contact me if we can provide further assistance.

Sincerely,



Allison Silvers
Chief Health Care Transformation Officer
Center to Advance Palliative Care (CAPC)
Allison.silvers@mssm.edu

Cc: Brynn Bowman, Chief Executive Officer CAPC



July 10, 2024

Re: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models (RFI)

Submitted electronically to PTAC@HHS.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to respond to this RFI regarding addressing the needs of patients with complex chronic conditions or serious illnesses in PB-TCOC models.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

Responses to select RFI Questions

*What are the characteristics of patients with complex chronic conditions or serious illnesses?
What are the characteristics of the highest cost patients with complex chronic conditions or serious illnesses?*

- C-TAC [defines serious illness](#) as a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life, or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).
- Currently, persons with serious illness often receive services contrary to their individual care preferences due to lack of informed care planning, while underutilizing community services, palliative care, and hospice. This leads to high unmet needs and poor quality of life.
- Persons with serious illness receive their care in multiple settings, and often without coordination or access to comprehensive palliative care services delivered by an

interdisciplinary group, leading to fragmented, uncoordinated care, and challenges accessing additional services that may be available in their community.

- Persons with serious illness that do not have access to care coordination earlier in their course of a serious illness can face burdensome healthcare costs due to frequent inpatient admissions, emergency department visits, facility stays, and low value treatments that impact quality of life for people and their family caregivers.

How are high-cost patients with complex chronic conditions or serious illnesses prospectively identified by payers, ACOs, and providers?

The current prevalence of persons with serious illness can be determined using the definition listed in the first answer or by a comprehensive analysis for those enrolled by a payer. Using administrative claims data, a state payor, such as Medicaid, or a private payer can identify members with serious illness using one of three different approaches:

1. Population-Based Approach. People identified through claims with specified diagnosis and functional criteria demonstrating ongoing decline, including proxies for level of function and risk of future hospitalizations.
2. Past hospice utilization. Members who have received hospice care. This approach will identify individuals with terminal illness closer to the end of life.
3. Decedents. Members who died during the specified period. This approach will identify individuals who may or may not have accessed hospice services prior to death. Sudden death and death from causes other than a serious illness should be removed from this analysis.

What are the major challenges that affect patients with complex chronic conditions or serious illnesses? What are the major challenges that affect providers' ability to care for these patients?

- As noted, persons with serious illness often receive services contrary to their individual care preferences, while underutilizing advance care planning, palliative care, home and community-based services, or hospice. These services help people make treatment decisions better aligned with their goals and values, address their important social needs, and provide education and support to them and those who matter most to them. This in turn reduces unwanted utilization.
- Providing access to specialty palliative care services throughout the continuum of care and across care settings, can reduce potentially preventable events and mitigate these challenges. Specialty palliative care includes a range of coordinated, specialized palliative care services delivered by an interdisciplinary team skilled in delivering person-centered care outside of the hospital and hospice settings and can be made available to people with serious illness across geographies and cultural settings. This can also include:
 - Ensuring each person's physical, social, psychological, and spiritual needs are assessed on an ongoing and standardized basis.
 - The development of care plans, using shared decision making, based on those needs and the person's individual goals and preferences.

- Accessible care 24/7 (using technology as appropriate) and available throughout the continuum of a serious illness (including in the home when appropriate).
- Comprehensive and coordinated care, with seamless transitions, and with integration of clinical and community-based services and supports for the person and family caregiver(s).

What are the major barriers associated with participation and engagement in APMs from providers serving patients with complex chronic conditions or serious illnesses?

Payment for models with serious illness populations should be value-based, available to qualified organizations of any size, and includes risk adjustment, upfront investment, accountability, standardized metrics, and quality improvement, and covers both clinical and social services.

While palliative care can lead to coordinated, high-value care that aligns with person preferences, the current reimbursement structures does not enable individuals to access interdisciplinary supportive services unless they are hospitalized or have elected hospice care. While outpatient palliative care consultations, assessments, and advanced care planning are reimbursable through fee-for-service for billable members of the interdisciplinary team, and are available to beneficiaries in a clinic or telemedicine setting today, these services do not typically extend into the home or allow for a team-based, longitudinal approach to care for the duration of a person's illness. This creates gaps in care which result in crises and emergency department visits or hospitalizations.

Introducing a bundled payment rate, or a pre-determined amount of money paid to a provider organization to cover the average costs of all services needed to achieve a successful outcome for a pre-defined episode of care, can allow for financial incentives to provide coordinated care that accounts for the higher risk associated with people who are seriously ill.

What are examples of effective care models for patients with complex chronic conditions and/or serious illnesses? What specific issues have these models focused on (e.g., patient-centered care, preventable events, management of care transitions, equity/health related social needs, specific conditions)?

- Care models that provide access to specialty palliative care services throughout the continuum of care and across care settings can reduce potentially preventable events and mitigate the challenges of fragmentation, underutilization, and unwanted care. Specialty palliative care includes a range of coordinated, specialized palliative care services delivered by an interdisciplinary team skilled in delivering person-centered care can be made available to persons with serious illness across settings. This can also include:
 - A comprehensive assessment to identify each person's physical, social, psychological, and spiritual needs on an ongoing and standardized basis.

- The development of person-informed care plans via a shared decision-making process that incorporates the needs and the person’s individual goals and preferences.
- 24/7 access to care, using technology as needed, and available throughout the continuum of a serious illness and across settings.
- Comprehensive and coordinated care, with seamless transitions, and with integration of clinical and community-based services and supports for the person and family caregiver(s).

What are best practices in performance measurement for patients with complex chronic conditions or serious illnesses?

The main goals of performance measures for PB-TCOC models for persons with serious illness should be to confirm the quality of the person’s experience. That would encompass the key aspects of care: access, affordability, timeliness, and clinical components addressing the person’s quality of life, their ability to be a partner in the plan of care and treatment plan, and their satisfaction with communication and information being provided. Ideally they would be patient-reported measures such as the [Ambulatory Palliative Care Patients’ Experience of Receiving Desired Help for Pain](#) and also the [2024 MIPS Measure #495: Ambulatory Palliative Care Patients’ Experience of Feeling Heard and Understood](#). Both were developed for community-based palliative care programs but are available for other models providing care to those with serious illness. We also advocate for assessment and support of the family caregiver since they are a key partner in ensuring people with serious illness get the care they need.

We do not see the need for PB-TCOC models measurement to differ from those of other APMs.

