



12/10/21

Dear Deputy Administrator Fowler:

I am writing to you on behalf of the Coalition to Transform Advanced Care (C-TAC). C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness receive comprehensive, high-quality, person- and family-centered care, consistent with their goals and values. C-TAC is made up of over 170 national and regional organizations who share a common vision of improving care for serious illness in the U.S., from the point of diagnosis through to the end of life.

We commend you and your leadership team for charting a path forward for the CMS Innovation Center over the next 10 years, building upon lessons learned from prior demonstrations. We also applaud the centrality of equity to the CMS Innovation Center's vision. We and our members are committed to help create a more equitable system of care for those with serious illness, especially given the fact that people of color suffer disproportionately in the face of serious illnesses, experiencing high unmet needs, poor quality of life, and excessive family caregiver burden.

To support the CMS Innovation Center's efforts, we have developed specific recommendations situated within the proposed future directions framework. These recommendations fall into three thematic areas:

- (1) Improved, **systematic identification** of individuals with serious illnesses and their care relationships;
- (2) Enhanced **integration of healthcare and social, community-based supports** in service delivery and quality models; and
- (3) **Sustainable financial and organizational models** that account for outcomes important to individuals with serious illnesses and the role that non-traditional healthcare providers may play in their care.

We believe that our recommendations can be incorporated into a range of current and future demonstrations, both those with broad population focus and those that may be tailored to individuals with serious illnesses. We welcome the opportunity to speak with you and your leadership team to elaborate on any of these recommendations. Once again, we appreciate your leadership and attention to these important issues.

Sincerely,

Jon Broyles
Chief Executive Officer

Improving Care for Populations with Serious Illnesses: Applications for Innovation Center Strategy Refresh

As the Innovation Center ushers in its next decade, federal policymakers are putting equity at the center of all efforts, seeking to drive, “meaningful change to make the health system better for all people, including those who have not had reliable access to health care previously, using the levers of Medicare, Medicaid and CHIP.”¹ Consistently serving and supporting populations with serious illness is key to this vision, for while not all underserved populations contend with serious illnesses, a significant subset do² and can experience a magnified, intersectional impact.

Currently, individuals with serious illnesses experience unnecessary suffering and often receive services contrary to their individual care preferences,³ while needed community services remain underfunded and utilization of palliative care and hospice is low.⁴ The evidence shows that people of color suffer disproportionately in the face of a serious illness, experiencing high unmet needs, poor quality of life, and excessive caregiver burden. For example, Black patients with serious illness are less likely to be asked about care preferences than White counterparts, less likely to have their pain adequately managed, and less likely to access care in a home setting.⁵

The Innovation Center has a unique opportunity to improve how individuals with serious illnesses are served within Medicare, Medicaid, and CHIP. This document outlines recommendations from the Coalition to Transform Advanced Care (C-TAC), detailing (1) the importance of focusing on this population; (2) alignment with the Innovation Center’s recently released strategy refresh; and (3) proposed next steps.

Prioritizing Strategies to Address Serious Illnesses

The Commonwealth Fund estimates that 12 million individuals age 18 and older living in the community have high healthcare needs, defined as “people who have three or more chronic diseases and a functional limitation in their ability to care for themselves (such as bathing or dressing) or perform routine daily tasks”⁶; this population includes a large portion of individuals with serious illnesses. The percentages of individuals facing such needs are even higher for populations of focus for the Innovation Center. In 2019, almost 54% of Medicare decedents used hospice care.⁷ From a cost perspective, the reason for focus on populations with serious illnesses is even clearer, as patients with serious illnesses use hospital services at more than twice the rates of patients with multiple chronic conditions only.⁸ While patients with serious illnesses reflect 14% of the overall population, they

¹ <https://www.healthaffairs.org/doi/10.1377/hblog20210812.211558/full/>

² <https://www.nap.edu/catalog/25530/improving-access-to-and-equity-of-care-for-people-with-serious-illness#toc>

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6145747/>

⁴ <https://hospicenews.com/2021/01/19/sociodemographic-barriers-to-hospice-and-palliative-care/>

⁵ Ibid.

