

Physician-Focused Payment Model Technical Advisory Committee LOI: Environmental Scan & Relevant Literature

American Academy of Hospice and Palliative Medicine
Letter Dated: 3/8/2017
Letter Received: 3/9/2017

The American Academy of Hospice and Palliative Medicine (AAHPM) is an association of hospice physicians and other health care providers. The AAHPM intends to submit a proposal to PTAC for two payment models for patients with serious illness that need palliative care in settings such as small independent practices, larger physician groups, hospitals, post-acute care facilities, and integrated health systems. Both models would be tiered based on patient complexity, functional status and intensity of interdisciplinary services and will be subject to quality measurement. AAHPM only expects one (PACSSI) to qualify as an APM under MACRA. The two models:

- 1) The Palliative Care Support to a Medical Home (PCS) is designed for palliative care teams to provide support to medical home or accountable care organizations in addressing unmet needs of patients with serious illness who are assigned or attributed to those accountable providers. Two types of payments are made under this model:
 - a) PCS Assessment and Planning Services (PCS-AP): a one-time payment to provide comprehensive assessment and care planning services; and
 - b) PCS Monthly Support Services (PCS-MS): monthly payments to allow for co-management of patients with ongoing needs.
- 2) The Patient and Caregiver Support for Serious Illness (PACSSI) model is designed to allow palliative care teams themselves to become accountable for the care they provide to patients, Monthly PACSSI payments would support interdisciplinary palliative care teams and payments would be adjusted up or down based upon performance on both quality and cost measures. There would be an option for palliative care teams to receive PACSSI Bundled Payments, requiring greater accountability for service delivery and total cost of care.

Key Search Terms

MedPAC, Hospice payment, Medicare, Palliative Care, Medicare, Hospice, Medicare Care Choices Model, Medicare Physician Fee Schedule, Advanced Care Planning, End of Life Care, Payment Reform, Hospice, Payment Method, Evaluation, Hospice Services, ACO, Hospice Accountable Care, End of life Spending, Payment

Research Task	Section	Contents
Environmental Scan	Section 1	Key documents, timely reports, grey literature, and other materials gathered from internet searches (9).
Relevant Literature	Section 2	Relevant literature materials (2).
Related Literature	Section 3	Related literature materials (4).
References	Section 4	References to environmental scan, relevant and related literature.

Section 1. Environmental Scan

Environmental Scan		
<i>Key words: MedPAC, Hospice payment, Medicare, Palliative Care</i>		
Organization	Title	Date
Medicare Payment Advisory Commission (MedPAC)	Chapter on Hospice Services in MedPAC report to Congress	3/2017
Purpose/Abstract		
<p>Background: Over the last 15 years, hospice spending has grown substantially, increasing at a rapid rate between 2000 and 2012, remaining flat between 2012 and 2014, and growing again in 2015. Between 2000 and 2012, Medicare spending for hospice care increased more than 400 percent, from \$2.9 billion to \$15.1 billion. Between 2014 and 2015, Medicare hospice spending increased 5.5 percent. In 2015, more than 1.38 million Medicare beneficiaries (including about 49 percent of decedents) received hospice services from over 4,200 providers, and Medicare hospice expenditures totaled about \$15.9 billion. Medicare is the largest payer of hospice services, covering more than 90 percent of hospice patient days in 2014.</p> <p>Summary: In chapter 12 of the March 2017 MedPAC annual report, authors address the adequacy of Medicare payments to hospice services in 2017. The authors assessed several indicators of payment adequacy including beneficiaries’ access to care, changes over time in the volume of services provided, quality of care, providers’ access to capital, and the relationship between Medicare’s payments and providers’ costs. Based on the assessment of the aforementioned indicators, hospices should be able to accommodate cost changes in 2018; thus, the authors recommend Congress do not update the 2017 base payments rates.</p>		
Additional Notes/Comments		
<p>Chapter 6 of MedPAC’s March 2009 report (page 347) has more details on how MedPAC suggests reform for the Hospice benefit</p>		

Environmental Scan		
<i>Key words: Medicare, Palliative Care, Hospice, Medicare Care Choices Model</i>		
Organization	Title	Date
Center for Medicare and Medicaid Innovation (CMMI or The CMS Innovation Center)	Medicare Care Choices Model	Last Updated: 2/12/2017 Accessed: 3/30/2017
Purpose/Abstract		
<p>Background: Launched in July 2015 with 140 participants, this CMMI pilot model provides new options for terminally ill patients by allowing Medicare beneficiaries who qualify for hospice to receive palliative care services and curative care at the same time. The model is being phased in over 2 years and intends to last for 5 years until 2020.</p> <p>Summary: Currently, Medicare beneficiaries are required to forgo curative care in order to receive access to hospice services. The Medicare Care Choices model (MCCM) allows Medicare and dually eligible beneficiaries who qualify for coverage under the Medicare or Medicaid Hospice Benefit to elect to receive the palliative and supportive care services typically provided by a hospice and continue to seek curative care from their providers. CMS is examining whether access to such services would result in improved quality of care, patient and family satisfaction, and whether there are any effects on use of curative services and the Medicare or Medicaid Hospice Benefit. Participating hospices are randomly assigned to two phases or cohorts. The first cohort began providing services to beneficiaries in January 2016, and the second cohort will begin providing services in January 2018. Hospices receive \$400 Per-Beneficiary-Per-Month for providing services.</p>		
Additional Notes/Comments		
Initial Request for Applications (2014) and Awardees by state (2015)		

Environmental Scan		
<i>Key words: Medicare Physician Fee Schedule, Advanced Care Planning, End of Life Care</i>		
Organization	Title	Date
Centers for Medicare & Medicaid Services (CMS)	Advance Care Planning	8/2016
Purpose/Abstract		
<p>Background: Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for voluntary Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS).</p> <p>Summary: The document describes the two new CPT codes 99497 and 99498 that physicians could use when providing services related to advance care planning (ACP) including the explanation and discussion of advance directives. The document notes that per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period and similarly CMS has not established any frequency limits. When the service is billed multiple times for a given beneficiary, CMS expects to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care. The document also includes information on billing guidance, beneficiary cost-sharing, and a hypothetical example of ACP.</p>		
Additional Notes/Comments		

Environmental Scan		
<i>Key words: MedPAC, Hospice payment, Medicare, Palliative Care</i>		
Organization	Title	Date
Medicare Payment Advisory Commission (MedPAC)	Hospice and Medicare Spending	4/7/2016
Purpose/Abstract		
<p>Background: This slide deck includes a MedPAC presentation from the April 2016 Commission meeting. Information contained in this document addresses the relationship between hospice care and Medicare spending. MedPAC contracted with Direct research, LLC (the Contractor) to review relevant literature and conduct further analysis.</p> <p>Summary: The slide deck discusses the following contractor analyses: national trends, replicating and evaluating literature, and market-level analysis. Findings suggest hospice primarily benefited patient care rather than costs. It did not appear that hospice reduced aggregate Medicare spending relative to conventional care at the end of life. Hospice may result in reduced spending for cancer patients, but higher spending for non-cancer or very long-stay patients. Higher aggregate hospice costs for some populations remain consistent with other 2015 studies.</p>		
Additional Notes/Comments		

Environmental Scan		
<i>Key words: Payment reform, Palliative Care, Hospice, Payment method, Medicare</i>		
Organization	Title	Date
Health Affairs	Hospice Payment Reforms Are A Modest Step Forward, But More Changes Are Needed	1/4/2016
Purpose/Abstract		
<p>Background: This blog highlights CMS payment reforms updating the Medicare hospice payment rates and wage index. The rule increased payment at the beginning and very end of Medicare enrollees' hospice stays but left the current per-diem payment structure intact. The authors state that the 2015 final rule leaves several fundamental issues unaddressed and should be viewed as a modest first step toward meaningful hospice payment reform.</p> <p>Summary: The authors provide a useful summary of the recent reforms in the 2015 final rule and while these reforms could begin to align Medicare hospice payments more closely with agency costs they do not address three payment-related issues that the authors argue are more important to the future of the Medicare hospice benefit: (1) the barriers to care posed by current hospice eligibility standards; (2) the exclusion of hospice from Medicare Advantage and other integrated payment models; and (3) the poor fit of the current hospice benefit for nursing home residents. The authors conclude that, the recent hospice payment reforms are a modest start toward aligning hospice payments with the benefit's current use, but these changes are only the first step in a more complicated challenge to develop and implement policies that help achieve high quality end-of-life care for all Medicare beneficiaries.</p>		
Additional Notes/Comments		
<p>The primary author has also authored a related perspective piece in the New England Journal of Medicine in November, 2012; "Growing Pains for the Medicare Hospice Benefit": http://www.nejm.org/doi/pdf/10.1056/NEJMp1208465</p>		