Furthermore, we recommend that PB-TCOC models should consider a range of performance characteristics including:

- Demographics of those accessing and utilizing services, including race/ethnicity, socioeconomic status, gender, and geography and allowing for self-identification.
- Completion and timeliness of assessments including those for cognitive and physical function, caregiver status and burden, pain, goals for care, and health related social needs.
- Beneficiary and caregiver experience of care and quality of life.
- Provider and care team experience of care.
- Health services utilization and costs, including primary care provider visits, inpatient admissions, readmissions, timeliness of care delivery/delays in care, pharmacy benefit utilization, access to home-based services, and hospice length of stay.
- Quality, including transitions of care and advance care planning

Thank you for the opportunity to respond to this RFI. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant and Torrie Fields

Advisors
Coalition to Transform Advanced Care (C-TAC)



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HOSPICE AND PALLIATIVE MEDICINE

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July 12, 2024

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Co-Chairs

Physician-Focused Payment Model Technical Advisory Committee

Office of the Assistance Secretary for Planning and Evaluation

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

RE: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models – Request for Input

Dear Co-Chairs Hardin and Sinopoli:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for the opportunity to comment on the Request for Input (RFI) on Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in PB-TCOC Models. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality, equitable palliative and hospice care.

Overview

AAHPM is pleased that PTAC has brought attention to the unique needs of patients with serious illness, and the challenges of meeting those needs in alternative payment models (APMs). As we noted when we submitted our [*Patient and Caregiver Support for Serious Illness \(PACSSI\)*](#) model to PTAC in August 2017, patients who have serious, potentially

life-limiting illnesses or multiple chronic conditions coupled with functional limitations are not well-served by the current fragmented, intervention-oriented health care system. Numerous research studies and pilot projects demonstrate that high-quality, interdisciplinary palliative care services can provide significant benefits for patients, caregivers, and payers.

Palliative care is an interdisciplinary model of care aimed at preventing and treating the debilitating effects of serious illness. It can be provided from the time of diagnosis and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath and unrelenting nausea.

Palliative care is patient- and family-centered—it focuses on matching treatment to achievable patient goals to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients traverse throughout the course of a serious illness. Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious illness. Hospice is care specially designed for those nearing the end of life.

Definition of Serious Illness

PTAC offers a working definition of Patients with Serious Illnesses as “those with advance illness and patients who are in their last years of life.” In particular, we object to the use of the word “advanced” to describe illness that may be affecting patients, which we do not believe is clearly defined or captures the whole universe of patients that our members may identified as seriously ill.

We encourage PTAC, the Centers for Medicare and Medicaid Services (CMS), and other policymakers to rely on an operational definition of serious illness, rather than a vague conceptual definition, and we highlight that extensive work has been done on this topic. Specifically, we highlight the work from Kelley et al.¹ which supports a two-factor combination that considers both specific diagnoses and indicators of unmet need, impaired function, and/or high symptom burden.

We note that, in collaboration with the members of the National Coalition for Hospice and Palliative Care (NCHPC), we have previously shared recommendations with CMS on methods to identify the population of patients with serious illness. We share our previous recommendations for your consideration as Attachment 1 to this letter.

Need for Increased Access to Palliative Care

For patients with serious and chronic illness, palliative care delivered through interdisciplinary teams can not only help to relieve pain and other distressing symptoms but also address patients’ psychosocial and

¹ Kelley AS, Ferreira KB, Bollens-Lund E, Mather H, Hanson LC, Ritchie CS. Identifying Older Adults With Serious Illness: Transitioning From ICD-9 to ICD-10. *J Pain Symptom Manage.* 2019 Jun;57(6):1137-1142. doi: 10.1016/j.jpainsymman.2019.03.006. Epub 2019 Mar 12. PMID: 30876955.

spiritual needs and improve their capacity to contend with the stresses associated with their illness. Palliative care also can improve patient and caregiver outcomes, including through improved care coordination and reduced utilization of high-cost interventions that are inconsistent with patients' goals and preferences. Unfortunately, current payment systems continue to pose numerous barriers that limit palliative care teams' ability to receive adequate reimbursement for providing comprehensive palliative care services – and therefore limit patients' ability to receive high-quality palliative care.

AAHPM has sought to address this gap through advocacy for a robust Medicare alternative payment model (APM) that would offer payment for palliative care services and enable palliative care teams to take on cost and quality accountability for patients with serious illness, initially with our submission of the PACSSI model to PTAC in the fall of 2017. Following PTAC's recommendation to the Secretary of the Department of Health and Human Services (HHS) for limited-scale testing of the PACSSI model, AAHPM – along with additional stakeholders – worked to inform the CMS Innovation Center on critical elements of a community-based palliative care model that should be tested in a demonstration project. In particular, we highlighted the need for a model to adhere to the following guiding principles:

- An APM for serious illness care should increase access to and ensure sustainability of high-quality palliative care and hospice services that improve quality of care and quality of life for patients with serious illness and their caregivers.
- To increase access to palliative care services:
 - An APM should allow participation by palliative care teams of many sizes and types, caring for patients throughout the course of serious illness, in many different markets and geographies, and at various levels of risk-readiness.
 - APM eligibility criteria should identify patients based on need, rather than arbitrary and inaccurate estimates of patient progress.
- The palliative care team structure and service requirements should be provided in accordance with the [*National Consensus Project \(NCP\) Clinical Practice Guidelines for Quality Palliative Care*](#).
- Quality measurement and accountability need to align with the state-of-the-field and should help advance our understanding of high-quality palliative care.
- Payment should be sufficient to cover the cost of delivering care in diverse communities, including rural and underserved urban communities, without increasing net costs to the Medicare program.² Payment benchmarks should also be accurately risk-adjusted, to avoid exaggerated losses or gains to providers.

² According to the CMS Innovation Center authorizing statute, the HHS Secretary can only expand models that have demonstrated cost savings or neutrality on initial testing, regardless of the magnitude of quality of life or experience of care benefits that they may provide. We note, however, that this requirement results in an overemphasis of cost saving over enhanced quality in the determination of high-value care and discourages the testing of models of services like palliative care which may require initial investments and result in delayed cost savings. AAHPM believes that there must be a willingness to conduct long-term tests of palliative care models that may not initially appear to reduce or maintain costs.

- The APM development process should be transparent and inclusive, with engagement by a breadth of stakeholders from the serious illness provider community – including the NCHPC and representatives from other relevant medical specialty societies and provider organizations – to address cross-cutting high-priority concerns.

The subsequent announcement of the Serious Illness Population (SIP) component under the Innovation Center’s Primary Care First (PCF) model in April 2019 appeared to be a first step for making community-based palliative care services available to Medicare patients with serious illness on a pilot basis, including in conjunction with the delivery of advanced primary care services for certain qualifying practices. However, in November 2021, CMS announced it would not move forward with the SIP component of the PCF model, unraveling years of investment and preparation by stakeholders seeking to participate in the SIP component and putting the brakes on the most advanced effort to date to test community-based palliative care services in the traditional Medicare program.

