C-TAC
COALITION TO TRANSFORM ADVANCED CARE

August 17, 2023

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-5540-NC, P.O. Box 8013,
Baltimore, MD 21244-8013

Re: Request for Information; Episode-based Payment Model

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this RFI regarding its effect on those living with serious illness.

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 is made up of over 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.

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).

We have been supportive of CMMI from the beginning and appreciate the dialogue between our two organizations over the years. We are especially grateful for the newly announced GUIDE Dementia model which incorporates all the core principles C-TAC has advocated for in models providing care for those living with serious illness and their families.

It is in that spirit that we submit our responses to the following questions:

A. Care Delivery and Incentive Structure Alignment

● How can CMS structure episodes of care to increase specialty and primary care integration and improve patient experience and clinical outcomes?

In developing models with our members and partners, we have become convinced that standards and requirements are key. In future models, CMS should ensure that there are standards and requirements built into the specialty and primary care models to assess beneficiaries for a full range of needs and to coordinate their care across settings. C-TAC has championed requiring and paying for holistic and comprehensive assessment of individuals with serious illness as an important way to identify unmet needs and triage the individual to appropriate services.

By comprehensive we mean going beyond just a thorough medical or physical assessment to also assess for social risk factors and needs, emotional, psychological, and spiritual issues, family caregiver concerns or burdens, financial concerns, etc. Advance care planning (ACP) and discussion of the person and family's values and goals are also a key component of such an assessment.

Comprehensive assessment is appropriate for anyone with a serious illness and their family caregiver. It is most appropriate if the person or caregiver are having issues interfering with their quality of life. This kind of assessment is ideally done by members of an interdisciplinary team using validated tools. Team members, or an individual if a team is not available, should also be aware of local community-based services available for any such needs identified in the assessment.

Ideally, a comprehensive assessment should be done early in a serious illness and then at appropriate intervals and whenever something significant changes for the individual or family caregiver. Such an assessment should always be done after transitions in care, such as when someone is discharged from the hospital or a rehabilitation stay or begins or completes new treatment for a serious illness. The person with the illness and/or their family caregiver should also be able to request such an assessment at any time.

This comprehensive assessment and care coordination can be performed by case managers, care navigators, and/or community health workers trained to perform these services. By improving access to care that people want and need through standardized assessments and coordination of referrals, more people will receive care where they want (at home instead of the hospital), which may improve their experience of care.

● How can CMS support providers who may be required to participate in this episode- based payment model?

Care providers, especially rural and community-based organizations, do not have the necessary infrastructure or capacity to participate in these models. We are therefore encouraged by the recent move to add upfront investment into CMMI models as this is something we have consistently advocated for. By offering investment funding to support organizations that cannot

meet requirements due to infrastructure gaps, it is likely that more care providers would participate in these models and in the models of managed care organizations. And many would be from under-resourced communities, so their participation could help promote more equitable health care.

● How can CMS promote person-centered care in episodes, which includes mental health, behavioral health, and non-medical determinants of health?

The comprehensive assessment advocated for in our earlier response would, of course, include identifying any mental and behavioral health and/or non-medical determinants of health needs. This would be the base for person-centered care planning. ACP is a conversation or process between an individual and a healthcare professional that helps adults at any age or stage of health to communicate their personal values, life goals, and preferences regarding future medical care--its benefits and burdens. C-TAC has historically supported improving access to ACP as it is foundational for person-centered care and shared decision-making.

● How can CMS support multi-payer alignment for providers and suppliers in episode- based and population-based models?

C-TAC has a Serious Illness Multi-Payer Learning Collaborative, an engaged group of leading health plans, integrated delivery systems, and accountable care organizations who are paving the way to deliver better care for those living with serious illness and their families**.**

C-TAC piloted a multi-payer workgroup in 2022 with the goal of bringing together a varied group of payers to share information on serious illness care efforts and agree on gaps and next steps to advance this type of care. By year's end this group had met several times and helped contribute to a payer guide for *Designing and Implementing Community-based Palliative Care*, an update on the ACT Index, and helped C-TAC secure funding for a pilot with the American Heart Association. The group grew to just under 50 and now ranges across more payer categories with participants from high level positions within their organizations. The group was also able to secure endorsements from AHIP, the Blue Cross/Blue Shield Association, and ACHP and even met with CMMI last year.