⁶ <https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use>

⁷ <https://www.nhpco.org/hospice-care-overview/hospice-facts-figures/>

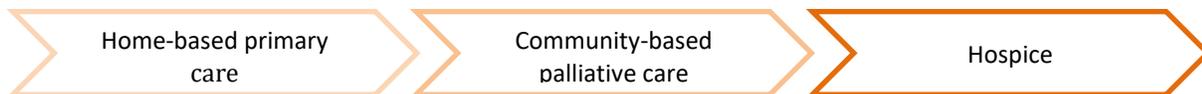
⁸ Commonwealth: High-Need, High-Cost Patients, 2016 Issue Brief

account for 56% of health care expenditures,⁹ with significant utilization of potentially preventable emergency department visits and hospitalizations.¹⁰

Certain Innovation Center model awardees and participants have addressed populations with serious illnesses, achieving meaningful cost and quality outcomes. Home-based palliative care within a Medicare Shared Savings Program was associated with significant cost savings (\$12,000 lower per patient during the final three months of life), fewer hospitalizations, and increased hospice use in the final months of life.¹¹ An independent analysis of the Advanced Illness Management (AIM) program, a CMS Innovation Center award recipient delivering team-based, daily home care to more than 2,000 seriously ill patients in California, reduced hospital days by 1,361 per 1,000 beneficiaries, inpatient payments by \$6,127, and total cost of care in the last thirty days of life by \$5,657 per beneficiary.¹² Another Innovation award recipient at University of Virginia focused on stage 4 cancer patients showed that early palliative care consults were associated with improved quality of care and reduced hospital/ED utilization.¹³

These findings are an encouraging first step. Yet the Innovation Center has an opportunity to further systematize, enhance, and test approaches to serve individuals with serious illnesses through a continuum of services ranging from (e.g.) home-based primary care to community-based palliative care to hospice. As the Innovation Center updates its portfolio, C-TAC encourages Innovation Center leadership to consider serious-illness specific strategies.

Serious Illness Care Continuum



⁹ <https://www.ncbi.nlm.nih.gov/books/NBK285684/>

¹⁰ <https://pubmed.ncbi.nlm.nih.gov/29049488/>

¹¹ <https://pubmed.ncbi.nlm.nih.gov/27574868/>

¹² <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05517>

¹³ <https://downloads.cms.gov/files/cmml/hcia-diseasespecific-secondevalrpt.pdf> (page 209)

Addressing Serious Illnesses within CMS Innovation Center Future Directions Framework

Innovation Center Strategic Objective	Innovation Center Aim	Proposed C-TAC Application to Populations with Serious Illnesses
<p>1. Drive Accountable Care</p>	<p>Increase the number of people in a care relationship with accountability for quality and total cost of care</p>	<p>IDENTIFY: Systematically identify and assess populations with serious illnesses and their caregivers</p> <p>IDENTIFY: Leverage successful community-outreach tactics deployed during the COVID-19/vaccine response and within models like Accountable Health Communities to increase trust and understanding of accountable care models</p> <p>IDENTIFY: Advance flexible alignment strategies to recognize strong relationships between individuals and their trusted community supports</p> <p>SUSTAIN: Consider financial tools to incent the delivery of high-value care to people with serious illnesses</p> <p>INTEGRATE: Include patient reported outcome and other quality measures to assess impacts of care, and adjust payments based on acuity and need</p>
<p>2. Advance Health Equity</p>	<p>Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations</p>	<p>INTEGRATE: Evaluate access to evidence-based serious illness supports within models, noting differential access among sub-populations, including historically underserved populations</p> <p>INTEGRATE: Encourage broad service capacity within models to address the needs of individuals with serious illnesses, recognizing the underlying heterogeneity of serious illness itself</p>
<p>3. Support Care Innovations</p>	<p>Leverage a range of supports that enable integrated, person- centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities</p>	<p>INTEGRATE: Incorporate C-TAC Core Principles into disease-specific or population-based models</p>

4. Improve access by addressing affordability	Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care	INTEGRATE: Enable beneficiaries to easily access affordable high-value community-based services
5. Partner to Achieve System Transformation	Align priorities and policies across CMS and aggressively engage payers, purchasers, providers, states and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs	SUSTAIN: Advance CBO capacity-building SUSTAIN: Explore “intensity add-on” for high-value CBO services that could be adopted across payer contexts

1. Innovation Center Objective: Drive Accountable Care

C-TAC Recommendations:

A. **Systematically identify and assess** populations with serious illnesses and their caregivers

C-TAC suggests that the Innovation Center implement a broad definition of individuals with serious illnesses, using best practices common among private payers and health systems. In defining populations in this manner, the Innovation Center can ensure that model participants are identifying and serving individuals who might not yet be at end of life, but are contending with issues that impede their quality of life and, if not addressed, potentially hasten decline. Up-front identification also furthers goals related to equitable access, as many people with serious illness are identified late in their trajectory, and systematic identification can overcome implicit biases.