Environmental Scan		
<i>Key words: Payment reform, Palliative Care, Hospice, Payment method, Medicare</i>		
Organization	Title	Date
Institute of Medicine (IOM)	Dying in America: Chapter 5: Policies and Payment Systems to Support High-Quality End-of-Life Care	3/19/2015
Purpose/Abstract		
<p>Background: The experience of dying in the United States is often characterized by fragmented care, inadequate treatment of distressing symptoms, frequent transitions among care settings, and enormous care responsibilities for families.</p> <p>Summary: <i>Dying in America</i> is a study of the current state of health care for persons of all ages who are nearing the end of life. This report evaluates strategies to integrate care into a person- and family-centered, team-based framework, and makes recommendations to create a system that coordinates care and supports and respects the choices of patients and their families. The findings and recommendations of this report address the needs of patients and their families and assist policy makers, clinicians and other stakeholders to provide the best care possible for people nearing the end of life. Chapter 5 of this report focuses on policies and payment systems to support high-quality end-of-life care and begins by summarizing the quality and cost challenges, provides background on programs responsible for financing and organizing U.S. health care and the perverse incentives in those programs that affect people near the end of life. Additionally, the chapter examines the gap between the services these programs pay for and what patients nearing the end of life and their families want and need and discusses opportunities and initiatives to address the shortfalls and gaps in the current system. Lastly, the chapter ends with the committee's findings, conclusions, and recommendations on policies and payment systems to support high-quality end-of-life care.</p>		
Additional Notes/Comments		

Environmental Scan		
<i>Key words: Medicare, evaluation, hospice services, payment method, palliative care</i>		
Organization	Title	Date
Abt Associates Inc.	Medicare Hospice Payment Reform - Analysis of How the Medicare Hospice Benefit is Used	12/3/2015
Purpose/Abstract		
<p>Background: Centers for Medicare and Medicaid Services (CMS) contracted with Abt Associates Inc., to conduct a comprehensive data analyses on how Medicare’s hospice benefit is used.</p> <p>Summary: The analyses was conducted in order to identify potential vulnerabilities within the hospice benefit. The objective was to understand whether there are areas within the hospice benefit which could be improved in order to not only protect the fiscal integrity of the benefit but especially to provide better care for beneficiaries and their families at the end of life. This report includes the following: an analysis of the total costs associated with hospice during FY2013; an analysis of Medicare utilization immediately prior to a beneficiary’s first hospice admission among beneficiaries with different hospice primary diagnoses, and then compares that pre-hospice utilization to utilization of the hospice benefit; describes trends and patterns in the Hospice Cost Reports from FY2004 through FY2013; presents basic trends concerning hospices that have exceeded their annual aggregate Medicare reimbursement cap; examines the rate of live discharge amongst hospices; presents descriptive estimates of drugs reported on the hospice claims, a result of a new data-reporting requirement recently implemented by CMS; describes patterns in Evaluation and Management (E&M) codes to determine whether beneficiaries are enrolled in hospice without having E&M services; compares visits received by beneficiaries electing the hospice benefit to visits received through Medicare’s home health benefit; and provides descriptive statistics on how frequently hospice beneficiaries lack skilled visits during their last two days of life.</p>		
Additional Notes/Comments		
<p>This report was a part of a series of reports commissioned by CMS that also include:</p> <ol style="list-style-type: none"> 1) “Medicare Hospice Payment Reform: Hospice Study Technical Report”(April 24, 2012) 2) “Medicare Hospice Payment Reform: A Review of the Literature” (April 19, 2013) 3) “Medicare Hospice Payment Reform: Analyses to Support Payment Reform” (May 1, 2014) 		

Environmental Scan		
<i>Key words: MedPAC, Hospice payment, Medicare, Palliative Care</i>		
Organization	Title	Date
Medicare Payment Advisory Commission (MedPAC)	Medicare Hospice Policy Issues	4/4/2013
Purpose/Abstract		
<p>Background: This slide deck includes a presentation made by MedPAC staff during the April 2013 Commission meeting. Information contained in this document describe current utilization and payment issues including data that show that hospice expenditures are highest in the initial few days of hospice election and the last few days of hospice patient’s life.</p> <p>Summary: MedPAC analyses show that between 2000 and 2007, Medicare hospice spending more than tripled; the number of hospice patients nearly doubled. At the same time, number of providers grew by approximately 45%, and mostly driven by growth of for-profits hospices. A MedPAC panel of hospice physicians and staff gave reports of lax admission and recertification practices at some hospices and raised concerns about financial arrangements between some hospices and nursing homes. MedPAC also postulated that long stays are more profitable than short stays because Medicare makes a flat payment per day (whether a visit is provided or not). MedPAC also found that more than half of hospice spending in 2011 was for patients with stays exceeding 180 days.</p>		
Additional Notes/Comments		

Environmental Scan		
<i>Key words: Palliative Care, Hospice, Payment method, Medicare</i>		
Organization	Title	Date
The Milibank Quarterly	Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care	9/2011
Purpose/Abstract		
<p>Background: A small proportion of patients with serious illness or multiple chronic conditions account for the majority of health care spending in the U.S. Despite the high cost, evidence demonstrates that these patients receive health care of inadequate quality, characterized by fragmentation, overuse, medical errors, and poor quality of life.</p> <p>Summary: This article examines data demonstrating the impact of the U.S. health care system on clinical care outcomes and costs for the sickest and most vulnerable patients. It also defines palliative care and hospice, synthesizes studies of the outcomes of palliative care and hospice services, reviews variables predicting access to palliative care and hospice services, and identifies those policy priorities necessary to strengthen access to high-quality palliative care. Policies focus on enhancing the palliative care workforce, investing in the field's science base, and increasing the availability of services in U.S. hospitals and nursing homes needed to ensure equitable access to optimal care for seriously ill patients and those with multiple chronic conditions.</p>		
Additional Notes/Comments		
https://www.ncbi.nlm.nih.gov/pubmed/21933272		

Section 2. Relevant Literature

Relevant Literature		
<i>Key words: Palliative Care, ACO, Medicare, Hospice accountable care, Payment Reform</i>		
Journal	Title	Date
Journal of Palliative Medicine	The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization	1/1/2017
Purpose/Abstract		
<p>Background: This article explores innovative models of palliative care that not only lower costs but better meet the needs of seriously ill people to receive care for advanced illnesses at home.</p> <p>Objectives: An evaluation was performed to assess the impact of a home-based palliative care (HBPC) program implemented within an Accountable Care Organization (ACO) on cost and utilization.</p> <p>Methods: A retrospective case-control analysis was performed to quantify cost savings associated with a home-based palliative care (HBPC) program in a Medicare Shared Savings Program ACO where total cost of care is available. Researchers studied 651 decedents; 82 enrolled in a HBPC program and 569 who received usual care, in three New York counties, comparing hospital admissions, emergency room (ER) visits, and hospice utilization rates in the final months of life.</p> <p>Results: The cost per patient during the final three months of life was \$12,000 lower with HBPC than with usual care (\$20,420 vs. \$32,420; $p = 0.0002$); largely driven by a 35% reduction in Medicare Part A (\$16,892 vs. \$26,171; $p = 0.0037$) expenditures. HBPC also resulted in a 37% reduction in Medicare Part B expenditures in the final three months of life compared to usual care (\$3,114 vs. \$4,913; $p = 0.0008$). Hospital admissions were reduced by 34% in the final month of life for patients enrolled in HBPC. The number of admissions per 1000 beneficiaries per year was 3,073 with HBPC and 4,640 with usual care ($p = 0.0221$). HBPC resulted in a 35% increased hospice enrollment rate ($p = 0.0005$) and a 240% increased median hospice length of stay compared to usual care (34 days vs. 10 days; $p < 0.0001$).</p> <p>Conclusion: HBPC within an ACO was associated with significant cost savings, fewer hospitalizations, and increased hospice use in the final months of life.</p>		
Additional Notes/Comments		

Relevant Literature		
Key words: Palliative Care, ACO, Medicare, Hospice accountable care, Payment Reform		
Journal	Title	Date
Journal of Palliative Medicine	Cost Savings and Enhanced Hospice Enrollment with a Home-Based Palliative Care Program Implemented as a Hospice–Private Payer Partnership	12/17/2014
Purpose/Abstract		
<p>Background: In the United States, 5% of the population is responsible for nearly half of all health care expenditures, with a large concentration of spending driven by individuals with expensive chronic conditions in their last year of life. Outpatient palliative care under the Medicare Hospice Benefit excludes a large proportion of the chronically ill and there is widespread recognition that innovative strategies must be developed to meet the needs of the seriously ill while reducing costs.</p> <p>Objective: This study aimed to evaluate the impact of a home-based palliative care program, implemented through a hospice-private payer partnership, on health care costs and utilization.</p> <p>Methods: This was a prospective, observational database study where insurance enrollment and claims data were analyzed. The study population consisted of Home Connections (HC) program patients enrolled between January 1, 2010 and December 31, 2012 who subsequently expired (n=149) and who were also Independent Health members. A control group (n=537) was derived using propensity-score matching. The primary outcome variable was overall costs within the last year of life. Costs were also examined at six months, three months, one month, and two weeks. Inpatient, outpatient, ancillary, professional, and pharmacy costs were compared between the two groups. Medical service utilization and hospice enrollment and length of stay were also evaluated.</p> <p>Results: Cost savings were apparent in the last three months of life—\$6,804 per member per month (PMPM) cost for palliative care participants versus \$10,712 for usual care. During the last two weeks of life, total allowed PMPM was \$6,674 versus \$13,846 for usual care. Enhanced hospice entry (70% versus 25%) and longer length of stay in hospice (median 34 versus 9 days) were observed.</p> <p>Conclusions: Palliative care programs partnered with community hospice providers may achieve cost savings while helping provide care across the continuum.</p>		
Additional Notes/Comments		