While we recognize that certain Innovation Center models have taken steps to focus on the needs of seriously ill patients, AAHPM continues to believe that increased coverage for and access to community-based, team-based palliative care services is necessary to support patients with serious illness and multiple chronic conditions. We also continue to stand by the guiding principles outlined above.

Quality Measures for Models that Include Seriously Ill Patients

Finally, AAHPM believes that quality of care that patients with serious illness receive should not depend on the payment model – whether fee-for-service, an accountable care model, or other alternative payment model – under which such patients receive their care. To that end, in the same set of NCHPC recommendations referenced above (see Attachment 1), we included recommendations for a standard set of high priority quality measures that would apply under any payment model that includes patients with serious illness. We believe these recommended cross-cutting quality measures are centered on what matters most to people with serious illness. These include measures that focus on:

- Patient-reported experience of serious illness care
- Prevention and treatment of symptoms
- Timely and appropriate use of hospice care, and
- Avoidance of potentially preventable hospital stays.

We continue to believe the inclusion of these measures in alternative payment models is necessary to promote high-quality care and protect patients with serious illness from unintended consequences of TCOC models.

* * * * *

Thank you again for the opportunity to provide feedback on this RFI. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at wchill@aaahpm.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vicki Jackson". The signature is fluid and cursive, with a large loop at the end of the last name.

Vicki Jackson, MD, FAAHPM
President



September 24, 2021

COALITION MEMBERS

American Academy of Hospice
and Palliative Medicine
(AAHPM)

Association of
Professional Chaplains
(APC)

The Catholic Health Association
of the United States
(CHA)

Center to Advance
Palliative Care
(CAPC)

HealthCare
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Society of Pain & Palliative
Care Pharmacists
(SPPCP)

Amy Bassano
Deputy Director
Center for Medicare and Medicaid Innovation

Sent via email

RE: National [Coalition](#) for Hospice and Palliative Care Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness

Dear Deputy Director Bassano,

The National Coalition for Hospice and Palliative Care appreciated the opportunity to meet with you and your team at the Center for Medicare and Medicaid Innovation (CMMI) on March 10, 2021, to discuss the delay in implementation of the Serious Illness Population option within the Primary Care First (PCF) model. During that meeting, you expressed an interest in hearing our latest recommendations on how to identify people with serious illness and measure and improve the quality of their care. To that end, we formed an interdisciplinary and cross-organizational workgroup to develop recommendations for a standard set of high priority quality measures for people with serious illness; we intend for these recommendations to apply under any payment model that includes patients with serious illness. Throughout this work, we were guided by one bottom line principle: ***For people with serious illness, the quality of care should not depend on the payment model.*** We are pleased to share our findings and recommendations with you here and would welcome a meeting to discuss them with you and your team in more depth.

We appreciate the strategic vision for CMMI that the CMS Leadership Team outlined in its recent article for *Health Affairs Blog*, particularly the call for making equity a centerpiece for every model, focusing on more integrated and scalable models, and encouraging a broader array of quality investments. We are committed to advancing equitable access to palliative care, which takes a person-centered approach and provides the social, spiritual and cultural supports that are key to reducing disparities. We agree that achieving the goal of more equitable and integrated models will require an investment in quality. Our Coalition believes that our proposal to develop cross-cutting quality measures centered on what matters most to people with serious illness aligns perfectly with this new strategy and vision for CMMI.

General Findings and Recommendations

- Structural and process quality measures, though the only tools currently available for some important quality concepts, have limited usefulness in driving quality improvement and accountability. Nonetheless, certain required structures and processes for serious illness care should be specified in all relevant models as provider participation requirements, as further detailed below. Attestation and audit are appropriate methods for ensuring participating providers' fidelity to these requirements.
 - **Structural requirements** for models providing care to people with serious illness should include the following:
 - i) Care is provided by an interdisciplinary team that includes a clinician licensed or certified to provide psychosocial-spiritual care (social worker, psychologist, counselor or chaplain) and at least one clinician with demonstrated palliative care expertise (for example, palliative care certification within their discipline).
 - ii) The clinical care team is available by phone, has access to health records, and can make visits when necessary on a 24/7 basis.
 - **Process requirements** for models providing care to people with serious illness should include the following:
 - i) A comprehensive assessment is completed shortly after admission; the assessment addresses the patient's treatment goals and preferences, identifies their physical, emotional, social, spiritual, cultural and practical needs, and guides the development of an individualized plan of care.
 - ii) Patients are assessed; the plan of care is updated; and care is coordinated following discharge from the hospital or any major care transition.
- Although cost measures and program integrity measures play an important role in determining overall value, they should not be used as proxy indicators for the quality of care provided and are not addressed further in this document.
- To be truly cross-cutting, currently available quality measures must be adapted to employ a broad denominator identifying the population with serious illness, tested across a full range of care settings and service delivery models, and adjusted to assess performance at the level of individual clinicians, group practices and populations.
- While we recognize the importance of scientific rigor and the value of review and endorsement by the National Quality Forum and Measures Applications Partnership, we also see an urgent need to accelerate the development of the next generation of quality measures. We support the testing of new and unendorsed measures within CMMI model demonstrations, provided the testing methodology is rigorous and incentives are not linked to such indicators until they have been demonstrated to be valid and effective. We appreciate that CMMI has taken this approach with the development and testing of the

Days at Home quality measure and propose making a similar investment in expanding, revising and testing the measures we recommend below.

- In considering our recommendations, ***we prioritized the following guiding principles:***
 - Focusing on what matters most to patients and families
 - Addressing healthcare inequities and social determinants of health
 - Supporting a thriving workforce
 - Building on the best and broadest measures available today or in development
 - Minimizing data collection burden on participating providers
- As detailed in the table below, our recommended four measures address the following high-priority measure concepts for improving care of people with serious illness:
 - Patient-reported experience of serious illness care
 - Prevention and treatment of symptoms
 - Timely and appropriate use of hospice care
 - Avoidance of potentially preventable hospital stays
- Please note that we have limited these recommendations to quality measures and concepts. We would welcome a separate discussion on other elements of accountability for quality, such as measure exclusions, risk adjustment, item weighting, scoring methodology, comparison groups, benchmarking and linkage to incentives.