Further, the Innovation Center can either encourage or require model participants to systematically assess for symptom burden, functional impairment, and caregiver burden in the identified population. Unaddressed sources of suffering not only severely impact quality of life for both patients and their family members, but also result in preventable emergency department visits and hospitalizations. Routine assessment for symptoms and stressors also can advance health equity, ensuring that the unmet needs of all populations are recognized by those responsible for coordinating and delivering their care.

B. **Leverage successful community-outreach tactics** deployed during the COVID-19/vaccine response and within models like Accountable Health Communities to increase trust and understanding of accountable care models

COVID-19 underscored the crucial role trusted community partners can play in educating individuals about care.¹⁴ We recommend that the Innovation Center build upon existing CBO

¹⁴ <https://www.healthmanagement.com/services/covid-19-resources-support/community-based-organization-needs/>

networks such as those developed under Accountable Health Communities (AHC) initiatives, contact tracing efforts or other federal initiatives like the Administration for Community Living's community-based integrated care networks. These networks could be marshalled to deliver education and outreach related to accountable care relationships. For individuals with serious illness, this approach is especially appropriate given the importance of non-traditional social supports for many individuals, mobility and transportation limitations, and limited familiarity with palliative,¹⁵ hospice care, and other serious illness specific offerings. Area Agencies on Aging and efforts by the Aging and Disability Business Institute, which has sought to create ties between CBOs and health care systems, may also provide helpful guidance and partnership to support this work.

C. **Advance flexible alignment strategies** to recognize strong relationships between individuals and their trusted community supports

People in underserved communities (including populations with serious illness) may not be well connected to care and therefore less likely to be detected in claims-based alignment methodologies. If care relationships indicated by Medicare/Medicaid claims are either undetected or not reflective of the individual's true relationships, it hampers the efficacy of efforts led by attributed providers to coordinate their care.

Promising Practice: [The Care, Assistance/Help, Stress, and Hopes/Fears](#) assessment tool has been used by chaplains caring for patients with serious illnesses. This tool helps organize discussion about concerns and hopes of patients with serious illness. Evidence indicates that individuals with serious illnesses want caregivers/healthcare professionals to address their existential and spiritual needs.

Further for many high-need populations, particularly individuals with serious illnesses, CBOs such as faith-based organizations, Area Agencies on Aging and peer networks may represent their most important care relationship. We suggest that the Innovation Center consider hybrid voluntary alignment for individuals with serious illnesses and other underserved populations, whereby individuals may select alignment to traditional primary or specialty medical providers (e.g. hospice or palliative care) **and** secondary alignment to CBOs if individuals choose CBOs as their foremost care relationship. In such cases of dual alignment, medical and CBO partners would be required to collaborate on care plans and subsequent care monitoring.

D. **Consider financial tools to incent the delivery of high-value care to people with serious illnesses**

Risk adjustment

Concerns are often raised about whether risk adjustment potentially leads to overpayments.¹⁶ In the case of high-risk populations, particularly those facing serious illnesses, risk adjustment methodologies tend to inadequately reflect the total complex of health and social needs, thereby shifting resources away from these populations.¹⁷ It would be ideal within population health-specific or disease-specific models to incorporate elements from the Program of All

¹⁵ <https://journals.sagepub.com/doi/abs/10.1177/1049909120973200>

¹⁶ <https://www.healthaffairs.org/doi/10.1377/hblog20200127.293799/full/>

¹⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710209/>

Inclusive Care of the Elderly (e.g. frailty adjuster) or other SDOH risk adjustment methodologies¹⁸ to adjust performance benchmarks or to calibrate population-specific capitation payments for populations with serious illnesses, ensuring adequacy of reimbursement.

Underlying value-based payment arrangements

Often value-based payment structures still include an underlying FFS chassis: providers still bill FFS in real-time and/or within larger capitated arrangements, with the promise of future shared savings to encourage innovation and offset non-billable costs. For seriously ill patients with complex needs, this can result in lack of access to social work or other non-billing health professionals, whose services are needed to improve quality of life and prevent crises for very sick patients.

As the Innovation Center issues fewer, larger-scale population models, we recommend that such models encourage participants to develop underlying value-based payment models for serious-illness related services in order to promote transformation and adequate investment. These models could tie portions of payments to performance measures described below.