Section 3. Related Literature

Related Literature		
<i>Key words: Medicare, Hospice payment, End of life spending, palliative care</i>		
Journal	Title	Date
Health Services Research	Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care	2/2017
Purpose/Abstract		
<p>Objective: To create and test three prospective, increasingly restrictive definitions of serious illness.</p> <p>Data Sources: Health and Retirement Study, 2000–2012.</p> <p>Study Design, Data Collection and Principal Findings: Researchers evaluated subjects’ 1-year outcomes for patients that met one of three definitions that are increasingly restrictive but not mutually exclusive:</p> <p>(1) one or more severe medical conditions (condition) and/or receiving assistance with activities of daily living (functional limitation); [Of 11,577 eligible subjects, 5,297 fell in this category which saw hospitalization of 33 percent, total average Medicare costs \$20,566 and a mortality of 13 percent]</p> <p>(2) condition and/or functional limitation and hospital admission in the last 12 months and/or residing in a nursing home (utilization); [Of 11,577 eligible subjects, 3151 were in this category which saw hospitalization of 44 percent, total average Medicare costs of \$26,349 and a mortality of 19 percent]</p> <p>(3) condition and functional limitation and utilization. [Of 11,577 eligible subjects, 1447 belonged in this category which saw hospitalization of 47 percent, total average Medicare costs \$30,828 and a mortality of 28 percent].</p> <p>In comparison, among those meeting no definition, 12 percent had hospitalizations, total Medicare costs averaged \$7,789, and 2 percent died.</p> <p>Conclusions: Prospective identification of older adults with serious illness is feasible using clinically accessible criteria and may be a critical step toward improving health care value. These definitions may aid clinicians and health systems in targeting patients who could benefit from additional services.</p>		
Additional Notes/Comments		

Related Literature		
<i>Key words: Medicare, hospice, payment</i>		
Journal	Title	Date
Journal of Pain and Symptom Management	Hospice Value-Based Purchasing Program: A Model Design	12/2016
Purpose/Abstract		
<p>Abstract: With the implementation of the Affordable Care Act, the U.S. government committed to a transition in payment policy for health care services linking reimbursement to improved health outcomes rather than the volume of services provided. To accomplish this goal, the Department of Health and Human Services is designing and implementing new payment models intended to improve the quality of health care while reducing its cost. Collectively, these novel payment models and programs have been characterized under the moniker of value-based purchasing (VBP), and although many of these models retain a fundamental fee-for-service (FFS) structure, they are seen as essential tools in the evolution away from volume-based health care financing toward a health system that provides “better care, smarter spending, and healthier people.” In 2014, approximately 20% of Medicare provider FFS payments were linked to a VBP program. The Department of Health and Human Services has committed to a four-year plan to link 90% of Medicare provider FFS payments to value-based purchasing by 2018. To achieve this goal, all items and services currently reimbursed under Medicare FFS programs will need to be evaluated in the context of VBP. To this end, the Medicare Hospice benefit appears to be appropriate for inclusion in a model of VBP. This policy analysis proposes an adaptable model for a VBP program for the Medicare Hospice benefit linking payment to quality and efficiency in a manner consistent with statutory requirements established in the Affordable Care Act.</p>		
Additional Notes/Comments		
<p>https://www.ncbi.nlm.nih.gov/pubmed/27697566</p>		

Related Literature		
<i>Key words: Medicare, Hospice payment, End of life spending, palliative care</i>		
Journal	Title	Date
Health Affairs	Medicare Hospice Spending Hit \$15.8 Billion In 2015, Varied By Locale, Diagnosis	10/2016
Purpose/Abstract		
<p>Background: Medicare’s hospice benefit, which provides palliative care for people who are terminally ill and have an estimated life expectancy of six months or less, is becoming more commonly used. In 2014, 48 percent of Medicare decedents had received hospice care, up from 23 percent in 2000. The cost of this care is directly related to the number of patients who receive it and the number of hospice care days they have. Hospice providers are paid a daily rate—\$159 in fiscal year 2015—for all routine home care services related to a patient’s terminal illness.</p> <p>Objective: The goal of the authors was to understand the recent growth in hospice spending by describing the variation in spending and spending growth.</p> <p>Study data and methods: All Medicare hospice claims were analyzed including those from beneficiaries enrolled in Medicare Advantage, for the period 2007–15. The analysis included beneficiary, claim, and claim line data from the Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Data Warehouse for the study period as of April 21, 2016.</p> <p>Results: Between 2007 and 2015, Medicare hospice spending rose by 52 percent, from \$10.4 billion to \$15.8 billion. Growth in spending was driven primarily by an increase in the number of patients in hospice care. Medicare spending on hospice care was \$642 million, or 4.2 percent, higher in 2015 than it was in 2014. The researchers observed substantial geographic variation in hospice spending, driven in part by the mix of patient diagnoses. Geographic variation may also be a result of differences in provider and patient characteristics and preferences. For example, in the South, where average spending per patient is higher, there are more for-profit hospice providers than in other regions. Compared to nonprofit hospice providers, for-profit providers enroll more patients with non-cancer diagnoses—patients who are more likely to have longer stays and thus higher average spending than patients with cancer. Providers’ specialties and previous experience enrolling patients in hospice may also affect regional hospice use.</p>		
Additional Notes/Comments		
<p>http://content.healthaffairs.org/content/35/10/1902.abstract</p>		

Related Literature		
<i>Key words: Medicare, Hospice payment, End of life spending, palliative care</i>		
Journal	Title	Date
Palliative Medicine	Evidence on the cost and cost effectiveness of palliative care: A literature review	7/9/2013
Purpose/Abstract		
<p>Background: In the context of limited resources, evidence on costs and cost-effectiveness of alternative methods of delivering health-care services is increasingly important to facilitate appropriate resource allocation. Palliative care services have been expanding worldwide with the aim of improving the experience of patients with terminal illness at the end of life through better symptom control, coordination of care and improved communication between professionals and the patient and family.</p> <p>Aim: To present results from a comprehensive literature review of available international evidence on the costs and cost-effectiveness of palliative care interventions in any setting (e.g. hospital-based, home-based and hospice care) over the period 2002–2011.</p> <p>Design: Key bibliographic and review databases were searched. Quality of retrieved papers was assessed against a set of 31 indicators developed for this review.</p> <p>Data Sources: PubMed, EURONHEED, the Applied Social Sciences Index and the Cochrane library of databases.</p> <p>Results: A total of 46 papers met the criteria for inclusion in the review, examining the cost and/or utilization implications of a palliative care intervention with some form of comparator. The main focus of these studies was on direct costs with little focus on informal care or out-of-pocket costs. The overall quality of the studies is mixed, although a number of cohort studies do undertake multivariate regression analysis.</p> <p>Conclusion: Despite wide variation in study type, characteristic and study quality, there are consistent patterns in the results. Palliative care is most frequently found to be less costly relative to comparator groups, and in most cases, the difference in cost is statistically significant.</p>		
Additional Notes/Comments		

Section 4. References

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PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL REGARDING

THE AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE
MEDICINE (AAHPM) PROPOSAL

WITH A PALLIATIVE CARE EXPERT

Thursday, November 9, 2017
10:00 a.m.

PRESENT:

PAUL CASALE, MD, MPH, PTAC Committee Member
ELIZABETH MITCHELL, PTAC Committee Member
BRUCE STEINWALD, PTAC Committee Member

ANN PAGE, Designated Federal Officer, Office of the
Assistant Secretary for Planning and Evaluation (ASPE)

NINA ROSS O'CONNOR, MD, Associate Professor of Clinical
Medicine, University of Pennsylvania; Program Director,
Hospice and Palliative Medicine Fellowship, University of
Pennsylvania; Chief Medical Officer, Penn Wissahickon
Hospice; Chief, Palliative Care Program, University of
Pennsylvania Health System

ANJALI JAIN, MD, Social & Scientific Systems, Inc. (SSS)
DAN WALDO, Actuarial Research Corporation (ARC)

1 P R O C E E D I N G S

2 [10:02 a.m.]

3 MS. PAGE: So, I -- I think we're all
4 here, and before, Paul, you get started, I -- I
5 just want to remind everybody that because we have
6 Dr. O'Connor here, we do have a transcriptionist
7 who will be transcribing her remarks, so you don't
8 have to worry about remembering it all. But, can
9 you all say your names, spell it, and so she knows
10 who is speaking?

11 DR. CASALE: Okay. So are we ready to get
12 started, Ann?

13 MS. PAGE: Sure. Go ahead, Paul.

14 DR. CASALE: Oh, good. Okay, great.

15 So thanks, everyone, for being on the
16 phone, particularly Dr. O'Connor. Thank you. We
17 appreciate your time and expertise, and we -- the
18 list of questions was sent to you, right, that
19 we --

20 DR. O'CONNOR: Yes. I have the list of --
21 the list of six questions, I have --

22 DR. CASALE: Okay.

23 DR. O'CONNOR: [unintelligible] on the
24 materials, which I reviewed.

1 DR. CASALE: Okay. So maybe it would be
2 worth, if Bruce and Elizabeth agree, to just go
3 through those questions first, and then, you know,
4 get your thoughts on those, and then we could sort
5 of open it up from there.