Recommended Set of Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness

Concept	Measure	Type	Stage of Development	Adaptation Needed
Patient-reported Experience of Serious Illness Care	Feeling Heard and Understood https://www.nationalcoalitionhpc.org/qualitymeasures/	Patient-reported experience of care	Submitted to CMS for consideration for the Measures Under Consideration (MUC) List and to the National Quality Forum (NQF) for endorsement	Alter denominator to identify a broad serious illness population, expand care and model settings, and expand to include relevant clinicians outside specialty palliative care

<p>Prevention and Treatment of Symptoms</p>	<p>Getting the Help Wanted for Pain https://www.nationalcoalitionhpc.org/qualitymeasures/</p>	<p>Patient-reported experience of care</p>	<p>Submitted for MUC List consideration and NQF endorsement</p>	<p>Alter denominator to identify a broad serious illness population, expand care and model settings, and expand to include relevant clinicians outside specialty palliative care</p>
<p>Timely and Appropriate Use of Hospice Care</p>	<p>Paired: Percentage of Patients Who Died and Received Hospice Care https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5735 and Hospice Median Length of Stay (MLOS) for Patients Who Died and Received Hospice Care https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5736</p>	<p>Utilization outcome</p>	<p>NQF endorsed 0215 and 0216</p>	<p>Expand to a broad population with serious illness besides cancer, change from who didn't to who did receive hospice care, and replace the hospice stay <3 days with the hospice MLOS</p>
<p>Avoidance of Potentially Preventable Hospital Stays</p>	<p>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2816</p>	<p>Utilization outcome</p>	<p>NQF endorsed 2888</p>	<p>Focus the denominator on the broad serious illness population within any model or care setting</p>

Recommended Method for Identifying the Serious Illness Population

CMMI has a tremendous opportunity to highlight the unique needs of people living with serious illness across *any* model or population, by defining a “denominator” sub-population and monitoring performance on the quality concepts noted above. To assess the sub-population with serious illness across broader models and populations, the Coalition proposes the

following method to identify Medicare and Medicaid beneficiaries in claims and encounter data.

Specifically, based on the most recent peer-reviewed evidence¹, we recommend using a **two-factor combination** to define the denominator: a qualifying diagnosis(es), together with a claims-based indicator of unmet need. The recommended diagnoses and indicators are:

Population for Evaluation	
<p>First, a qualifying diagnosis(es): at least one of these</p> <p>(The full list of relevant ICD-10 codes modeled in Kelley et al., 2021, is available upon request)</p>	<ul style="list-style-type: none"> → Advanced cancer (locally advanced or metastatic) → End stage or stage 5 renal disease → Advanced dementia → Advanced lung disease with home oxygen or hospitalized for the condition → Advanced heart failure with home or oxygen or hospitalized for the condition → Advanced liver disease → Diabetes with severe complications → Advanced Parkinson’s disease → Amyotrophic Lateral Sclerosis, Huntington’s, progressive supranuclear palsy or other neurodegenerative diseases → Hip fracture, over age 70 → Stroke requiring hospital admission → Human Immunodeficiency Virus (HIV) with complications of Acquired Immunodeficiency Syndrome (AIDS)
--AND--	
<p>At least one of these indicators of unmet need, impaired function, and/or high symptom burden</p>	<ul style="list-style-type: none"> → One or more emergency department visits within past six months → One or more hospital admissions within the past six months → Home health episode with date of admission not following a hospital discharge (e.g., community referral) → Sequential home health episodes → Durable medical equipment claims consistent with impaired function or high symptom burden (as used in the proposed Serious Illness Population option of the PCF model) → Documented difficulty with activities of daily living captured in ICD-10 codes, or documented in post-acute discharge data → Documented social needs (e.g., unsafe housing, food insecurity) captured in ICD-10 codes, or documented in a social needs screen such as in the Accountable Health Communities program

¹ Kelley AS, Ferreira KB, Bollens-Lund E, Mather H, Hanson LC, Ritchie CS. Identifying Older Adults With Serious Illness: Transitioning From ICD-9 to ICD-10. *J Pain Symptom Manage*. 2019 Jun;57(6):1137-1142. doi: 10.1016/j.jpainsymman.2019.03.006. Epub 2019 Mar 12. PMID: 30876955.

We are mindful that systemic biases in diagnostic testing, assessment of social needs, and recording may lead to an under-representation of Black, Indigenous, and People of Color (BIPOC) in the two-factor denominator.² We encourage CMMI to test for this bias with current Medicare claims, and if disparities are noted, to consider expanded criteria for BIPOC beneficiaries, perhaps including an age indicator or age plus dual eligibility to minimize inequities in quality monitoring.

In conclusion, we have identified persistent quality measurement gaps and recommend that CMS increase its support for quality measure development and stewardship in general and particularly that CMS invest in the testing of a cross-cutting broad denominator to identify the serious illness population and measure key quality concepts across all relevant care settings and payment models.

We appreciate and request the opportunity to bring together the small group from our Coalition to discuss these recommendations with you and your team soon. Our Coalition looks forward to working with you and your staff to improve the care for Medicare beneficiaries with serious illness. Amy Melnick, Executive Director, amym@nationalcoalitionhpc.org, will work with your staff to coordinate a convenient time to continue our dialogue. Thank you for your consideration and review of our Coalition's recommendations.

Coalition Signatories

American Academy of Hospice and Palliative Medicine

Association of Professional Chaplains

Center to Advance Palliative Care

Health Care Chaplaincy Network

Hospice Palliative Nurses Association

National Association of Home Care & Hospice

National Hospice and Palliative Care Organization

National Palliative Care Research Center

Physician's Assistants in Hospice and Palliative Medicine

Social Work Hospice and Palliative Care Network

Society for Pain and Palliative Care Pharmacists

² Obermeyer, Z., Powers, B., Vogeli, C., & Mullainathan, S. (2019). Dissecting racial bias in an algorithm used to manage the health of populations. *Science*, 366(6464), 447–453. <https://doi.org/10.1126/science.aax2342>

July 15, 2024

Lauran Hardin, MSN, FAAN, Co-chair
Angelo Sinopoli, MD, Co-chair
Physician-Focused Payment Model Technical Advisory Committee
Department of Health and Human Services
Hubert H. Humphrey Building,
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically to PTAC@HHS.GOV

RE: Request for Input (RFI): Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models

Dear Co-chairs Hardin and Sinopoli:

