

April 14, 2017

**Response to the Preliminary Review Team Questions
Regarding Proposal for a *Physician-Focused Payment Model: Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model***

Attached, please find a submission from the Coalition to Transform Advanced Care (C-TAC) for questions 5-12 from the Preliminary Review Team.

If you have any questions related to the submission, please contact:

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Responses to the Preliminary Review Team Questions Questions 5-12

Section 1. The ACM Entities

5. Please identify the responsibilities of the entities that will implement an ACM.

The ACM is a defined service delivery and advanced alternative payment model. ACM entities are organizations that will assume primary responsibility and accountability for fulfilling the requirements of the ACM care delivery and alternative payment model. The ACM entities, on their own or through agreement(s) with physicians, other PFPM eligible professionals, and/or participating organizations, are able to deliver the full range of ACM services and meet all ACM requirements. These entities have the responsibility to:

- (1) Be accountable for all ACM services and requirements,
- (2) Serve as the primary point of contact for the ACM, including primary participant for the ACM APM
- (3) Assure the full range of required ACM services are offered,
- (4) Submit all required reports and documentation associated with the ACM APM for the Quality Payment Program, including physician or other eligible professional reporting,
- (5) Enter into services and payment agreement(s) with physicians, other eligible professionals, and/or other health care organizations involved in provision of ACM services,
- (6) Receive and distribute the ACM payments in accordance with agreements between the ACM entity and participating physicians, other eligible professionals, and/or other health care organizations that may include shared savings or shared risks,
- (7) Pay CMS for any losses according to the ACM shared-risk payment model, and
- (8) Assure feasibility of the ACM entity, participating physicians, other eligible professionals and/or other health care organizations to assume quality and financial risks.

6. What are the necessary qualifications, capabilities, and functionalities required of an ACM entity?

An ACM entity must have the necessary qualifications and capabilities to fulfill the responsibilities and functions described above, in the response to question 5. Core qualifications and capabilities for the ACM entity include:

- (1) The entity must be a Medicare provider with the appropriate PFPM identification requirements from CMS,
- (2) The entity must have a system for administering billing/financial transactions for the ACM APM between the ACM entity and CMS,

- (3) The entity must have a system to distribute payments, shared savings and or shared risks between the ACM entity and participating physicians, other eligible professionals, and/or other health care organizations,
- (4) The entity must have a data system to generate and submit the necessary reports required by the ACM and to share reports generated from the ACM entity and CMS to participating physicians, eligible professionals, and/or other health care organizations,
- (5) The entity must have appropriate licenses to deliver the ACM services, either directly or under arrangements with other providers, and
- (6) The entity must have a defined network of participating physicians and other eligible professionals with a sufficient underlying advanced illness patient volume. A minimum ACM patient volume is required so that the ACM entity can have sufficient power to measure statistically significant differences between the financial performance of the ACM and its spending target. CMS can consider setting the minimum patient volume threshold at a level projected to detect at least a 4% difference in total cost of care in the last year of life, which represents the minimum savings and loss rate for the ACM.

Below are three diagrams to illustrate various ways an ACM entity can be organized to meet the ACM requirements; a vertically integrated structure (Diagram A), a collaborative structure (diagram B) or a consortium structure (diagram C). Under each of these structures, the ACM entity at minimum must have the ability to administer the ACM APM, including receiving payments or paying the CMS according to the shared saving or shared risk plan. The ACM entities, by nature, are Medicare provider organizations. On the other hand, there are no restrictions of the types of organizations that can provide purchased services or collaborate under arrangements with the ACM entity. Furthermore, the ACM entity has flexibility in designing the financial arrangements with its participating providers, other eligible clinicians, and/or other health care organizations. Lastly, ACM entity may operate across state lines and priority be given to ACM entity that includes small independent practices and/or rural geography.