6 DR. O'CONNOR: Absolutely. I'm happy to
7 do that and also, you know, take any -- any
8 questions as we go along. I don't have to
9 necessarily --

10 DR. CASALE: Yeah.

11 DR. O'CONNOR: -- follow through the
12 questions. Happy to do whatever is most helpful to
13 you.

14 DR. CASALE: Agree.

15 MS. PAGE: And, if folks can just identify
16 themselves when they ask a question, please.

17 DR. O'CONNOR: Sure.

18 Do you need any sense of my background? I
19 don't know if you need, you know, to know my
20 training or my background before we talk through?

21 MS. PAGE: They have your CV (curriculum
22 vitae).

23 DR. O'CONNOR: Perfect. Great. Okay.

24 DR. CASALE: Yeah. And we talked before,

1 right?

2 MR. STEINWALD: -- We're the same people
3 you talked --

4 DR. CASALE: We're the same people --
5 yeah --

6 DR. O'CONNOR: All right. Okay.

7 DR. CASALE: -- with the PTAC (Physician-
8 Focused Payment Model Technical Advisory
9 Committee).

10 DR. O'CONNOR: Wonderful.

11 DR. CASALE: Yeah. So we're all familiar.

12 DR. O'CONNOR: Very good. Well --

13 DR. CASALE: We appreciated -- we
14 appreciated all of your thoughtful comments on the
15 C-TAC (Coalition to Transform Advanced Care)
16 proposal, so we look forward to hearing your
17 comments on this one.

18 DR. O'CONNOR: Sure. Absolutely.

19 So, the first question was a general one,
20 you know, "What are your impressions of this
21 model?" And obviously, this is somewhat similar to
22 the last one we talked about, you know, to the PTAC
23 model. You know, it's a community-based palliative
24 care model, which is, you know, I think, a growing

1 method to provide care for patients with serious
2 illness. It does show, you know, promising
3 outcomes in the literature, and it is a kind of
4 care that doesn't really fit into the current
5 reimbursement structure as well. So, some places
6 do it using fee-for-service, which is difficult.
7 Some programs use a home health, reimbursement
8 structure, which doesn't always work if patients
9 aren't homebound or don't have a skilled need. So,
10 I -- I think it is an area for innovation in terms
11 of figuring out how community-based palliative care
12 fits into the health care process.

13 You know, this -- this one is a bit --
14 it's fairly general in that it doesn't specify a
15 lot of detail about what the palliative care team
16 members need to include or what they need to do
17 beyond just a visit a month. So, you know, I think
18 it would give palliative care teams a lot of room
19 to innovate. That being said, it was pretty
20 general.

21 But, that being said, it -- you know, I
22 think it -- it asked them to manage patients across
23 different sites, you know, from home to the office
24 to the hospital, and be able to -- to visit and

1 interact with patients and families and caregivers
2 in all of those settings. So, I think that's a
3 strength and one that might actually be important
4 for outcome.

5 It -- It's also actually fairly similar to
6 [the] Medicare Care Choices Model, which is under
7 way. You know, some of the sites are already
8 starting to collect some data. But it -- it -- I
9 think it's a bit more comprehensive, includes more
10 diagnoses, and obviously, the payment model is
11 different with the risk sharing, so --

12 DR. CASALE: So, I -- I was wondering if
13 you had any comments particularly about the
14 inclusion criteria, you know, the eligibility
15 criteria --

16 DR. O'CONNOR: Yes.

17 DR. CASALE: -- and if you had any
18 thoughts in terms of how they have outlined this
19 and then how they also have sort of a Tier 1 and a
20 Tier 2.

21 DR. O'CONNOR: Yes. Let me turn to that
22 section.

23 Well, I'll be honest, I found them
24 somewhat confusing. I've read them multiple times.

1 They're a bit complex. I think they're getting at
2 the difficulty of prognostication in this patient
3 population.

4 So looking at the, you know, table on page
5 5 of the proposal, under diagnosis, the -- the
6 serious illness is specified diseases and
7 disorders, which are then in Table 2. That seems
8 pretty straightforward, and those seem, you know,
9 very appropriate for community-based palliative
10 care.

11 We can talk about them specifically. I
12 had some questions on just two of them.

13 But, I think that the chronic conditions
14 [are] a little bit more difficult. A patient could
15 really have three or more chronic conditions and
16 live quite a long time. So, I was a little more
17 concerned that that could be vague in a big group
18 of patients.

19 And I think they're trying to narrow it
20 down using the functional status and the -- the
21 health care utilization. But the health care
22 utilization is actually pretty -- pretty
23 conservative. One -- one ED (emergency department)
24 visit in a year, you could argue isn't a -- you

1 know, isn't the patient that has high utilization,
2 for example. So, I think they're trying to get --
3 get the right patient population. It's a hard
4 thing to do.

5 You know, I noticed there's no prognosis.
6 The PTAC proposal and Medicare Care Choices Model
7 both include an estimated prognosis to try and get
8 health clinicians [to] sort of conceptualize which
9 patient populations they're trying to get at, and
10 this just doesn't have a prognosis, you know, or a
11 way that a physician might certify a patient, you
12 know, as being eligible beyond these conditions.

13 DR. CASALE: Yeah. Well, I think -- go
14 ahead. I'm sorry. Bruce, did you -- sorry, Bruce.
15 Were you going to say something?

16 MR. STEINWALD: No, I wasn't.

17 DR. CASALE: Oh, I'm sorry. I thought I
18 heard somebody. I thought I heard somebody. Maybe
19 I'm hearing myself.

20 You know, I have to say I think in our
21 initial conversation amongst the PRT (Preliminary
22 Review Team), we had a similar concern around these
23 chronic conditions being sort of sufficient --

24 DR. O'CONNOR: Right.

1 DR. CASALE: -- too and then -- and also
2 around the utilization.

3 I guess the other question is, Is there
4 really a need for a tier -- different tiers? Or,
5 would the -- would it be -- just in terms of your
6 thoughts around that. Would it make more sense just
7 to have one set of criteria?

8 DR. O'CONNOR: Yeah. I think it might be
9 unnecessarily complex, you know, looking at it as a
10 clinician who might potentially refer patients or
11 identify patients.

12 I wonder if it would be easier just to
13 have maybe even just a second tier, or one tier
14 perhaps, with patients that are maybe closer or
15 have an even shorter prognosis.

16 I know they're trying to be inclusive, but
17 it's just really complicated. I could imagine it
18 being very difficult for clinicians to understand
19 and enroll patients.

20 DR. CASALE: Okay. Yeah. And I think
21 there was also, at least in some of the
22 conversation we had with -- with OACT (Office of
23 the Actuary), that there might be the potential to
24 sort of game the system a bit, you know, like

1 because you get higher pay for, you know, the
2 higher tier, and since the criteria is a bit, you
3 know, complex that it might -- you know, it might
4 lead to some movement towards Tier 2 that may not
5 be appropriate as well.

6 DR. O'CONNOR: Right. I mean, the other
7 liability is the PPS or -- which is Palliative
8 Performance Scale, which is a functional
9 assessment. It fluctuates. So, one day, you know,
10 a patient might -- or one week, they might have a
11 lower PPS than they do later. So that's not an
12 objective measure. So, you know, I guess that
13 could -- that could lead to the same thing you're
14 saying of classifying patients of [a] higher tier,
15 if that's a key criteria.

16 DR. CASALE: Before moving on, I don't
17 know if either Bruce or Elizabeth, have any other
18 sort of questions or in terms of Dr. O'Connor's
19 overall impression of the model?

20 MR. STEINWALD: No [unintelligible].

21 DR. CASALE: Okay. Great.

22 MS. MITCHELL: Nope. None here.

23 DR. CASALE: Okay. Great. Okay.

24 So, I guess if you wouldn't mind just

1 moving on to the next question, then?

2 DR. O'CONNOR: Sure. So, "How do you
3 assess the composition of the Palliative Care Teams
4 in the proposal, and do you have views about the
5 experience or training needed to be successful?"

6 COURT REPORTER: And I'm sorry. Dr.
7 O'Connor, this is the court reporter. Can you keep
8 your voice up, please? Thank you.

9 DR. O'CONNOR: Yes. I'm sorry.
10 So, I read the second question, "How do
11 you assess the composition of the Palliative Care
12 Teams in this proposal? Do you have any views
13 about the experience or training of the team
14 members to be successful?"

15 So there -- there was not a lot of detail
16 about this. I'm finding the section in the
17 proposal -- I think they speak of allowing
18 individual teams to determine what's needed, in
19 their geographic region and for their specific
20 patient.

21 I - I did not specifically see a
22 requirement to have a medical director or a nurse
23 practitioner overseeing the team, which is
24 something that's commonly required, you know, in

1 community-based palliative care, and I think might
2 be important.

3 MR. STEINWALD: Dr. O'Connor, this is
4 Bruce.

5 We sent the proposer a set of questions
6 and recently got responses to the questions. And in
7 this case, they did say that there has to be a
8 physician member of the team, and that one of the
9 members of the team, not necessarily the physician,
10 has to have the certification in palliative care.

11 DR. O'CONNOR: Perfect. Yes, I agree with
12 that. I think to really call it community-based
13 palliative care, and for it to be able to
14 effectively interact with the other physicians or
15 providers on the team, they need that level of
16 expertise.