The American Nurses Association (ANA) is pleased to submit the following comments in response to the above-captioned RFI. ANA shares PTAC's concerns regarding complex conditions and serious illnesses and urges PTAC to continue looking for ways to improve care for this patient population. While there has been plenty of information given on the care that physicians give to Medicare beneficiaries, PTAC needs to look at the care that registered nurses (RNs) and advanced practice registered nurses (APRNs) provide as well. There is a predicted physician shortage within the next few years¹ and other qualified health care practitioners (QHPs) are well positioned to provide needed access, and in many cases are doing so already. Medicare payment policy must recognize that QHPs are filling the gaps and APRNs are leading the way. ANA's comments will focus on:

- 1) Characteristics of the Population who have Complex Conditions or Serious Illnesses**
- 2) Challenges of Caring for Patients with Complex Conditions or Serious Illnesses**
- 3) Encouraging Use of Alternative Payment Models (APMs)**

Characteristics of the Population who have Complex Conditions or Serious Illnesses

PTAC is looking for information on characteristics of patients with either complex conditions or serious illnesses and then the highest cost. These two questions are interrelated as patients with complex conditions or serious illnesses tend to have the highest costs. The lens of health equity is important as these patients frequently come from lower socioeconomic backgrounds and may not have received the required care when the serious or complex conditions could have been prevented. Frequently, patients with these conditions are older as well and that adds additional

¹ "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036." American Association of Medical Colleges, <https://www.aamc.org/media/75231/download?attachment>. Accessed July 9, 2024.

challenges to their care. Older patients may have challenges with mobility and newer technology which can make it more difficult to either schedule or attend meetings with their practitioners.

Another segment of the population that may have complex and serious conditions are those who live in rural areas. Many rural areas do not have access to adequate health care. Nurse practitioners (NPs) are one way to help alleviate this shortage as NPs in the past have shown a willingness to move to rural areas and provide primary care. Preventative primary care is one of the best ways to prevent serious or complex conditions as patients can see practitioners and receive treatment for simple conditions before they have the chance to become more complex and serious.

Finally, PTAC is asking about how COVID-19 affected patients with complex conditions. Many of the early COVID-19 deaths took place in nursing homes and this shed light on conditions in nursing homes overall. Many nursing homes were, and still are, understaffed. The Biden Administration has promulgated rules for long term care facilities requiring minimum staffing as the lower numbers of staff may have affected the care patients in these facilities received during the public health emergency (PHE).

Challenges of Caring for Patients with Complex Conditions or Serious Illnesses

PTAC is looking at the challenges in caring for these patients. One of the biggest challenges is the shortage of practitioners. While NPs are trained to do this kind of care, and in some parts of the country provide more than half of primary care, there are states that severely limit how NPs, and other APRNs, practice. Allowing NPs to practice to the top of their license would help alleviate the shortage and help ensure that more patients receive the care that they need.

The shortage of practitioners also means that patients cannot get appointments to see their primary care provider when they have health concerns or questions. This is one of the biggest problems in healthcare today, as primary care is the most cost-efficient and effective way to ensure that patients either stay healthy or manage their chronic diseases. When these patients are not able to access primary care, they either visit more expensive specialists or, the emergency room which can increase risks for the patient with the chronic condition for poorer health outcomes and higher costs than if they had been able to see their primary care.

Another strategy that can be used to ensure patients receive proper care is the continued use of telehealth. While telehealth cannot be used for all patients or patient visits, there are many cases where it can be used to treat patients. Patients with complex conditions or serious illnesses might not want to leave their homes for follow-up visits, or if they have questions about their care that can be answered without a full physical appointment, but Medicare frequently does not allow these visits. During the COVID-19 PHE, many telehealth waivers were implemented and over the last four years they have been shown to treat patients effectively and safely. Congress has been willing to extend the waivers for a short-term basis, but the upcoming expiration date leaves the future of telehealth for Medicare patients in doubt. By not having to travel to their appointments, these patients have been able to see their practitioners and receive the treatment they require without having to overcome many barriers to visit the physical office.

PTAC should also look at the care provided by RNs. As the practitioners who spend the most time with patients, RNs are uniquely suited to treat patients and understand their needs. Nursing care is undervalued in today's reimbursement systems, and the care provided by nurses has been subsumed into care provided by physicians and other practitioners who are reimbursed by Medicare. As a result, ANA encourages all nurses to obtain NPIs and would urge PTAC to make a similar recommendation. Obtaining NPIs would allow facilities to track the work currently being done by RNs and would show how much of the care nurses are currently providing.

ANA urges PTAC to look at the care that nurses provide as it is an integral part of the health care system, but at the same time is not treated equally. Hospitals, and other healthcare facilities, do not have enough nurses and the result is that patients do not receive proper care which worsens conditions, particularly for those needing serious and chronic care.

RNs are also qualified to take part in care coordination models. ANA has advocated for use of nurses in care coordination and has a position statement covering the role of the RN in care coordination.² RNs must be recognized as core team members in care coordination.

Encouraging Use of Alternative Payment Models (APMs)

ANA would also encourage usage of APMs in healthcare, but the problem is that APMs often do not appropriately account for the role of nurses and nursing care. Services provided to Medicare beneficiaries by RNs are what drive patient health outcomes—especially in hospitals and skilled nursing facilities. In every setting and region, particularly for populations in rural and medically underserved areas, APRNs and RNs advance both access to health care and the delivery of high quality, cost-effective healthcare. To date, their services have not been effectively utilized and at best have only partially been recognized and compensated. Value-based strategies cannot appropriately account for the costs of care if nursing services are not explicitly considered in payment methodologies. ANA has long held that all value-based payments in Medicare recognize and account for all clinical inputs, especially nursing services.

It is vital that APRNs be permitted to practice to the full extent of their state licensure to more wholly participate in Medicare value-based payment models. As discussed above, outdated laws frequently restrict how APRNs practice medicine. Some of these restrictions were waived during the COVID-19 PHE which translated to necessary system capacity and expanded access to high-quality care for patients.

Conclusion

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the

² "Care Coordination and Registered Nurses' Essential Role." Nursing World, <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/care-coordination-and-registered-nurses-essential-role/>. Accessed July 9, 2024.

public. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all settings, including hospital outpatient settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

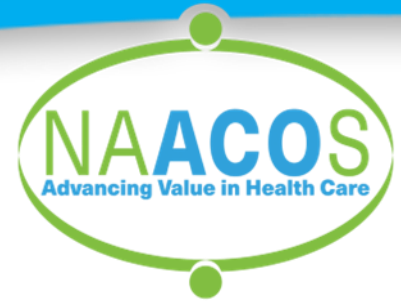
ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with HHS. Please contact me at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,



Tim Nanof
Vice President, Policy and Government Affairs

cc: Jennifer Mensik Kennedy PhD, MBA, RN, NEA-BC, FAAN, ANA President
Angela Beddoe, ANA Interim Chief Executive Officer
Debbie Hatmaker, PhD, RN, FAAN, ANA Chief Nursing Officer



August 9, 2024

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

RE: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models Request for Input (RFI)

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for input on addressing the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models. NAACOS is a member-led and member-owned nonprofit of more than 470 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS represents over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). Patients with complex conditions or serious illness require special considerations in the context of value-based care models and NAACOS appreciates the PTAC's focus on this important topic. Our comments below reflect the concerns of our members and our shared goals to support clinicians in delivering high-quality, efficient, person-centered care to these patient populations.