Diagram 1. ACM Vertically Integrated Structure

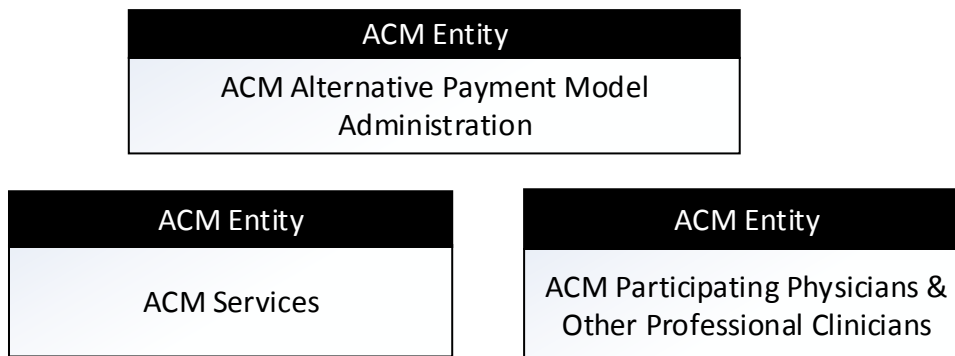


Diagram 2. ACM Collaborative Organizational Structure

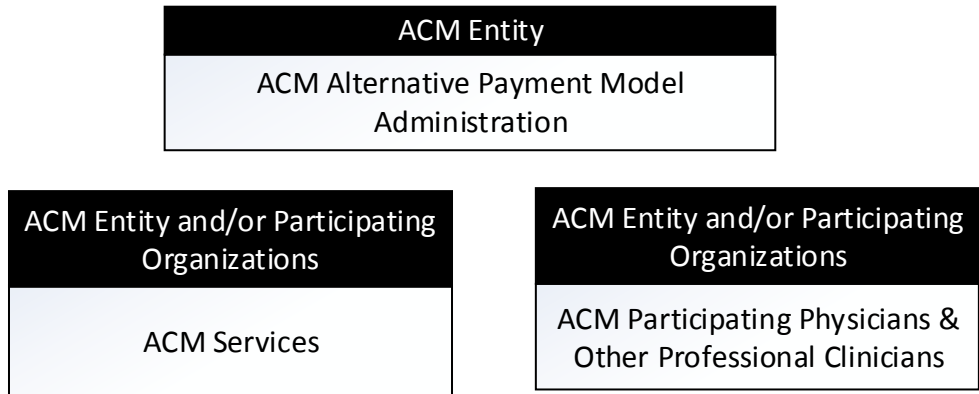
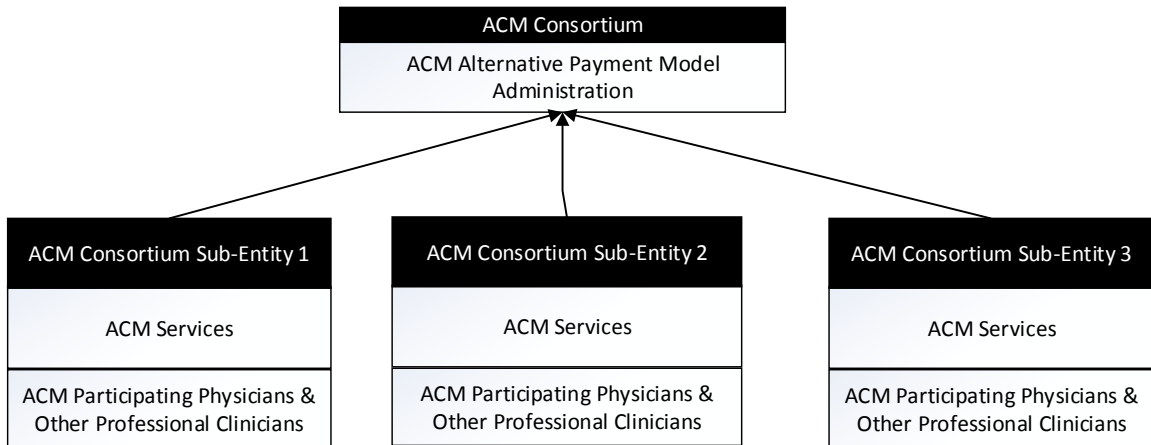


Diagram 3. ACM Consortium Structure



Question 7. How would it be determined who would qualify as an ACM entity?

Organizations that have the qualifications and capabilities to deliver the ACM should be considered as an ACM entity. Furthermore, these organizations must be able to provide the CMS a robust operational plan demonstrating that the organization is prepared to implement the ACM with high degree of model integrity. In reviewing an ACM operational plan, CMS would consider the following:

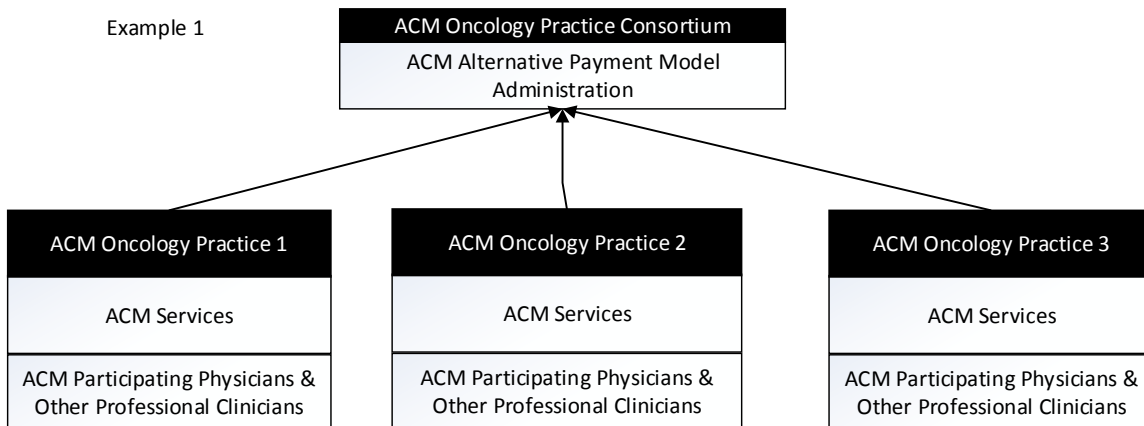
- (1) The ACM organizational structure and rationale,