17 DR. CASALE: And just to be -- just to
18 clarify that, because they don't specify that the
19 physician needs to be certified, just that one of
20 the team members needs to be certified in
21 palliative care, does that --

22 MR. STEINWALD: That's -- that's how I
23 read it, yes.

24 DR. O'CONNOR: Interesting.

1 DR. CASALE: So, I don't know -- yeah.

2 MS. MITCHELL: Yeah. That's a pretty
3 important distinction is -- Do you support that
4 aspect of it?

5 DR. O'CONNOR: I think ideally there
6 should be either the physician or a nurse
7 practitioner who's certified in palliative care.
8 Nurse practitioners can get certification through a
9 different process.

10 You know, the rate-limiting step is there
11 are not -- there are not many board-certified
12 palliative care physicians in the country, so that
13 could limit access in rural areas or some
14 communities that don't have board-certified
15 palliative care physicians. And it's no longer
16 possible for palliative care physicians to go back
17 and get board-certified without completing
18 fellowships. So, there are certainly practicing
19 physicians in smaller communities that are not
20 board-certified.

21 But for nurse practitioners, it's
22 experience-based, and so a practicing nurse
23 practitioner could get [a] certification, you know,
24 15 years into practice, even if she was -- had not

1 originally done so.

2 MS. PAGE: This is Ann, and I'm looking at
3 the response to [the] question that Bruce
4 referenced. And in their response, they referred to
5 a nurse as opposed to a nurse practitioner. So
6 they referenced the clinical practice guidelines
7 for quality palliative care, and that by
8 definition, it requires an interdisciplinary team.

9 And then I guess the core, the physician,
10 must be part of the team along with a nurse, social
11 worker, and a spiritual care provider.

12 And then the last sentence is the one
13 Bruce has mentioned, "At a minimum, one of the core
14 interdisciplinary team members must have
15 certification in palliative care to support
16 specialty-level practice."

17 DR. O'CONNOR: So it could be -- for
18 example -- it could be the spiritual care provider
19 or the social worker who was certified.

20 MS. PAGE: Yeah. I don't know what this
21 last [unintelligible] -- at a minimum, one of the
22 core interdisciplinary team members must have
23 certification in palliative care "to support
24 specialty-level practice" -- I don't know what

1 those last five words, "to support specialty-level
2 practice" -- So, I don't know if you know if nurses
3 who are not nurse practitioners, you know,
4 master's-prepared, advanced practice nurses, can
5 get specialty certification in palliative care?

6 DR. O'CONNOR: They can. So theirs is
7 also a -- a pathway by which after a certain number
8 of specialty clinical hours, they can sit for an
9 exam and then get [a] certification. So that would
10 be for an RN (registered nurse), not a master's-
11 prepared nurse.

12 And similarly, social workers with a
13 certain number of hours of clinical experience in
14 palliative care can then get certified, and there's
15 a pathway for -- for chaplains as well. But I
16 still --

17 MS. PAGE: Okay. So they're saying it
18 could be any one of those four parties.

19 DR. O'CONNOR: Any one of those, right.

20 DR. JAIN: When they say -- this is Dr.
21 Jain. When they say specialty level, do they mean
22 like fellowship-trained? Is that --

23 MS. PAGE: It's unclear. That's all they
24 say, "To support specialty-level practice," so --

1 and this is their response to our questions. So, I
2 -- I guess it's just unclear.

3 DR. O'CONNOR: So fellowships would only
4 pertain to the physicians. There aren't
5 fellowships in palliative care really for the other
6 team members. So they go through this process of
7 acquiring a certain number of specialty practice
8 hours and then taking an exam to be certified.

9 Physicians complete a fellowship just like
10 any other specialty and then are board-certified.
11 The struggle in palliative care is that there are
12 only 300 fellowship slots per year offered, and so
13 the number of physicians who are fellowship-trained
14 and board-certified is small nationally. There are
15 a lot of practicing physicians who grandfathered in
16 prior to fellowship requirements or programs who
17 are not fellowship-trained but who actually do, you
18 know, practice palliative care.

19 MS. MITCHELL: Ann, this is Elizabeth.

20 I have a question that is a little far
21 afield maybe, but given the interest in these
22 topics from Congress yesterday -- Is it within
23 bounds for us to make recommendations or at least
24 share observations about other needed changes

1 beyond the model? Because the interest in
2 participation by small and rural practices was, you
3 know, super high. And, how to deal with, I think,
4 physician shortages or training barriers, is that
5 within the bounds of our work?

6 MS. PAGE: Not directly, I would say.

7 One of the comments that -- and so for the
8 court reporter and Anjali and folks, two PTAC
9 members -- the Chair and Vice Chair -- were on the
10 Hill yesterday in response to an invitation on a
11 hearing.

12 One of the things that I heard that made
13 me smile and partly addresses your issue,
14 Elizabeth, is there was another witness who has not
15 submitted a proposal but is planning to submit a
16 proposal -- or maybe recently has and hasn't gotten
17 it there yet, but he said that our website was a
18 "treasure trove of information." That if you go on
19 the website and you read the comments that the PTAC
20 has made on different proposals and the kinds of
21 questions and answers, that there's a lot that can
22 be gleaned from them about what a good proposal
23 should look like.

24 And I thought that was really interesting

1 because we've kept in our boundaries of not
2 providing TA (technical assistance), but we've all
3 known that a side effect of what we do is -- you
4 know, that there's information that people can
5 [unintelligible] --

6 MS. MITCHELL: Yeah.

7 MS. PAGE: -- PTAC is thinking.

8 So I think --

9 MS. MITCHELL: I think he called us the
10 "University of APMs (Alternative Payment Models)."

11 MS. PAGE: Yeah.

12 So, I think -- I think that, again, the
13 Committee, the full PTAC, is not constrained in the
14 comments that it makes to the Secretary (the U.S.
15 Department of Health and Human Services Secretary).
16 You know, we're supposed to do a recommendation and
17 comments, and I think that, you know, there's no
18 limit. The statute does not limit what the PTAC
19 says in its comments, so that's a venue.

20 MS. MITCHELL: Yeah. I guess I'm just
21 hearing that even if there are merits in this
22 model, if there are limits on access to
23 appropriately trained clinicians --

24 MS. PAGE: Mm-hmm.

1 MS. MITCHELL: -- I would think that that
2 would be very relevant.

3 MS. PAGE: Yeah. And I think that
4 that's -- I think that's something that the full
5 PTAC would want to point out. So, for example, the
6 PTAC could say, "You know, we like this model. We
7 think there's a lot to it. Our one concern is that
8 it may not be feasible because in all instances or
9 as widely as we like because of limitations of
10 trained practitioners, and, you know, we recommend
11 in addition to what everyone will say about this
12 proposal that -- that the Secretary also address
13 this other issue."

14 MS. MITCHELL: Okay. Thank you.

15 COURT REPORTER: And was that Elizabeth?

16 MS. MITCHELL: Yes.

17 MS. PAGE: Yes.

18 THE COURT REPORTER: Thank you.

19 MR. STEINWALD: So, let me continue on
20 that. So, Dr. O'Connor, so based on the discussion
21 you just heard, do you see that this model would be
22 unavailable in many small practices and rural
23 practices, or do you think the way it's structured,
24 there would be a way for those kinds of practices

1 to participate? Even if, let's say, they couldn't
2 find a certified physician, the broad certification
3 provisions of the model might make it more
4 accessible in rural areas. Do you think that's
5 true, or what's your impression there?

6 DR. O'CONNOR: No, I think that's correct.
7 If you required physician board certification, it
8 likely would be inaccessible in smaller communities
9 and rural areas.

10 If you allowed a physician who practices
11 related medicine or who has clinical experience in
12 palliative medicine, and then made sure that maybe
13 a nurse practitioner or a nurse has advanced
14 certification, and the whole team has additional
15 training and support, then it probably could be
16 offered in rural areas.

17 You know, in rural areas, often hospices
18 are those groups that have the expertise, and they
19 don't have the credentials or the board
20 certification. But they have people who know a lot
21 about serious illness care and palliative care.
22 So, I think the decision about whether or not to
23 require a physician board certification would
24 greatly impact the ability of this model to be

1 rolled out in different communities because we have
2 to address the physician workforce issue first.

3 MS. MITCHELL: That's very helpful.

4 DR. CASALE: This is Paul.

5 Just following up on that, do you think --
6 well, I guess, is it too broad in terms of the
7 current -- I know -- you know, really you can get
8 certification amongst any of the team members?
9 Would you think it would be better to specify
10 certain team members, as you just said, the nurse
11 practitioner or nurse --

12 DR. O'CONNOR: Yes.

13 DR. CASALE: -- or is it adequate, as you
14 said, the chaplain be certified and everyone else
15 not be certified?

16 DR. O'CONNOR: I think you'd probably want
17 at least the nurse and the -- or the nurse
18 practitioner because in reality a lot of the
19 patient contact is -- and care coordination is
20 probably going to be done by, you know, the nurse
21 or the nurse practitioner. I've seen it done, done
22 both ways.

23 DR. CASALE: Yeah.

24 DR. O'CONNOR: I think probably having the

1 chaplain wouldn't be adequate. That would be
2 nice --

3 DR. CASALE: Yeah.

4 DR. O'CONNOR: That would be -- that would
5 be a bonus.

6 DR. CASALE: Right.

7 DR. O'CONNOR: But maybe instead, either
8 the physician, nurse, or a nurse practitioner, one
9 of those three needs to be certified.