CONSIDERATIONS FOR COMPLEX OR SERIOUSLY ILL POPULATIONS IN APM DESIGN

Patients with complex chronic conditions or serious illnesses have some of the highest health care costs and some of the greatest opportunities to benefit from the care coordination and wraparound services that value-based care can provide. However, program policies are often not designed with these populations in mind, making it difficult for them to be attributed to and benefit from these models. Similarly, this makes it challenging for health care provider organizations that predominantly serve complex and high needs patients to participate and succeed in value models. For example, program elements of the MSSP have been designed based on the traditional Medicare population writ large. When organizations serving a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise.

Complex and seriously ill populations are significantly different than the average traditional Medicare population. Attempting to fit these high needs populations into APMs designed for standard populations will always fall short of accounting for their unique needs and circumstances. Due to this, these

beneficiaries have historically had limited participation in APMs. In recent proposed Medicare Physician Fee Schedules, CMS acknowledged that “higher spending populations are increasingly underrepresented in the program and access to ACOs appears inequitable as evidenced by data indicating underserved populations are less likely to be assigned to a Shared Savings Program,” and that proposed policies were intended “to encourage growth of ACOs in underserved communities based, in part, on recent observations where the highest earning ACOs had a higher proportion of beneficiaries who were members of racial and ethnic minority communities and included a greater proportion of end-stage renal disease (ESRD), disabled, and aged/dual eligible beneficiaries than the lowest earning ACOs.” We suggest that the MSSP changes made to date do not go far enough to gain rapid rates of adoption for providers serving these complex populations. Lessons from organizations serving complex or seriously ill populations in the High Needs Track of ACO REACH and in the MSSP can help inform future model design appropriately tailored to these populations. Future APM design should enable and incentivize participation of organizations providing care to these populations by appropriately accounting for these considerations.

NAACOS recommends the following considerations in model development:

- **Design alternative program policies to account for high-cost, high needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.**
- **Ensure participation criteria do not exclude high needs beneficiaries from benefitting from value-based care models.**
- **Account for the care settings and care delivery models through which these populations are often receiving care in attribution models.**
- **Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.**

Identifying high cost, high needs populations

In the ACO REACH Model, beneficiaries can only be attributed to High Needs Population ACOs if they meet all attribution eligibility criteria and meet additional beneficiary-level eligibility criteria related specific conditions or risk scores (e.g., having a risk score of 3.0 or greater). These criteria can be limiting and prevent beneficiaries served by High Needs ACOs from being attributed to the model. For example, one High Needs ACO found that only 35 to 40 percent of their traditional Medicare population met the High Needs eligibility criteria, despite 100 percent of their patients being homebound. Part of the challenge is the timeliness of data CMS uses to determine eligibility. If a beneficiary’s health status declines quickly, this would not be reflected in risk scores until significantly later. Given these populations are often in their last years of life and have a higher mortality rate than the average Medicare beneficiary, high needs beneficiaries may not appear to meet these criteria before the end of life. The beneficiary-level eligibility criteria could be improved by incorporating factors that provide more timely information about a beneficiary’s status, such as if the patient is homebound or a permanent nursing home resident.

One solution would be to define an APM entity as high needs if most of its patients are high needs. Beneficiary-level criteria could be used to define high needs beneficiaries, and if the APM entity exceeds a certain threshold of high needs beneficiaries it would qualify as high needs and all of its beneficiaries would be subject to the high needs program policies. This method would help identify patients before coding and risk scores have caught up and recognize the differences of organizations that exclusively focus on complex and seriously ill populations. Additionally, current approaches do not account for high needs beneficiaries receiving care from organizations that don’t exclusively focus on those populations. High needs beneficiaries served by all ACOs are subject to program policies that do not account for the

specific characteristics of these beneficiaries. Alternative policies for high needs beneficiaries tested through the ACO REACH Model should apply for any ACOs, with policies tailored to those subsets of the ACO's population. Using both a threshold approach for organizations dedicated to caring for high needs beneficiaries and a beneficiary-level approach to support all ACOs in caring for high needs beneficiaries ensures that all high needs beneficiaries can be included in and benefit from these models, regardless of their specific needs or where they choose to receive care.

Accounting for care patterns in attribution methods

Standard claims-based attribution models don't work well for these populations and frequently lead to misalignment to community providers that a beneficiary was previously receiving care from. For example, a beneficiary who was prospectively aligned to a community-based primary care provider and experienced health changes that led them to begin receiving care in a long-term care (LTC) facility, the beneficiary would not be aligned to the providers managing their overall care until at least the next performance year. More timely approaches are needed to attribute high needs patients to the providers managing their care. ACO REACH is testing a more flexible and timely voluntary alignment option, but there are challenges when using it with complex or seriously ill populations. Importantly, providers cannot discuss voluntary alignment with homebound patients, including those residing in assisted living facilities or LTC facilities, which constitute a large portion of high needs beneficiaries. The policy to prohibit discussing voluntary alignment in a patient's home was designed as a protection for average Medicare beneficiaries but has the unintended consequence of excluding complex and seriously ill patients from a model designed to support them. At a minimum, MSSP ACOs serving beneficiaries with complex needs should be allowed to use a paper-based voluntary alignment form to document their primary care clinician selection given that many of these beneficiaries are unable to access Medicare.gov.

Attribution models must also account for the care delivery models employed by organizations serving complex and seriously ill patients, which heavily emphasize a team-based approach. While attribution at the National Provider Identifier (NPI)-level is preferred in most instances, high needs beneficiaries are more often aligning to a particular care type or setting (e.g., nursing home or homebound care providers) where they receive an array of services from a comprehensive team. Unlike patients receiving primary care in an ambulatory care setting, who may have a relationship with an individual clinician and follow that individual if they leave the practice, high needs beneficiaries are more likely to remain with the organization they are receiving care from. Allowing alignment to a practice rather than an individual clinician for these populations would support this approach and prevent beneficiaries from becoming unattributed if an individual provider leaves the organization and the beneficiaries remain with the organization. A more team-based approach to attribution would also alleviate challenges for patients residing in LTC settings, who often receive primary care services from nurse practitioners (NPs) and physician associates (PAs). Currently in MSSP, beneficiaries can only be attributed to an ACO if they have had a physician visit, which impedes attribution for beneficiaries who only see NPs and PAs for primary care.