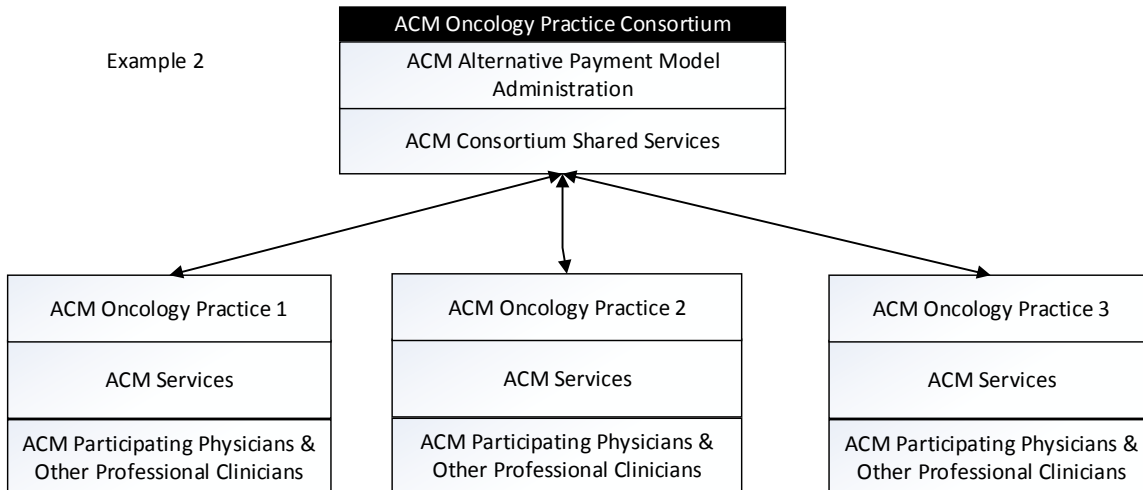
- (2) The ACM entity’s financial arrangements with participating physicians, other eligible clinicians and/or other health care organizations to bear the ACM shared-risk
- (3) The qualifications and capabilities of the ACM entity and participating providers, other eligible clinicians and/or health care organizations,
- (4) An ACM implementation plan that describes how the full range of ACM services will be provided and all ACM requirements will be satisfied,
- (5) An ACM engagement plan for patients, families, and physicians and/or other eligible clinicians,
- (6) An ACM training and ongoing workforce development plan,
- (7) An ACM quality assurance and continuous improvement plan, and
- (8) An ACM risk mitigation plan

Question 8. Please give an example of how small independent practices could aggregate to form a consortium to serve as an ACM entity.

The consortium ACM structure by definition consists of an aggregation of two or more small ACM sub-entities that, by themselves, do not have sufficient ACM patient volume. The consortium structure is comprised of the ACM sub-entities and may include participating health care organizations that provide shared services spanning the sub-entities. The consortium, in the simplest form, is an agreement between sub-entities to participate in the ACM in aggregation (Diagram 4, Example 1). The consortium can also include organizations that provide shared services across sub-entities (Diagram 4, Example 2).

Diagram 4. Examples of Consortium Organizational Structure





We propose that the consortium entity be allowed to operate across state lines and priority be given to consortium models that include rural areas. The CMS can also invest in additional tools to support the success of the consortium structure. Examples of helpful tools include training of the ACM services workforce and access to a CMS registry for data collection and reporting.

9. How is this proposed model different from what an ACO is trying to do to improve the management of patients at the end-of-life?

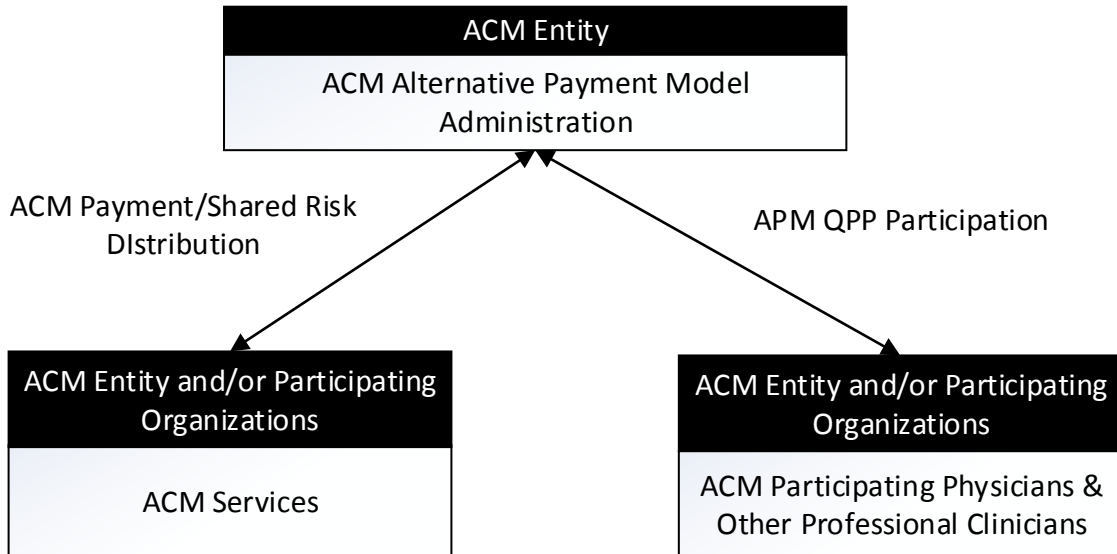
The ACM is specifically designed to improve care and quality for advanced illness beneficiaries. The ACM’s primary opportunity is for the majority of advanced illness Medicare FFS beneficiaries who are not attributed to an ACO. Secondly, it is designed to also integrate and strengthen existing APMs, including the Medicare Shared-Savings Program or the Comprehensive Primary Care Plus Model.