10 DR. CASALE: Yeah. Okay. Great.

11 DR. O'CONNOR: Yeah.

12 You know, the social worker is very, very
13 important in serious illness care, and you can't
14 forget that piece because so much of family
15 decision-making relates to the kinds of issues that
16 the social worker addresses, but I don't think
17 certification of the social worker would be
18 sufficient.

19 DR. CASALE: Yeah.

20 DR. O'CONNOR: It's critical, though.

21 DR. CASALE: Okay. Great. Well, thank
22 you for that feedback.

23 DR. O'CONNOR: Sure.

24 DR. CASALE: The next, if you wouldn't

1 mind moving on to the third question about the
2 population, and we talked about this a little, I
3 guess, in your overall impressions.

4 DR. O'CONNOR: Right. So, "What are your
5 opinions about the population that would be served
6 by this model?"

7 You know, I can see their intention in not
8 wanting to limit it to patients that have one life-
9 limiting diagnosis because there are patients with
10 multi-morbidity who don't fall into that, but I
11 think the risk of the three chronic conditions
12 without a prognostic designation is that that
13 really could be a very large population that could
14 be on service for a long time. And I didn't see a
15 limit for how long patients could be on the
16 program. Maybe I missed it. I think the one from
17 C-TAC had a limit.

18 MS. PAGE: Yeah. This one did not --

19 DR. O'CONNOR: Did not.

20 MS. PAGE: -- have a limit.

21 DR. O'CONNOR: The C-TAC one had a year
22 limit for service. So maybe they think about
23 either adding a limit, or another way to think
24 about the patients with three chronic illnesses --

1 DR. CASALE: And they -- yeah.

2 DR. O'CONNOR: -- area of --

3 DR. CASALE: Sorry.

4 DR. O'CONNOR: Sorry. That was my major
5 area of concern on that.

6 DR. CASALE: Yeah.

7 MS. PAGE: This is Ann.

8 So, I'm, you know, trying to learn more
9 and more about palliative care, but is it the view,
10 then, that palliative care is just for people who
11 have a -- in the near future, life-limiting illness
12 versus individuals that have a serious -- I think
13 the title of this proposal from the beginning
14 seemed different to me that -- that it was targeted
15 to people with serious illnesses.

16 DR. O'CONNOR: Right.

17 MS. PAGE: And so I guess I'd like to hear
18 your thoughts about -- or is palliative care for
19 people with serious illness or life-limiting
20 illness, or is it -- shouldn't be [unintelligible]
21 in those buckets?

22 DR. O'CONNOR: No. It's definitely for
23 serious illness. It doesn't necessarily need to be
24 for patients who are at the end of life. And so

1 palliative care is appropriate for any patient with
2 serious illness.

3 I guess I was just imagining a scenario
4 under this model where a patient could have, you
5 know, diabetes, heart failure, and vascular disease
6 for 20 years, and you wouldn't want them on this
7 particular care management plan for 20 years.
8 That's more of where I was going.

9 You know, the thing about palliative care
10 is really almost anybody could benefit from
11 palliative care in some ways, who's having
12 significant health issues, and so, you know, the
13 patients with chronic illness would probably
14 benefit from this model. But it might not be, you
15 know, in a resource-constrained environment, it
16 might not be an efficient use of palliative care,
17 if that helps.

18 So maybe they also could specify -- maybe
19 they could boil down the chronic conditions,
20 specify them a little bit more, or add some
21 prognostic suggestion, you know, someone you might
22 not -- you wouldn't be surprised if they died in
23 the next year or two, for example. That's commonly
24 used. Or more health utilization -- so maybe if

1 you're going to use chronic condition, you know,
2 use someone who's had two hospitalizations within a
3 year or more -- more intense health care
4 utilization who would more greatly benefit from the
5 care management and the help with goals and
6 coordination.

7 DR. CASALE: And in the list of the
8 serious illness criteria, so putting aside the
9 three chronic, you know, amongst that list, besides
10 the cancer diagnosis, you know, there's heart
11 failure and Class 3 or 4, and, you know, the -- I
12 guess I have a similar concern -- I'm a
13 cardiologist -- But, I mean, there was just another
14 article in the New York Times about how it's so
15 hard to prognosticate for someone who's
16 particularly --

17 DR. O'CONNOR: I saw that, yeah.

18 DR. CASALE: -- in heart failure. Yeah.

19 So, I'm wondering, you know -- well, just
20 your thoughts about this list. It seems like
21 there's a lot in it, and again, may be too broad --

22 DR. O'CONNOR: Right.

23 DR. CASALE: -- you know, in terms of --
24 and again, reflecting on that there's a significant

1 payment associated with -- and you want to do it to
2 the appropriate patient, but you just don't want
3 it, you know, to be too broad.

4 So anyway -- so I just wondered if you had
5 thoughts on the list of the Option 1 criteria.
6 Obviously, I picked out the heart failure because
7 that --

8 DR. O'CONNOR: Right.

9 DR. CASALE: -- because I know that, but
10 there's others on there too.

11 DR. O'CONNOR: Right.

12 DR. CASALE: I wondered what you thought
13 about the list.

14 DR. O'CONNOR: No. absolutely. So this is
15 Table 2.

16 I mean, the chronic illnesses you'd really
17 want to capture are probably on the Option 1. So,
18 I don't know if you even need the three serious
19 chronic conditions.

20 You know, the difficulty is it's hard to
21 prognosticate some of these. Like you mentioned
22 heart failure or COPD (chronic obstructive
23 pulmonary disease) is another one. Dementia can
24 have a variable course. Liver failure. You know,

1 and yet those are a large number of patients.

2 I was sort of surprised they had Class 3
3 or Class 4 heart failure, just [unintelligible]
4 heart failure, but I think it can be difficult to
5 prognosticate.

6 Yeah. I think you don't want to build a
7 model, though, that's just cancer-focused. That's
8 probably the easiest to prognosticate but would be
9 missing a large --

10 DR. CASALE: Right.

11 DR. O'CONNOR: -- part of the patient
12 population, so you're going to end up with some of
13 these, like heart failure and COPD, that are more
14 difficult.

15 DR. JAIN: What did you think of -- this
16 is Anjali Jain again. What did you think about
17 that separating the dementia because of its
18 tendency to have a longer course -- as a primary
19 illness?

20 DR. O'CONNOR: I think that's -- that's
21 like -- that's usually true that dementia is a
22 longer course.

23 DR. JAIN: It sounds like others are as
24 well, and so it's hard to --

1 DR. O'CONNOR: Right. Heart failure can
2 be a longer course. Some of the pulmonary diseases
3 can be a longer course, and those three are
4 difficult because it's not going to -- a slower
5 decline, but then a precipitous event or an
6 exacerbation or, you know, an unexpected
7 complication that leads to somebody's
8 hospitalization or even their death. So they're
9 definitely harder to put into the model but
10 important from a population health perspective to
11 include.

12 I think that's where they tried to combine
13 it with health utilization and functional status,
14 which does make sense. You know, these are ones we
15 struggle with even on the hospice side to
16 prognosticate whether people are appropriate and
17 whether they're going to decline or not.

18 So, I think if they're combining it with
19 functional status and with health care utilization,
20 that may be the best that you can do.

21 And it looks like every six months the
22 patients are supposed to be reevaluated for whether
23 they are appropriate.

24 DR. CASALE: And just to follow up, you

1 were saying with the PPS, there is some variability
2 around that, so -- and make sure I heard this
3 right, you were thinking maybe sort of increasing
4 the thresholds on the utilization might be a way to
5 try to narrow this population down?

6 DR. O'CONNOR: I think so, and that comes
7 actually from some work we've done at Penn where,
8 you know, with limited palliative care resources,
9 we found that we have greater impact on patients
10 who have high health care utilization. They tend
11 to have, you know, less coping, more gaps in their
12 coordination, more conflicted modes of care, less
13 clear events they're planning.

14 And as I said, everybody with serious
15 illness could benefit from palliative care, but if
16 we're thinking about where could we actually change
17 patient and family experience and, you know, health
18 care cost, it's probably in the group of patients
19 with serious illness that have significant health
20 care utilization. So someone with dementia who's
21 hospitalized a lot with infections, for example,
22 that might really improve the patient experience ...
23 the care givers' stress, and obviously the cost as
24 well.

1 And the function is just harder because --
2 because it's subjective. It fluctuates from day to
3 day based on how people are feeling --

4 DR. CASALE: Mm-hmm.

5 DR. O'CONNOR: -- whereas health care
6 utilization might help scope it down to the
7 patients with serious illness who would most
8 benefit, and then the pilot might show, you know,
9 positive results as well.

10 DR. CASALE: Okay. Great. Well,
11 appreciate all that feedback.

12 So we could go -- move on to the fourth
13 question about the interaction or the potential
14 conflict between the palliative care team and
15 primary and specialty. In terms of how the model
16 is set up, do you see any potential issues?

17 DR. O'CONNOR: Sure. So I had some
18 questions about how the primary and specialty team,
19 you know, would know that a patient was on this
20 program. You know, there's no requirement for the
21 physicians to certify the patients for it.
22 Presumably, the palliative care team [is]
23 communicating with the primary and specialty care
24 physicians, but obviously, that would be very, very

1 important -- important to make sure that happens.