Creating sustainable and predictable financial incentives

The design of financial methodologies is critical to the success of any APM. Today, CMS uses hierarchical condition code (HCC) risk scores and Medicare enrollment types to determine differential benchmark policies. This approach fails to capture nuances within the traditional Medicare population and CMS should explore different ways to look at subsets of beneficiaries for different benchmark policies. Current benchmarking methodologies typically rely on historical utilization and comparison to national and regional reference populations. Patients with complex chronic conditions or serious illnesses are

often in the top three percent of Medicare spending, making them outliers compared to other beneficiaries in the region and nationally. Despite this, MSSP methodologies cap many benchmark adjustments using a percent of national per capita FFS expenditures for assignable beneficiaries which does not adequately account for a complex population's differences in severity and case mix. As a result, ACOs with high concentrations of complex and seriously ill populations are perceived to be regionally inefficient, receive a lower percent of their prior shared savings for renewal contract benchmarks, and will be eligible for a smaller Health Equity Benchmark Adjustment (HEBA) as proposed in the 2025 Medicare Physician Fee Schedule. These populations also have unique impacts on benchmarks due to their high mortality rates, making historical utilization data less reliable. CMS could establish, and the Medicare Payment Advisory Commission should recommend, separate benchmark and risk adjustment policies for high cost, high needs beneficiaries, similar to how it has established differential payment policies for beneficiaries with ESRD to account for their unique circumstances.

Utilizing relevant quality measures

Many MSSP ACOs serving complex, high needs populations were early adopters of Merit-based Incentive Payment System clinical quality measure (MIPS CQM) reporting. The main reason for this was the ability to move from 10 web interface quality measures, most of which were not relevant to complex populations at the end of life, to three MIPS CQM quality measures, which were more relevant to these populations. In the proposed 2025 Medicare Physician Fee Schedule, CMS will increase the number of CQM measures from three to five, increasing to six measures in Performance Year (PY) 2026 and to eight measures in PY 2028. Many of these "new" measures are not relevant for complex populations at the end of life, e.g. colorectal cancer screening and breast cancer screening. This is an example of CMS policy moving in the wrong direction, especially for ACOs serving complex populations at the end of life. We encourage CMS to leverage the learnings from the simplified quality measurement approach adopted by the ACO REACH program, which focuses on quality outcome measures calculated using administrative claims data and differentiates measures for ACOs exclusively serving high needs subsets of the Medicare fee-for-service population.

CONCLUSION

Thank you for the opportunity to provide feedback on the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on efforts to support the inclusion of complex and seriously ill populations in value-based care models. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



Clif Gaus, Sc.D.
President and CEO
NAACOS

August 9, 2024

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

RE: Addressing the Needs of Patients with Complex Chronic Conditions or Serious Illnesses in Population-Based Total Cost of Care (PB-TCOC) Models Request for Input (RFI)

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

LTC ACO appreciates the opportunity to submit comments in response to the request for input on addressing the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models.

LTC ACO is an Enhanced Track MSSP ACO for Medicare beneficiaries who reside in long term care nursing facilities. In PY 2022, our participating providers attributed over 12,000 beneficiaries, 98.6% of whom were LTI (long-term institutionalized) status and 88.73% were dual eligibles, the highest among all participating ACOs. We also earned a quality score of 91.21%, the highest of any ACO reporting MIPS CQM/eCQM. Our participating providers have generated over \$130 million in estimated gross savings to the Medicare Program from 2018 through 2023. By participating in LTC ACO, the unique delivery system of physicians, nurse practitioners and physician assistants that provide primary care to this underserved, high cost population are recognized and rewarded for improving the quality and cost of care delivered to this subset of the Medicare population. It is our experience that these providers are highly motivated to participate in Medicare's value-based care initiatives.

Our providers recognize that patients with complex conditions or serious illness require special considerations in the context of value-based care models and LTC ACO appreciates the PTAC's focus on this important topic. Our comments below reflect our goals to support clinicians serving Medicare beneficiaries residing in nursing facilities in delivering high-quality, efficient, person-centered care to these patient populations.

CONSIDERATIONS FOR COMPLEX OR SERIOUSLY ILL POPULATIONS IN APM DESIGN

Patients with complex chronic conditions or serious illnesses have some of the highest health care costs and some of the greatest opportunities to benefit from the care coordination and wraparound services that value-based care can provide. However, program policies are often not designed with these populations in mind, making it difficult for them to be attributed to and benefit from these models. Similarly, this makes it challenging for health care provider organizations that predominantly serve

complex and high needs patients to participate and succeed in value models. For example, program elements of the MSSP have been designed based on the traditional Medicare population writ large. When organizations serving a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise.

Complex and seriously ill populations are significantly different than the average traditional Medicare population. Attempting to fit these high needs populations into APMs designed for standard populations will always fall short of accounting for their unique needs and circumstances. Due to this, these beneficiaries have historically had limited participation in APMs. In recent proposed Medicare Physician Fee Schedules, CMS acknowledged that “higher spending populations are increasingly underrepresented in the program and access to ACOs appears inequitable as evidenced by data indicating underserved populations are less likely to be assigned to a Shared Savings Program,” and that proposed policies were intended “to encourage growth of ACOs in underserved communities based, in part, on recent observations where the highest earning ACOs had a higher proportion of beneficiaries who were members of racial and ethnic minority communities and included a greater proportion of end-stage renal disease (ESRD), disabled, and aged/dual eligible beneficiaries than the lowest earning ACOs.” We suggest that the MSSP changes made to date do not go far enough to gain rapid rates of adoption for providers serving these complex populations. Lessons from organizations serving complex or seriously ill populations in the High Needs Track of ACO REACH and in the MSSP can help inform future model design appropriately tailored to these populations. Future APM design should enable and incentivize participation of organizations providing care to these populations by appropriately accounting for these considerations.