- E. **Include patient reported outcome (PROM) and other quality measures** to assess impacts of care, and adjust payments based on acuity and need

C-TAC supports the Innovation Center's desire to incorporate additional PROM into models. As it relates to serious illnesses, we suggest that the Innovation Center incorporate two recently validated measures: (1) How much patients feel seen and heard and (2) if patients got the help they wanted for their pain;¹⁹ while these measures have been developed in the context of community-based palliative care, the Innovation Center could test outcomes for other programs for serious illnesses. We also recommend that the Innovation consider a range of fulfillment or process metrics that reflect the optimal delivery of care to populations with serious illnesses, such as substantiation of shared-decision making.²⁰

2. Innovation Center Objective: Advance Health Equity

C-TAC Recommendations:

- F. **Evaluate access to evidence-based serious illness supports** within models, noting differential access among sub-populations, including historically underserved populations

C-TAC wholeheartedly supports all of the measures and steps included in this Innovation Center objective. As the Innovation Center incorporates a broadened definition of serious illness into future models and creates frameworks for expanded care relationships, there is a unique

¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710209/>

¹⁹ <https://www.nationalcoalitionhpc.org/qualitymeasures/>

²⁰ <https://store.qualityforum.org/collections/advanced-illness-care/products/issue-brief-opportunities-or-advancing-quality-measurement-in-community-based-serious-illness-care>

opportunity to evaluate impacts on access to care. Research indicates that certain groups face added challenges and poorer outcomes when contending with serious illnesses.²¹ We also believe that by broadening the types of providers that can participate in Innovation Center Models to encompass social service providers, the Innovation Center will promote better access to care for underserved populations with serious illnesses. Sub-group analyses within population health programs would further understanding of how to improve experiences among people of color and historically marginalized groups with serious illnesses.

G. **Encourage broad capacity** within models to address the needs of individuals with serious illnesses, recognizing the underlying heterogeneity of serious illness itself

Effectively supporting individuals with serious illnesses involves more than palliative and hospice care, although these services are crucial components of the care continuum (see page three). In recognition of a broader definition of serious illnesses, we suggest that the Innovation Center encourage an expansive concept of provider capacity to serve this population. For example, this capacity could be reflected not simply through specialty care provider

Promising Practice: The [Center to Advance Palliative Care](#) has developed specific training recommendations for clinicians serving populations with serious illnesses. This guidance is tailored for a range of disciplines including physicians, registered nurses, social workers, chaplains, and more. The recommendations are available [here](#).

participation in models (e.g. inpatient and outpatient hospice/palliative care), but also documentation of serious illness-related training completion among key specialists such as oncology, cardiology, pulmonology, and nephrology in skills such as symptom management and communication/shared decision-making.

Further, capacity could be demonstrated through codified partnerships between provider networks and CBOs delivering care to people with serious illnesses. The Innovation Center might recommend model

elements of downstream MOUs or contracts within models, that incorporate additional expectations such as requiring care managers to have competency in assessing for distress and holding meaningful conversations.

3. Innovation Center Objective: Support Care Innovations

H. **Incorporate C-TAC Core Principles** into disease-specific or population-based models

C-TAC has developed a [set of core principles](#) to guide any ideal service delivery model for populations with serious illnesses, informed by input from our members (a wide range of providers, beneficiaries, and researchers). C-TAC would welcome further discussion with the

²¹ <https://www.capc.org/project-equity-improving-health-equity-for-people-with-serious-illness/>

Innovation Center to leverage our network of members to inform future model design and expand upon any of these principles (metrics, workflows etc) in general or to discuss specific strategies for incorporating palliative care, as one example, into disease specific models.

PROMISING PRACTICE: [Community Aging in Place – Advancing Better Living for Elders \(CAPABLE\)](#) helps older adults remain at home. Based on financial need, this program helps people who have a hard time completing daily tasks, like taking a bath or cooking a meal. The CAPABLE care team includes a nurse, occupational therapist, and handyman.

4. Innovation Center Objective: Improve access by addressing affordability

C-TAC Recommendation:

- I. Enable beneficiaries to easily access affordable **high-value community-based services**, as well as medical and pharmaceutical supports

Programs like CAPABLE’s nurse handyman model combines supports for activities of daily living alongside other needs (e.g. minor home repairs) that can impact quality of life and self-care management. We request that the Innovation Center explore how to enable individuals with complex social needs, including populations with serious illnesses, easily and affordably access supportive community services that are often funded outside the traditional healthcare system. Affordability could be supported through healthcare investments in high-value CBO services that allows such services to be offered for free or nominal fees.

In particular, Black family caregivers face outsized financial impacts in caring for their family members living with serious illness,²² impacting their savings and their employment. Access to personal care services during serious illness is essential to relieve these burdens and ensure equitable experiences. We would also support any other efforts by the Innovation Center to address medical and pharmaceutical affordability.