2 You know, in general, palliative care
3 teams always partner with primary and specialty
4 physicians and are very used to that collaborative
5 relationship. So, I think that's not outside the
6 scope of how this usually works. The palliative
7 care team is never the primary. They are a
8 supportive service in addition to the specialists
9 or the primary care physician. So, I think that
10 part would work.

11 It just would be important to have good
12 communication so that the specialty practice wasn't
13 coordinating care, you know, in parallel and
14 separately and differently than the palliative care
15 team.

16 But in principle, it's very common to have
17 a, you know, a primary care doctor, an oncologist
18 or cardiologist, and a palliative care team, you
19 know, involved in the same case.

20 DR. CASALE: So -- and part of the model,
21 you know, with the palliative care team, is getting
22 this either \$400 or 650 per beneficiary? Then the
23 primary care couldn't bill for like chronic care
24 management and that kind of thing.

1 DR. O'CONNOR: Right.

2 DR. CASALE: So -- do you think that might
3 -- or again, I'm just raising the question. Would
4 that potentially create a conflict, or do you not
5 see that as necessarily a big issue?

6 DR. O'CONNOR: My sense is that these
7 patients are often the most time consuming to do
8 chronic care management for and care coordination
9 for. So, the primary care physician might be
10 absolutely fine with that. There doesn't seem --
11 in the enrollment process, though, there probably
12 needs to be verification that nobody else is, you
13 know, isn't -- is managing the patient in that
14 capacity and just clear -- clear communication with
15 the other physicians with the patient involved.

16 I could see maybe some conflict with some
17 of the oncology practices that are doing the
18 [unintelligible] model. That might be an issue.

19 DR. CASALE: Mm-hmm.

20 Bruce or Elizabeth, do you have any
21 questions before we move on around that?

22 MR. STEINWALD: No. Let's move on.

23 DR. CASALE: Okay.

24 Any comments on then the quality measures

1 in the proposal?

2 DR. O'CONNOR: Sure. Those are on page
3 13.

4 DR. CASALE: Mm-hmm.

5 DR. O'CONNOR: Actually, I like the three
6 categories they showed. I think those categories
7 broadly make sense -- some sort of patient-reported
8 outcomes.

9 You know, it's pretty general, and there's
10 no existing survey that they're going to use. So
11 they'd have to develop that. But we certainly would
12 want some sort of feedback from patients on their
13 care.

14 For completion of care processes, it looks
15 like they only required it at admission. Some of
16 them are a little duplicative. You know, the first
17 and second look duplicative, but I think they look
18 fairly -- fairly thorough.

19 I guess one question would just be whether
20 you would want to repeat them at recertification or
21 periodically rather than just once?

22 MS. PAGE: I want to -- this is Ann. I
23 just wanted to point out that one of the public
24 comment letters that we received commented on the

1 Category 3 measures, the utilization of health care
2 service, and they said these consist entirely of
3 three death-related measures.

4 DR. O'CONNOR: Yeah.

5 MS. PAGE: Died receiving hospice, died
6 receiving hospice for more than seven days, and
7 died but didn't have any days in ICU (intensive
8 care unit).

9 DR. O'CONNOR: Yeah.

10 MS. PAGE: And so they found that, you
11 know, not adequate.

12 DR. O'CONNOR: Yeah. I was surprised they
13 don't -- they don't have anything about -- about
14 acute care utilization or, you know, a quality
15 metric that's being used more in palliative care is
16 number of days at home. You know, that's a
17 patient-centered one that also obviously reflects
18 utilization. These are very death-focused. So ED
19 visits, that's something that patients and families
20 care about. That is also a utilization metric that
21 might be -- might be useful, or nursing facility
22 time, you know, "Are they managing care better so
23 patients don't have to be in a skilled nursing
24 facility?" You know, that might be a valuable one.

1 So, I agree with that comment actually
2 that they could -- they could build this out with
3 some that were less focused on death.

4 MS. MITCHELL: This is --

5 MR. STEINWALD: This is Bruce.

6 Let me point out on page 32 of the
7 responses to our questions, they -- what they say
8 is they expect the percentage of patients who go
9 into hospice would be increased. Those that
10 weren't there for more than seven days increased,
11 and those with days in the ICU decreased. But they
12 don't have any particular targets for those
13 measures.

14 But they -- the reason that they included
15 them is that they -- they expect a difference from
16 what you see in standard care in directions that
17 they think are appropriate. And, so that gives a
18 little bit more content to why they included these
19 measures. But, I wonder if you have any reaction
20 to their -- I know you said they could include
21 other utilization measures that weren't death-
22 focused, but do you think it's a good idea to
23 include these, given that they hope to see a change
24 in the -- in the percentages of those three

1 measures?

2 DR. O'CONNOR: I think these three are
3 appropriate, and it -- certainly, tracking hospice
4 is important to make sure that this model doesn't
5 actually discourage or prevent patients from
6 transitioning to hospice in an appropriate way.
7 And it is a -- it's not the goal, but it is often
8 the side effect of having more discussions around
9 advanced care planning and goals of care.

10 We know most patients would prefer not to
11 die in the hospital. So, I think they -- I think
12 they're reasonable to track.

13 It's hard to set -- set metrics because
14 these particular measures vary greatly regionally
15 and even, you know, within communities, but vary
16 much regionally, and also between different patient
17 populations and groups. There's -- there's, for
18 example, there's [a] big cultural difference in the
19 hospice utilization. So it's hard to set a target,
20 you know, a benchmark.

21 MR. STEINWALD: Okay. Thanks.

22 DR. CASALE: Okay. Great. The -- it's
23 the last one --

24 MS. MITCHELL: Excuse me. Paul?

1 DR. CASALE: Yeah?

2 MS. MITCHELL: Do you mind if I go back
3 just a little bit?

4 So our -- Do you think there are key
5 measure gaps that we should prioritize?

6 DR. O'CONNOR: Measure gaps. So, I think
7 more utilization outcomes that are about, you know,
8 unwanted acute care.

9 MS. MITCHELL: Yep.

10 DR. O'CONNOR: I think that's important,
11 actually. Maybe even skilled nursing facility or ED
12 care. That seems like a significant gap to me.

13 DR. CASALE: Okay.

14 MR. STEINWALD: Just -- this is Bruce.
15 Just want to make sure we understand. The measures
16 of unwanted utilization, such as skilled nursing
17 and hospitalization. Did I hear that right?

18 DR. O'CONNOR: Well, this is just a
19 snapshot, but these are measures right before
20 death. I think you'd want to also know acute care
21 utilization for ED visits or skilled nursing
22 facility days, you know, that [unintelligible] they
23 would want to have time at home.

24 MR. STEINWALD: Mm-hmm.

1 DR. O'CONNOR: Some programs have tried to
2 have a metric for goal concordant care, meaning,
3 "What does the patient want and then how does that
4 compare with what they get?" But that's really
5 difficult. That's very, very difficult to track.

6 MS. MITCHELL: But -- this is Elizabeth --
7 I would like to, if the group agrees, to at least
8 note that that might be preferable or optimal, even
9 if we note the challenge of implementation.

10 DR. O'CONNOR: Yeah. I mean, optimal
11 would be goal concordant care and then --

12 MS. MITCHELL: Yeah.

13 DR. O'CONNOR: -- time at home or time --
14 time in the patient's preferred location. Those
15 are the most patient-centered utilization goals.

16 MS. MITCHELL: I think those would be
17 really great to at least identify.

18 DR. O'CONNOR: Yeah.

19 DR. CASALE: Yeah. No, no. I agree.
20 Because in fact, several of their quality measures
21 are sort of in -- you know, in development, anyway.
22 You know, they're not all established.

23 So, highlighting what we think would be,
24 you know, sort of more ideal measures, I think

1 would be great.

2 MR. STEINWALD: This is Bruce. I agree.

3 DR. CASALE: Any other questions or
4 comments?

5 But thanks, Elizabeth, for that on the
6 quality measures.

7 DR. JAIN: Can I ask -- yeah. Can I ask a
8 question?

9 DR. CASALE: Yes, of course.

10 DR. JAIN: Is there -- in practice, is
11 there a psychological kind of impact of going --
12 like let's say this was a time-limited benefit. Is
13 there like a family, or a patient impact, of going
14 kind of off and on of a palliative care kind of
15 benefit that would need to be accounted for, or is
16 that less of a concern?

17 DR. O'CONNOR: No, that's actually a
18 really important question.

19 So we see this. We have a community-based
20 palliative care program that is paid under the home
21 health benefit that uses nurses and social workers
22 that way. And when the patients no longer qualify,
23 they have to be discharged or transitioned to other
24 services. And patients and families get extremely

1 attached to their palliative care team because, in
2 many ways, it's such patient-centered care, and
3 it's extra support for the caregivers. And so, you
4 know, it is difficult if you have something that's
5 going to -- that's time-limited or that patients
6 might go on and off, which gets back to trying to
7 select the right patients up front, you know, maybe
8 even picking patients a little bit more downstream
9 so that you wouldn't take patients on and off it a
10 lot.

11 It's why patients who get discharged from
12 hospice actually struggle with that transition
13 because they're used to this extra support -- the
14 24-hour availability. So, I think that is a
15 consideration.

16 DR. JAIN: Is there a way to sort of
17 account for that as one of the -- I don't know that
18 a quality measure is really appropriate. But like
19 how would you recommend sort of building that kind
20 of sensitivity into the model?