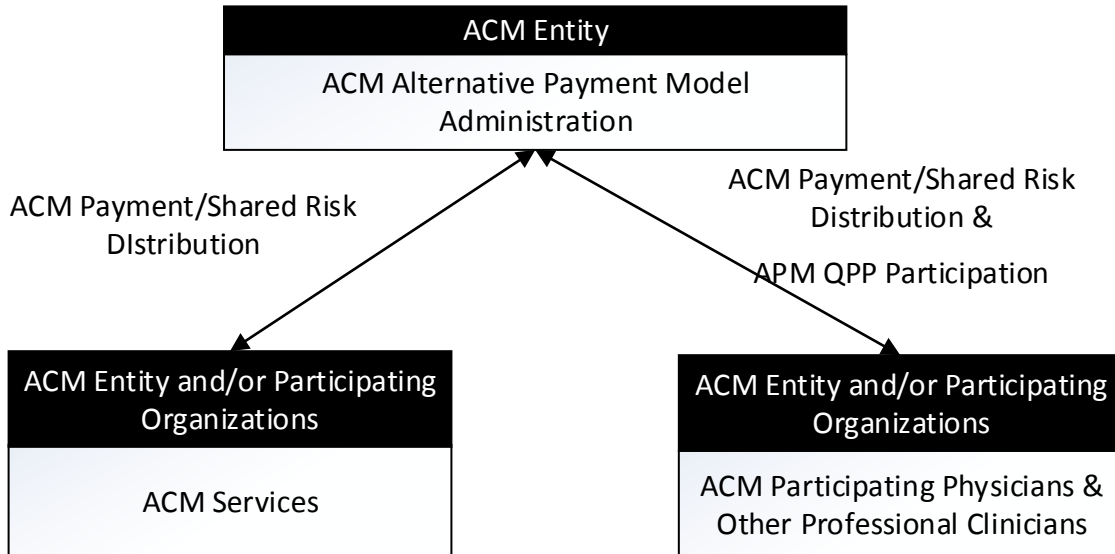
In theory, an ACO is able to organize and deliver the ACM services under the ACO payment model. However, ACOs efforts are limited without a defined set of services, focused payment model, evaluation capability and the availability to benchmark performance with peers. In general, ACOs tend to invest in care improvement activities for a broader group of Medicare patients. It is often challenging for an ACO to invest in extensive services such as the ACM for a small subset of its overall population without upfront payment. Additionally, without a defined program, ACOs don’t have the ability to evaluate its performance or benchmark its efforts. Organic improvement in advanced illness care under the ACO payment model is expected to continue to progress on a gradual basis, with varying efficacy without a formal program. Under the ACM program, the ACO have the option to apply its advanced illness population to the ACM program as well as expand to new advanced illness beneficiaries.

10. What is the compensation structure within the ACM? If savings are not generated and participating providers owe money, what mechanisms would the ACM entity employ to collect these funds?

The ACM entity may take full accountability for the ACM shared risk or distribute the shared risk to participating members. Ultimately, the ACM is responsible for paying the CMS any owed money. If the shared-risk is distributed to participating members, then the participating members are responsible for paying the ACM their share of the losses. Examples of possible financial structure of the ACM are depicted in Diagram 5. Further description of the financial relationships for physicians and/or other eligible clinicians with the ACM entity is provided in the response to question 11, *Components of the Model*.

Diagram 5. Potential Financial Relationships within an ACM Entity





Section II. Components of the Model

11. Page 4 of the proposal states that, “In CTAC’s ACM readiness survey to a representative sample of member organizations over a 3-day timeframe, 100% of respondents indicated interest in participation in the ACM....” Please specify what roles the members were expressing interest in. Were they expressing interest in participating as risk-bearing ACM entities, interest in having their clinicians provide palliative care to beneficiaries, some other role?

The CTAC member organizations include providers and payers. Provider organizations are interested in implementing the ACM model, as the ACM entity. Payer organizations are interested in participating as a payer along with CMS as well as serve as a participating member to an ACM entity.

12. The intervention would consist of “provider-directed interdisciplinary teams” functioning across inpatient, outpatient, and home settings to provide: “comprehensive, person-centered care management including a personalized and evolving mix of ‘curative’ and palliative services; systematic and continuous advance care planning, patient and family engagement, and 24/7 access to a clinician.”

“Comprehensive care management is defined as care coordination and care management of the patient’s total health care needs, both curative and palliative, encompassing all services including provider, hospital, post-acute, and social services.”

The team is to include: at a minimum: “a provider with palliative or hospice care expertise, RN, licensed social worker and may include other clinicians and non-clinicians practicing within their state’s scope of practice licensure.”

- a) The composition of the team and its relationship to the ACM entity is unclear. Will each team include a physician?*
- b) Will there be a clinical leader of the team?*
- c) How will this team work with the patient's primary care provider and any specialist(s) providing ongoing care to the patient?*
- d) Who is clinically accountable for the clinical performance of the team?*
- e) The team must include "a provider with palliative or hospice care expertise." What constitutes "palliative or hospice care expertise?" What standards will be used to assess whether this qualification standard is met?*
- f) What is the relationship between the ACM entity and the interdisciplinary teams providing the ACM services? Are they employees of the ACM entity, employees of affiliated organizations, some other arrangement?*
- g) Who is managerially and financially responsible for the interdisciplinary teams?*