LTC ACO recommends the following considerations in model development:

- **Design alternative program policies to account for high-cost, high needs beneficiaries, including beneficiaries who reside in nursing facilities and assisted living facilities, who are significantly different from the average traditional Medicare beneficiary.**
- **Ensure participation criteria do not exclude high needs beneficiaries from benefitting from value-based care models.**
- **Account for the care settings and care delivery models through which these populations are often receiving care in attribution models.**
- **Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.**

Identifying high cost, high needs populations

In the ACO REACH Model, beneficiaries can only be attributed to High Needs Population ACOs if they meet all attribution eligibility criteria and meet additional beneficiary-level eligibility criteria related specific conditions or risk scores (e.g., having a risk score of 3.0 or greater). These criteria can be limiting and prevent some beneficiaries residing in nursing facilities from being attributed to the model. Part of the challenge is the timeliness of data CMS uses to determine eligibility. If a beneficiary’s health status declines quickly, this would not be reflected in risk scores until significantly later. Given these populations are often in their last years of life and have a higher mortality rate than the average Medicare beneficiary, high needs beneficiaries may not appear to meet these criteria before the end of life. The beneficiary-level eligibility criteria could be improved by incorporating factors that provide

more timely information about a beneficiary's status, such as if the patient is homebound or a permanent nursing home resident.

One solution would be to define an APM entity as high needs if most of its patients are high needs. Beneficiary-level criteria could be used to define high needs beneficiaries, and if the APM entity exceeds a certain threshold of high needs beneficiaries it would qualify as high needs and all of its beneficiaries would be subject to the high needs program policies. This method would help identify patients before coding and risk scores have caught up and recognize the differences of organizations that exclusively focus on complex and seriously ill populations. Alternative policies for high needs beneficiaries tested through the ACO REACH Model should apply for any ACOs, with policies tailored to those subsets of the ACO's population. Using a threshold approach for organizations dedicated to caring for high needs beneficiaries ensures that all high needs beneficiaries can be included in and benefit from these models, regardless of their specific needs or where they choose to receive care.

Accounting for care patterns in attribution methods

Standard claims-based attribution models don't work well for these populations and frequently lead to misalignment to community providers that a beneficiary was previously receiving care from. For example, a beneficiary who was prospectively aligned to a community-based primary care provider and experienced health changes that led them to begin receiving care in a long-term care (LTC) facility, the beneficiary would not be aligned to the providers managing their overall care until at least the next performance year. More timely approaches are needed to attribute high needs patients to the providers managing their care. ACO REACH is testing a more flexible and timely voluntary alignment option, but there are challenges when using it with complex or seriously ill populations. Importantly, providers cannot discuss voluntary alignment with homebound patients, including those residing in assisted living facilities or LTC facilities, which constitute a large portion of high needs beneficiaries. The policy to prohibit discussing voluntary alignment in a patient's home was designed as a protection for average Medicare beneficiaries but has the unintended consequence of excluding complex and seriously ill patients from a model designed to support them. At a minimum, MSSP ACOs serving beneficiaries with complex needs should be allowed to use a paper-based voluntary alignment form to document their primary care clinician selection given that many of these beneficiaries are unable to access Medicare.gov.

Attribution models must also account for the care delivery models employed by organizations serving complex and seriously ill patients, which heavily emphasize a team-based approach. While attribution at the National Provider Identifier (NPI)-level is preferred in most instances, high needs beneficiaries are more often aligning to a particular care type or setting (e.g., nursing home or homebound care providers) where they receive an array of services from a comprehensive team. Unlike patients receiving primary care in an ambulatory care setting, who may have a relationship with an individual clinician and follow that individual if they leave the practice, high needs beneficiaries are more likely to remain with the organization they are receiving care from. Allowing alignment to a practice rather than an individual clinician for these populations would support this approach and prevent beneficiaries from becoming unattributed if an individual provider leaves the organization and the beneficiaries remain with the organization. A more team-based approach to attribution would also alleviate challenges for patients residing in LTC settings, who often receive primary care services from nurse practitioners (NPs) and physician associates (PAs). Currently in MSSP, beneficiaries can only be attributed to an ACO if they have

had a physician visit, which impedes attribution for beneficiaries who only see NPs and PAs for primary care.

Creating sustainable and predictable financial incentives

The design of financial methodologies is critical to the success of any APM. Today, CMS uses hierarchical condition code (HCC) risk scores and Medicare enrollment types to determine differential benchmark policies. This approach fails to capture nuances within the traditional Medicare population and CMS should explore different ways to look at subsets of beneficiaries for different benchmark policies. Current benchmarking methodologies typically rely on historical utilization and comparison to national and regional reference populations. Patients with complex chronic conditions or serious illnesses are often in the top three percent of Medicare spending, making them outliers compared to other beneficiaries in the region and nationally. Despite this, MSSP methodologies cap many benchmark adjustments using a percent of national per capita FFS expenditures for assignable beneficiaries which does not adequately account for a complex population's differences in severity and case mix. As a result, ACOs with high concentrations of complex and seriously ill populations are perceived to be regionally inefficient, receive a lower percent of their prior shared savings for renewal contract benchmarks, and will be eligible for a smaller Health Equity Benchmark Adjustment (HEBA) as proposed in the 2025 Medicare Physician Fee Schedule. These populations also have unique impacts on benchmarks due to their high mortality rates, making historical utilization data less reliable. CMS could establish, and the Medicare Payment Advisory Commission should recommend, separate benchmark and risk adjustment policies for high cost, high needs beneficiaries, similar to how it has established differential payment policies for beneficiaries with ESRD to account for their unique circumstances.

Utilizing relevant quality measures

Many MSSP ACOs serving complex, high needs populations were early adopters of Merit-based Incentive Payment System clinical quality measure (MIPS CQM) reporting. The main reason for this was the ability to move from 10 web interface quality measures, most of which were not relevant to complex populations at the end of life, to three MIPS CQM quality measures, which were more relevant to these populations. In the proposed 2025 Medicare Physician Fee Schedule, CMS will increase the number of CQM measures from three to five, increasing to six measures in Performance Year (PY) 2026 and to eight measures in PY 2028. Many of these "new" measures are not relevant for complex populations at the end of life, e.g. colorectal cancer screening and breast cancer screening. This is an example of CMS policy moving in the wrong direction, especially for ACOs serving complex populations at the end of life. We encourage CMS to leverage the learnings from the simplified quality measurement approach adopted by the ACO REACH program, which focuses on quality outcome measures calculated using administrative claims data and differentiates measures for ACOs exclusively serving high needs subsets of the Medicare fee-for-service population.

CONCLUSION

Thank you for the opportunity to provide feedback on the needs of patients with complex chronic conditions or serious illnesses in population-based total cost of care models. LTC ACO is committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on efforts to support the

inclusion of complex and seriously ill populations in value-based care models. If you have any questions, please contact Kristen Krzyzewski, our Chief Strategy and Program Development Officer, at kristenk@ltcaco.com.

Sincerely,

A handwritten signature in black ink, appearing to be 'J. Feuerman', written in a cursive style.

Jason Feuerman
President and CEO
LTC ACO