21 DR. O'CONNOR: Right. I think a best
22 practice would be to -- best practice would be for
23 the palliative care team to identify alternative
24 community resources. If a patient's being

1 discharged, you know, if they need additional
2 behavioral health services or they need, you know,
3 additional homemaker services or they need a
4 different kind of care coordination, to make sure
5 that there's a requirement if patients are
6 discharged for appropriate planning.

7 I don't know how you would measure that,
8 but --

9 DR. JAIN: Yeah.

10 DR. O'CONNOR: -- it might be worth just
11 mentioning even in the model.

12 Dr. JAIN: Okay.

13 DR. CASALE: Okay. Great. Thank you.

14 So, in terms of the potential for gaming
15 in the model, the bit around complexity and such,
16 do you think that there are sort of safeguards --
17 well, I guess I'm just looking for your view on
18 that. As you look at this model, is there risk of
19 gaming, or have they addressed that through their
20 criteria?

21 DR. O'CONNOR: You know, there's -- I
22 think there -- I'm not sure it would be
23 intentional, but there would be -- you know, there
24 would be the possibility of taking some lower-risk,

1 more chronic-condition patients, and the
2 requirement for just one visit a month is fairly
3 low, you know, so you could imagine having some
4 fairly stable patients on for a long time and
5 getting the reimbursement and not needing to
6 provide a lot of services.

7 The way they talk about hospice, where
8 they get the entire payment, even if the patient
9 transitions on the second day of the month, I would
10 hate to think someone would work when the patient
11 transitioned to hospice that way, but I noticed
12 that.

13 MS. PAGE: This is Ann.

14 I just want to call out another letter
15 that we got, a public comment letter, which to me
16 spoke to the gaming issue. And, this was a letter
17 from actually the National Hospice and Palliative
18 Care Organization. And, they recommend, "A
19 desirable outcome of this demonstration would be
20 increasing the patient length of stay in hospice.
21 Therefore, we recommend the Committee strengthen
22 this proposal by measuring the percent of patients
23 who died in hospice and setting the benchmark
24 higher than the proposed seven days and then

1 further by tying payment to this performance
2 measure."

3 And when I read that, I thought kind of
4 "Holy cow!"

5 [Laughter.]

6 MS. PAGE: You know, that this is a
7 hospice organization saying, "Make more use of our
8 service a performance measure," and of course, they
9 get paid on a per-diem rather than a per-month.

10 DR. O'CONNOR: Right.

11 MS. PAGE: And so that to me was sort of a
12 gaming flag.

13 DR. O'CONNOR: Yeah. You know, I think
14 the strength of this particular proposal is it
15 respects that not all patients will ever want
16 hospice, which is true, and that's okay.

17 We know hospice outcomes, in terms of
18 bereavement, are better with longer length of stay.
19 So, the literature shows that patient families have
20 less complicated grief and bereavement if they're
21 on hospice for more than seven days. So, I think
22 that's where that number tends to come from. And
23 that comes from a literature base of patients who
24 are admitted to hospice and die quickly won't

1 benefit from the bereavement care as much.

2 But I don't think we want to
3 [unintelligible]. I think it's important to keep
4 palliative care and hospice separate. And, to focus
5 on having the goals-of-care discussions and
6 supporting families with advanced care planning,
7 and the side effect of that is usually more hospice
8 because most patients don't want to die in the
9 hospital, but -- I don't know that you'd want to
10 link payment to hospice length of stay.

11 DR. CASALE: Yeah. Okay. I know we've
12 gone through the list.

13 Bruce or Elizabeth or Ann or others on the
14 phone, do you have other questions for Dr.
15 O'Connor?

16 MR. STEINWALD: It's Bruce.

17 I don't, but I certainly do appreciate,
18 once again, the time that you've spent with us.
19 It's extremely helpful.

20 MS. MITCHELL: Agreed.

21 MS. PAGE: This is Ann.

22 I have a question. I keep grappling with
23 the prognosis component that has appeared now in
24 both of these palliative care proposals, and it

1 seems like the prognosis issue has two parts to it.
2 One, is the clinician trying to prognosticate
3 prognosis, and then the other part is communicating
4 to the patient. And, if this were just a patient-
5 provider relationship, I'd say it's sort of none of
6 our business. But then I worry, that said, about
7 regulating and having to have programs that are
8 going to mandate certain things.

9 And the little bit of literature that I
10 was able to see -- and the most recent meta-
11 analysis, I found was 2010, so granted, that's
12 outdated -- but, that most patients seem to want to
13 hear this in qualitative rather than quantitative
14 terms like, "You have a very serious life-
15 threatening illness," rather than "You have six
16 months left to live," and that they wanted it sort
17 of communicated in positive terms like, "Twenty
18 percent of people live more than five years,"
19 rather than, "Eighty percent of people die within
20 five years." And of course, this is all very, very
21 individualized, you know, about patients.

22 So, I guess I want to hear what does the
23 community, the clinical community -- what is --
24 what is the evidence base that is evolving, or what

1 is the evidence base around what patients want to
2 know about prognosis, and are there practice
3 guidelines out there for talking with patients
4 about this?

5 DR. O'CONNOR: That's a good -- a good
6 question, and certainly palliative care proposals
7 like these that would communicate a prognosis or
8 require a prognosis, that needs to be a
9 consideration. This one doesn't.

10 So, I think that the literature shows that
11 patients don't understand numeric prognoses very
12 well. So the 30 percent of patients die within six
13 months doesn't -- doesn't have -- doesn't -- isn't
14 meaningful and is often really misunderstood.

15 Patients often think of prognosis more in
16 terms of function, and so there's developing work
17 in palliative care on alternative kinds of
18 prognoses. You know, something like, "I'm worried
19 that this may be as strong as you [will] feel and
20 that things could get harder," for example.
21 Patients can internalize that, and that's a useful
22 kind of prognosis. Or, "I'm worried that you might
23 get sick quickly and unexpectedly," you know, that
24 kind of simple -- or simple statement.

1 We've been talking an hour about how hard
2 it is to prognosticate based on time, and so if a
3 clinician gives a time-based prognosis and if
4 they're wrong, the patients often anchor to that,
5 and that can cause a lot of distress. You know, if
6 a doctor gives a time-based prognosis and then they
7 outlive that, it makes them skeptical, and it can
8 cause a lot of psychological harm.

9 So, I don't know that there's any practice
10 guidelines, but there are evolving training tools
11 for clinicians and literature based around these
12 alternative ways of talking about prognosis and
13 even thinking about prognosis with patients that
14 help them make the preparations they need in their
15 life, without necessarily pinning a number down
16 that's hard to get in many ways outside of the
17 cancer community in practice.

18 MS. PAGE: Thank you. That's really
19 helpful.

20 DR. O'CONNOR: Sure.

21 DR. CASALE: Just one other additional
22 question. About these payment amounts, I wondered
23 if you had any thoughts, you know, the \$400 and
24 650. I mean, they referenced that they -- they

1 referenced this Four Seasons Compassion for Life
2 project, and then they -- and then they got input
3 from the -- from their task force that developed
4 the model. So, I -- I just wondered what your
5 reaction was to those amounts?

6 DR. O'CONNOR: You know, I think if a
7 patient was fairly stable and didn't have high
8 health care utilization or a lot of psychosocial
9 distress, that probably would be -- would be
10 generous and would work well. If somebody was
11 going in and out of the hospital a lot and the
12 palliative care team was tracked -- to get on top
13 of it, you know, they might need several visits per
14 week, or phone calls, to really manage that
15 situation. Obviously, that's -- that's at the
16 other end of the -- of the extreme.

17 I think they got -- they got input from --
18 they got input from --

19 DR. CASALE: Well, they mentioned the
20 Innovation Award, this Four Seasons Compassion for
21 Life project at Duke --

22 DR. O'CONNOR: Yes.

23 DR. CASALE: -- which -- well, I just
24 wondered because, you know, it seemed, as you've

1 already referenced, you know, they only need to
2 contact the patient at a minimum -- or, you know,
3 just at least once a month --

4 DR. O'CONNOR: Right.

5 DR. CASALE: -- et cetera. So, yes, there
6 certainly could be variability. But you can
7 imagine, as you just said, [unintelligible] there's
8 a relatively stable person who fits the criteria --

9 DR. O'CONNOR: Right.

10 DR. CASALE: -- those dollar amounts would
11 seem -- but again, to me they would seem like a
12 lot, but I was really looking for your -- your
13 thoughts.

14 DR. O'CONNOR: Yes. I actually thought
15 more than -- the one visit per month was low, that
16 that was -- that that was low. Then it would be
17 difficult to manage in many of these patients with
18 that. That it would take a lot more touches to --

19 DR. CASALE: Mm-hmm.

20 DR. O'CONNOR: -- really case-manage this
21 group of patients, unless you were taking all sort
22 of chronic care, stable patients. I think that --
23 that number of touches per month, is low for a
24 palliative care patient.

1 DR. CASALE: Yeah. Okay.

2 Great. Well, if there are no other
3 questions from anyone else, I again want to thank
4 you. You've been extremely helpful, as you were
5 with the C-TAC model, and so we appreciate your
6 time and thoughtful review of the model. So, thank
7 you very much.

8 DR. O'CONNOR: Thank you.

9 MS. PAGE: Thank you.

10 [Whereupon, at 10:55 a.m., the conference
11 call concluded.]

12