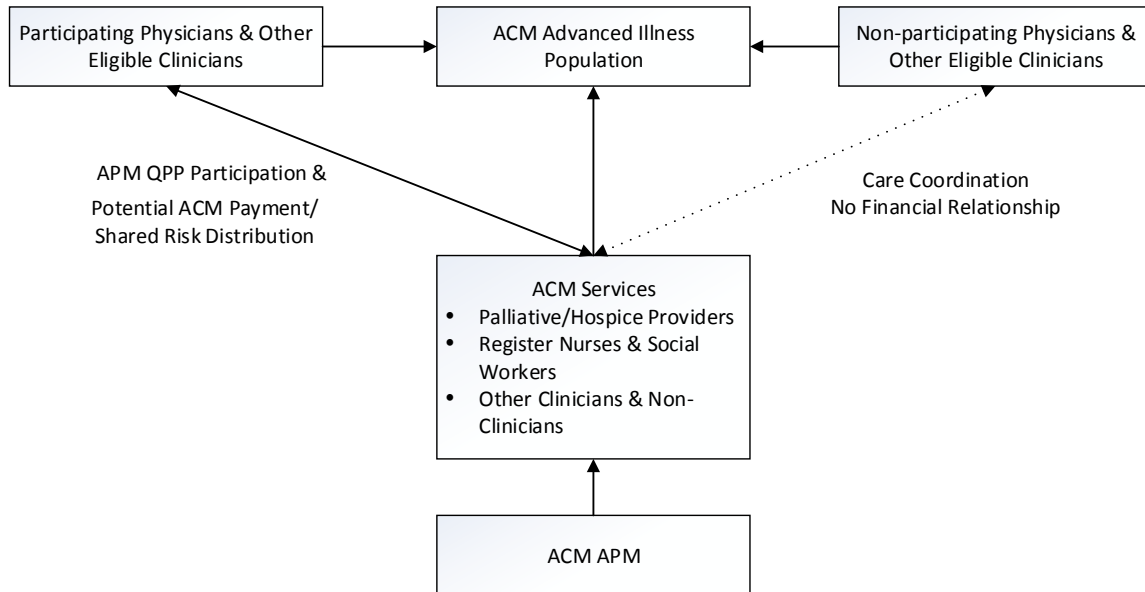
Overview: The ACM care delivery is comprised of (1) the specified ACM service delivery by an ACM care team who collaborates with (2) the patient's participating providers and (3) non-participating providers. The underlying advanced illness patient population of the participating providers represents the target population for the ACM. The ACM care team works with the participating providers to identify these advanced illness patients for enrollment in the ACM. The participating providers, by virtue of their participation in the ACM, can become a qualifying participant in the Quality Payment Program (QPP) Advanced APM track. The participating providers may also arrange with the ACM entity to participate in the ACM shared-risk model. The participating providers assist in the identification of advanced illness patients and are committed to working with the ACM team to improve patient care and quality outcomes.

The non-participating providers are other providers involved in the advanced illness beneficiary's usual care who are not formally aligned with the ACM. While the ACM will coordinate with the patient's active providers including those who do not participate in the ACM, by virtue of their non-participation, these non-participating providers are not eligible for the QPP APM track.

The relationships between the three care delivery components are depicted below in Diagram 6. Palliative care or hospice physicians and other eligible clinicians are a required resource of the ACM team. These ACM physicians and other eligible clinicians' E&M payments will be transitioned to a team-based and value-based payment under the ACM APM.

Diagram 6. Relationship Between Physicians and Other Eligible Clinicians within the ACM

Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model



a) *The composition of the team and its relationship to the ACM entity is unclear. Will each team include a physician?*

The ACM services consist of provider-directed interdisciplinary teams” functioning across inpatient, outpatient, and home settings to provide: “comprehensive, person-centered care management including a personalized and evolving mix of ‘curative’ and palliative services; systematic and continuous advance care planning, patient and family engagement, and 24/7 access to a clinician. The composition of the team must at minimum include a palliative or hospice provider (e.g. physician, NP, PA), register nurse and social worker. The ACM interdisciplinary team may include other clinicians and non-clinician resources such as chaplains, pharmacist and non-clinical health care navigators or coaches as deemed appropriate by the ACM entity. As noted in the previous questions, the ACM entity may employ, purchase, and or develop agreements with other health care organizations to provide the ACM services. Since the ACM entity is responsible for administering the ACM APM, the ACM entity is a recognized Medicare provider. As such, it is expected that the ACM entity is directly involved in delivering a part of the ACM services, although that is not a required function of the ACM entity.

b) *Will there be a clinical leader of the team?*

Oversight of the ACM interdisciplinary team is expected from an ACM physician or eligible clinician (NP/PA) who will function as a clinical leader of the team.

c) *How will this team work with the patient’s primary care provider and any specialist(s) providing ongoing care to the patient?*

The patient’s primary care provider and specialists may relate to the program in two different scenarios: as participating or non-participating providers. Regardless of the

provider's participation status with the ACM, advanced illness beneficiaries have no change to the choices and services available to them. Furthermore, the ACM team will interact with the patient's treating providers to deliver the ACM services including comprehensive care coordination regardless of the treating provider's participation status. The participating treating providers have the following distinguishing elements in the ACM:

- (1) The participating treating providers' underlying advanced illness population represents the target population for the ACM entity,
- (2) The participating treating providers are committed to the Triple Aim outcomes for advanced illness including better experience of care, higher quality and lower cost,
- (3) The participating treating providers are committed to working with the ACM to assist in patient identification,
- (4) The participating treating providers, by virtue of their collaboration, can access the QPP APM track,
- (5) The participating treating providers may participate in additional payment or shared risk from the ACM APM, by establishing such arrangement(s) with the ACM entity
- (6) The participating treating providers may clinically integrate with the ACM entity as deemed appropriate between the participating treating providers and the ACM entity

d) Who is clinically accountable for the clinical performance of the team?