5. Innovation Center Objective: Partner to Achieve System Transformation

C-TAC Recommendations:

- J. Advance **CBO capacity-building**

We appreciate the Innovation Center’s willingness to consider the modest up-front investments to pave the way for smaller primary care providers to ease into value-based payment. We understand that this approach is intended to cultivate providers that may have strong relationships with underserved populations, but less experience in accountable care. We suggest that community-based organizations be another area of focus. Instead of up-front investment, the Innovation Center might test non-monetary, capacity building supports for community-based organizations, with a particular emphasis on such supports directed to high-need communities or populations.²³

²² https://www.caregiving.org/wp-content/uploads/2020/05/Caregiving-in-the-US-2015_AfricanAmerican_CGProfile.pdf

²³ Such as HRSA Medically Underserved Populations/Areas or CDC Community Vulnerability Index, as an example

This support could take the form of technical assistance to CBOs or connection or support for professional services such as data analytics and revenue cycle management that optimally position these providers to participate in healthcare value-based payment arrangements and healthcare providers to select appropriate partners.

K. **Explore “intensity add-on” for high-value CBO services** that could be adopted across payer contexts

Policymakers, payers, and researchers continue to evaluate how and if community-based organization services contribute to improved healthcare outcomes. Unlike healthcare interventions that have clinical standards and medical indications, social services often vary widely in application. Additionally, social service capacities and needs can be quite different depending on the state of community infrastructure.²⁴ As a result, establishing a “fee schedule” or highly prescriptive payments for community-based organization services in the context of Innovation Center models and multi-payer initiatives appears impractical at this time.

Instead, we suggest that the Innovation Center explore conversations with managed care entities across markets and sectors to consider an intensity add-on or lump-sum that would incentivize participating networks to collaborate with high-value, locally governed CBO networks. Such payments would be counted against total cost of care (similar to other care management payments). With this approach, payers could be incentivized through service level agreements or partnerships with CBO-collaboratives to formalize SDOH relationships and continue to test impacts on total cost of care.

Such agreements might also prioritize partnerships with minority-owned businesses delivering supports to individuals with serious illnesses and other needs, as a form of community building and in furtherance of equity objectives.

²⁴ <https://www.atsdr.cdc.gov/placeandhealth/svi/index.html>

Conclusion

Addressing these concepts partially or together in new and future models could dramatically impact both the quality and experience of care for populations with serious illnesses. C-TAC welcomes the opportunity to discuss how to further expand upon any of the concepts defined herein within the context of existing models that serve populations with serious illnesses or forthcoming models.

C-TAC Innovation Center Strategic Refresh Recommendations

- A. IDENTIFY: Systematically identify and assess** populations with serious illnesses and their caregivers
- B. IDENTIFY: Leverage successful community-outreach tactics** deployed during the COVID-19/vaccine response and within models like Accountable Health Communities to increase trust and understanding of accountable care models
- C. IDENTIFY: Advance flexible alignment strategies** to recognize strong relationships between individuals and their trusted community supports
- D. SUSTAIN: Consider financial tools to incent the delivery of high-value care** to people with serious illnesses
- E. INTEGRATE: Include patient reported outcome and other quality measures** to assess impacts of care, and adjust payments based on acuity and need
- F. INTEGRATE: Evaluate access to evidence-based serious illness supports** within models, noting differential access among sub-populations, including historically underserved populations
- G. INTEGRATE: Encourage broad service capacity** within models to address the needs of individuals with serious illnesses, recognizing the underlying heterogeneity of serious illness itself
- H. INTEGRATE: Incorporate C-TAC Core Principles** into disease-specific or population-based models
- I. INTEGRATE: Enable beneficiaries to easily access affordable high-value community-based services**
- J. SUSTAIN: Advance CBO capacity-building**
- K. SUSTAIN: Explore “intensity add-on” for high-value CBO services** that could be adopted across payer contexts

C-TAC Core Principles for Care Models

Aims

1. Care is person- and family-centered, improving quality of life.
2. Care is inclusive – reducing inequities and disparities, and removing barriers to access and to quality care.

Care

3. Each person's physical, social, psychological, and spiritual needs are assessed on an ongoing and standardized basis.
4. A care plan is developed, using shared decision making, based on those needs and the person's individual goals and preferences.
5. Care is provided by a qualified core interdisciplinary team, with additional team members as needed.
6. Care is accessible 24/7 (using technology as appropriate) and available throughout the continuum of a serious illness (including in the home when appropriate).
7. Care is comprehensive, coordinated, with seamless transitions, and with integration of clinical and community-based services and supports for the person and family caregiver(s).

Payment

Payment is 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.

12-10-21