Payers participating in this Learning Collaborative have expressed that one of the most important things that CMS can do is to develop guidance and care standards that can be used across payors. Our work with the AHA shows that this is especially true for those with serious illness, where services like palliative care are not well defined and therefore cannot be implemented in a standardized fashion across health systems or managed care organizations. Offering clear guidance on eligibility criteria for care models and service standards would make it easier for payers to implement new models. Payers also need support and technical assistance when evaluating new models or requirements. We would be happy to use C-TAC's Learning Collaborative as a resource to inform future episode payment models.

● How can CMS include home and community-based interventions during episode care transitions that provide connections to primary care or behavioral health and support patient independence in home and community settings?

CTAC recommends that assessments for cognitive and physical function be documented and performed for Medicare beneficiaries, and that the comprehensive assessment noted earlier be reimbursed for people with serious illness to determine their level of need and refer them to any appropriate services. Increased outreach and engagement efforts and assessment requirements can serve to increase referrals to home and community-based services.

In addition, organizations delivering home and community-based services often need investment support to ensure they are able to provide interoperability and secure protection of health data when partnering with health systems and managed care organizations.

B. Clinical Episodes

● Which clinical episodes are most appropriate for collaboration between episode-based model participants and ACOs?

Clinical episodes like palliative care services would be an appropriate collaboration between episode-based model participants and ACOs. By palliative care, we mean interdisciplinary care focused on improving the quality of life for the person and their family caregiver(s) at any point appropriate in a serious illness.

Heart failure may be a promising clinical episode that could include the integration of palliative care services. Palliative care is currently required as a component of left-ventricular device (LVAD) insertion evaluation, the only such requirement in Medicare policy. However, it would also be appropriate to require palliative care for any episode for heart failure in general. The AHA issued a policy statement in 2016 saying that palliative care "should be integrated into the care of all patients with advanced cardiovascular disease and stroke early in the disease trajectory". Since then, palliative care has been included in the 2021 American College of Cardiology Heart Failure Guidance. Therefore, any episode-based payment model for this population should require it as well.

C-TAC's work with the AHA on integrating palliative care into heart failure care is already delivering the following:

1. Standardized eligibility criteria for when a person with heart failure would be situated for a referral for a consultation with specialty palliative care provider.
2. Standard referral criteria and workflow to effectively refer people who meet criteria to specialty palliative care services.
3. Provider and consumer-facing collateral to support clinician confidence in adopting agreed-upon criteria.
4. A body of evidence on the impact of a referral to specialty palliative care services on the quality of life of people with heart failure.

C-TAC would be happy to share the AHA project's information and learnings with CMMI.

Beyond specific episodes, palliative care services would ideally support people with serious illness regardless of their assigned care model. This type of bundled payment rate may be an opportunity to ensure access to these services across all models and allowing a high engagement rate for these services.

D. Health Equity

A history of disenfranchisement has led to healthcare gaps in the U.S and is an issue for those with serious illness. Per a 2021 Commonwealth report on racial and ethnic health equity, communities of color live fewer years, on average, than white people, are more likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and primary care mean many are diagnosed only at a late or end-stage of illness, when disease-modifying treatment is typically no longer effective. The COVID-19 pandemic has only made things worse, with average life expectancies among these groups falling more sharply compared to white people. Those from historically under-resourced communities who also have serious illness experience poorer care and access, making improving their care a health equity opportunity. Therefore, we would encourage CMMI to continue to explore various ways to support more equitable access to care for those with serious and other health conditions.

In terms of risk adjustment, we are supportive of the just announced changes to the ACO REACH model and encourage CMMI to continue to work to determine the most effective risk adjustment strategies going forward.

E. Quality Measures and Multi-payer Alignment

● Which quality measures, currently used in established models or quality reporting programs, would be most valuable for use across care settings?

We recommend the new patient-reported quality measure "Felt Heard and Understood" developed by The National Coalition of Hospice and Palliative Care, AAHPM, and RAND and endorsed by the National Quality Forum (NQF) for CMMI models. While developed and endorsed for home-based palliative care programs, it would be a good measure for any future CMMI model as it focuses on communication between the person and their medical provider and so would be appropriate across care settings.

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

Sincerely,

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