The ACM entity has primary accountability for the ACM performance including the clinical performance. If the ACM services are delivered jointly between the ACM entity and another participating organization, the clinical accountability can be distributed between the organizations involved in the ACM care delivery.

e) The team must include "a provider with palliative or hospice care expertise." What constitutes "palliative or hospice care expertise?" What standards will be used to assess whether this qualification standard is met?

A provider with palliative or hospice care expertise is a provider with a hospice or palliative care certification or who have practice more than half time in hospice or palliative care for at least 3 years.

f) What is the relationship between the ACM entity and the interdisciplinary teams providing the ACM services? Are they employees of the ACM entity, employees of affiliated organizations, some other arrangement?

Described in response to question 12 a, the ACM entity may employ, purchase, and or develop agreements with other health care organizations to provide the ACM services. Since the ACM entity is responsible for administering the ACM APM, the ACM entity is a recognized Medicare provider. As such, it is expected that the ACM

entity is directly involved in delivering a part or all of the ACM services, although that is not a required function of the ACM entity.

g) Who is managerially and financially responsible for the interdisciplinary teams?

Described in response to question 12a, the ACM entities have primary accountability for the financial and clinical outcomes of the ACM. If the ACM services are delivered jointly between the ACM entity and another participating organization, accountability of the ACM services including financial, clinical or managerial performance can be distributed between the organizations involved in the ACM care delivery.

April 25, 2017

Physician-Focused Payment Model Technical Advisory Committee
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**RE: Response to the Preliminary Review Team Questions, Part 2
Proposal for a *Physician-Focused Payment Model: Advanced Care Model (ACM)
Service Delivery and Advanced Alternative Payment Model***

Attached, please find part 2 submission from the Coalition to Transform Advanced Care (C-TAC) for the remaining questions from the Preliminary Review Team. For reference, part 1 submission on April 14, 2017 for questions 5-12 is also attached.

Thank you for the opportunity to provide clarifications on the ACM proposal and your consideration. If you have any questions related to the submission, please contact:

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Response to the Preliminary Review Team Questions Part II

SECTION 1. Questions about the target population and participant enrollment

1. *The proposed model would target individuals in the last year of their life.*

Please:

- a. *Explain why you selected the last 12 months of a patient's life as the principal criterion for who would be eligible for this PFPM;*

Improving care for people in the last twelve months of life is a quality and moral imperative. 25% of Medicare spending is concentrated in the last year of life, and intensive services such as hospitalizations rise exponentially as a beneficiary approaches the last weeks of life.¹ By the time a beneficiary reaches the terminal phase of illness, in the last six months of life, their care becomes more fragmented and intensive rather than holistic, coordinated and person-centered. A beneficiary sees on average 10.5 different physicians and spends 10.4 days in the hospital during this phase of illness.² While hospice care has increased over the years, it often consists of a few days of home-based care preceding death, tacked onto the end of a long siege of intensive inpatient treatment.³ This care is not just costly and fragmented, but largely inconsistent with people's values and preferences. The ACM is designed to specifically address these concerns. Accountable to person-centered care delivery, patient goals, and quality; the ACM provides interdisciplinary care team support for patients, families, and their existing care teams (treating physicians, hospital, and post-acute care) to help this ecosystem become more integrated, coordinated and comprehensive.

There is now mounting, publicly available evidence of the effectiveness of the ACM. Most recently, in March 2017, the Center for Medicare and Medicaid Innovation (CMMI) published in Health Affairs an evaluation of the five most promising models of care that involve physician extenders with a focus in the home from its Round 1 Health Care Innovation Awards (HCIA).⁴ Two of the five models utilize the ACM services interventions: **AIM (Advanced Illness Management)** and **DASH (Doctors Assisting Seniors at Home)**. These two models were the only models that met all of the quality measures as well as significantly reduced inpatient utilization. While DASH serves patients with a one-year prognosis or longer, AIM focuses on a one-year prognosis. Of the five models, AIM produced the most significant reduction in hospitalizations and total health care cost, while DASH did not produce significant savings. Summary of the models and results as published in Health Affairs are provided below in Exhibits 1-4. While patients with greater than 1 year prognosis may benefit from additional APMs, the ACM is specifically designed to address the critical gap in care in the last twelve months of life.

Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

EXHIBIT 1

Description of five home visit models for older adults

Model	Intervention	Frequency	General description	Home visit staff*
ABC (n = 1,244)	Provides individualized and integrated care management through interdisciplinary care teams across 2 sites	Monthly or quarterly home visits	Assesses patients' health status, monitors their medication and adherence, and delivers certain care protocols; offers environmental assessment; serves as a liaison between the patient and other members of the care team	21 lay health workers, 3 registered nurses, 2 social workers
CAPABLE (n = 171)	Delivers a tailored combination of services to older adults who are beneficiaries of both Medicare and Medicaid	10 home visits over a 5-month period	Assesses participants' functional difficulties, pain, depression, and home environment; provides referrals to home and community-based services; and home modifications that allow seniors to age in place	4 registered nurses, 6 occupational therapists, 3 handymen
Stroke Mobile (n = 412)	Provides home-based follow-up care for a year after discharge from hospital after stroke and targeted stroke education for participants and their families and caregivers	Monthly home visits over 1-year period	Offers educational modules to participants and their family members and caregivers to address post-stroke care, prevent additional strokes	3 lay health workers, 4 registered nurses
DASH (n = 1,112)	Offers two-part episodic coordination of care for beneficiaries of Medicare and Medicaid who want to remain at home	Uses home-based assessment by nurses and follow-up by nurse practitioners or physicians	Preempts the need for emergency services while participating in advance care planning, medication reconciliation, receiving referrals for home and community-based services, and confirming a connection to primary care providers	5 registered nurses, 3 nurse practitioners, 2 physicians
AIM (n = 2,922)	Provides care coordination among hospital, home health care, physician's office, and telephone support for patients with late-stage illness at 13 sites within the Sutter Health system by nurse-led teams	Weekly or biweekly home visits over 6-8 weeks	Enables patients to remain at home if they do not qualify for Medicare skilled home health care; during visits provides patient and caregiver engagement and education, advance care planning, medication reconciliation, assessment of patient's health status, navigation services, and referrals for durable medical equipment and home and community-based services	6 registered nurses, 13 licensed practical nurses, 10 social workers

SOURCE Authors' analysis of information gathered by NORC from site visits, interviews, and program materials, as of July 2015. **NOTES** The ns are numbers of beneficiaries receiving home visits for each model. ABC is Aging Brain Care. CAPABLE is Community Aging in Place, Advancing Better Living for Elders. DASH is Doctors Assisting Seniors at Home. AIM is Advanced Illness Management. *Numbers of individuals employed in each position as of July 2015, the end of the innovation period, as reported to NORC by each model.

EXHIBIT 2

Components of five home visit models for older adults

Home visit program	Category of need					
	Care coordination	Patient or caregiver education	Referrals to home and community-based services	Disease management	Advance care planning	Environmental assessment or redesign
ABC	■	■		■	■	■
CAPABLE	■	■	■			■
DASH	■	■	■	■	■	
Stroke Mobile	■	■		■	■	
AIM	■	■	■	■	■	

SOURCE Authors' analysis of information gathered by NORC from site visits, interviews, and program materials, as of December 2015. **NOTES** ABC is Aging Brain Care. CAPABLE is Community Aging in Place, Advancing Better Living for Elders. DASH is Doctors Assisting Seniors at Home. AIM is Advanced Illness Management. See the text for more details on these five models.

EXHIBIT 3

Estimated effects of five home visit models on utilization and cost

Model	Hospitalizations		ED visits		Medicare expenditures	
	Per quarter, per 1,000 patients*	95% CI	Per quarter, per 1,000 patients*	95% CI	Per quarter, per patient*	95% CI
ABC (over a 3-year period)	-4	-14, 6	2	-12, 16	\$ 60	-311, 431
CAPABLE (over a 2-year period)	3	-36, 42	-26	-69, 17	-2,765**	-4,963, -567
Stroke Mobile (over a 2-year period)	-52**	-113, -8	35	-28, 98	2,088	-2,157, 6,333
DASH (over a 3-year period)	-17**	-25, -9	-24***	-36, -12	-316	-745, 113
AIM (in the last month of life, over a 3-year period)	-76***	-100, -51	30***	11, 49	-5,985***	-7,010, -4,959

SOURCE Authors' analysis of Medicare claims from five home visit models for the period 2010-15. **NOTES** The exhibit shows difference-in-differences estimates that compare the pre-post changes in a treatment to those in the comparison group. The estimates are from a generalized estimating equation model with log link and gamma distribution, using population-averaged logit models. A negative number indicates a favorable finding for model beneficiaries, relative to members of the comparison group. The Appendix presents baseline rates of utilization (see Note 14 in text). Significance refers to differences between patients in the model and those in comparison groups. ED is emergency department. CI is confidence interval. ABC is Aging Brain Care. CAPABLE is Community Aging in Place, Advancing Better Living for Elders. DASH is Doctors Assisting Seniors at Home. AIM is Advanced Illness Management. *For Stroke Mobile, "patient" is replaced by "beneficiary episode." †Thirty-day readmissions (the start of the intervention is a hospital admission for a stroke). *p < 0.10 **p < 0.05 ***p < 0.01

EXHIBIT 4

Improved quality of care associated with home visits provided by five home visit models for older adults

Home visit program	Improvement in quality of care			
	Increased self-management confidence	Improved self-management of health behavior	Improved physician communication	Reduced caregiver burden
ABC	■		■	■
CAPABLE	■	■		
Stroke Mobile	■	■	■	
DASH	■	■	■	■
AIM	■	■	■	■

SOURCE Authors' analysis of information gathered by NORC from site visits, interviews, and program materials, as of December 2015. **NOTES** "Improved physician communication" is improved communication between the physician and the patient or another provider. ABC is Aging Brain Care. CAPABLE is Community Aging in Place, Advancing Better Living for Elders. DASH is Doctors Assisting Seniors at Home. AIM is Advanced Illness Management. See the text for more details on these five models.

In addition to the robust evidence behind the proposed ACM services, there is also an operationally feasible, accepted and evidence-based approach to identifying patients with a one-year prognosis, the ACM principal target population. The components of the ACM patient identification criteria such as functional status, nutritional status, surprised question, prior inpatient utilizations, and established performance scales (PPS, KPS, ECOG) have been widely studied and shown to correlate with one-year mortality risk.⁵

b. Provide evidence of the accuracy of clinicians' predictions about when a patient is in the last year of his or her life;

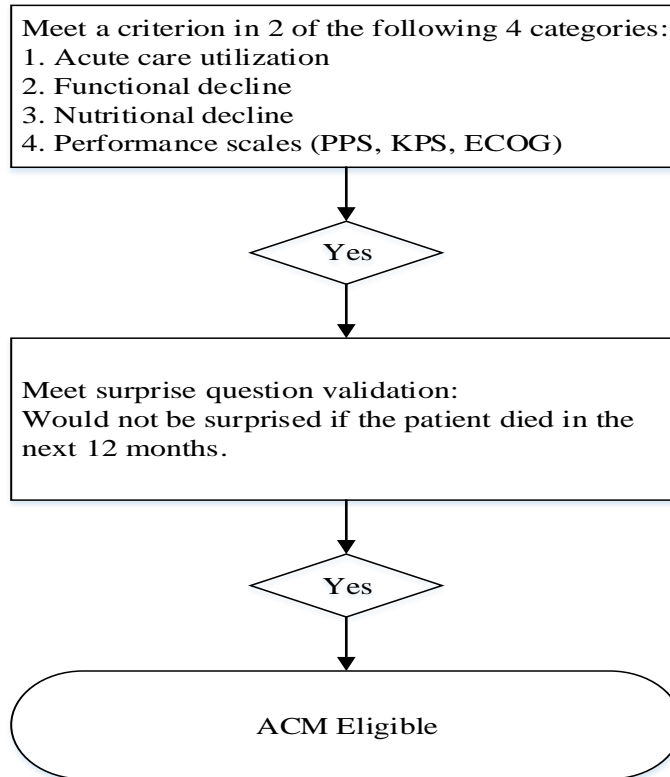
Evidence indicates the accuracy of the ACM eligibility approach to be even higher than the high level of accuracy (88%) shown by the most successful HCIA round one program, as detailed below.

The components of the ACM patient identification and eligibility criteria are

1. Acute Care Utilization,
2. Functional Decline,
3. Nutritional Decline,
4. Performance Scale,
5. Surprise Question Validation

The beneficiary is eligible for the ACM if they meet the criterion in two of the four component categories (Acute Care Utilization, Functional Status, Nutritional Status or Performance Scales) followed by validation with the surprise question, as illustrated in Figure 1.

Figure 1. ACM Eligibility Determination Process



Description of each criterion is provided in table 1 below.

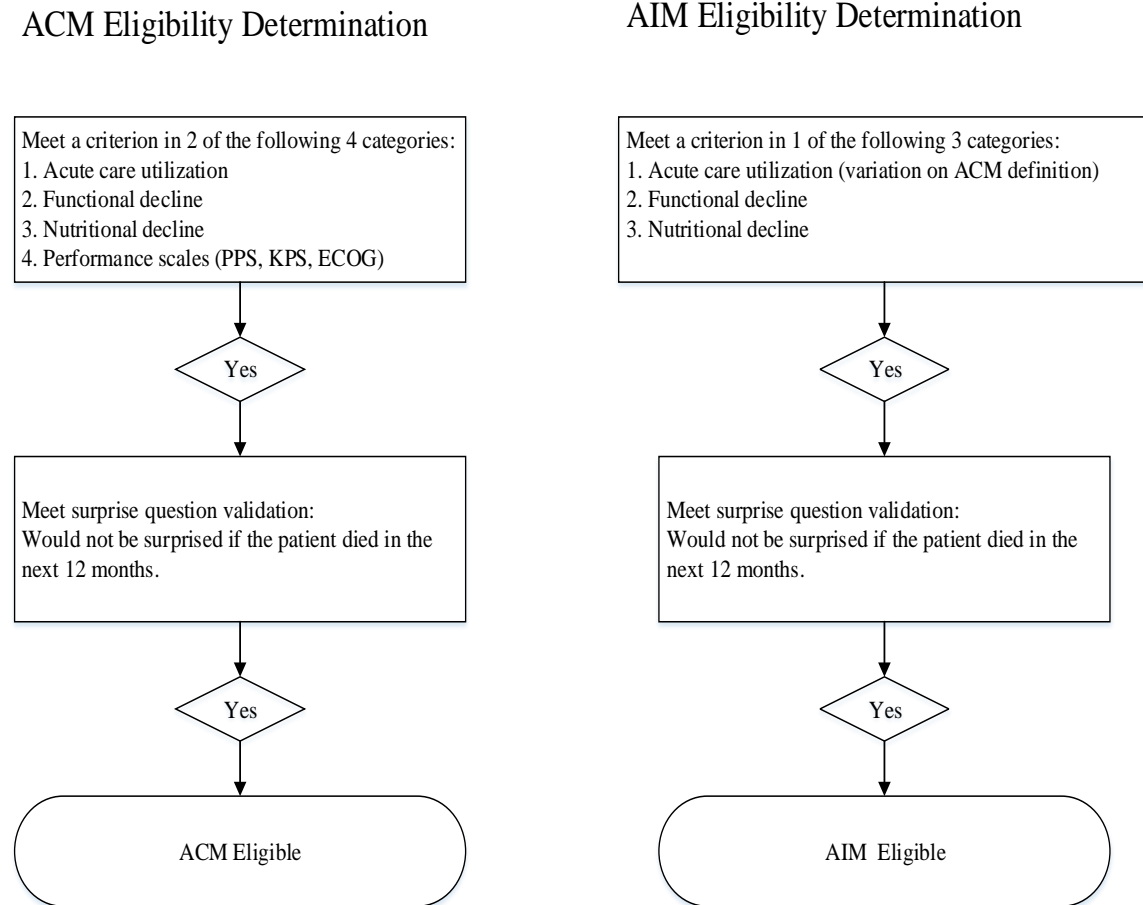
Table 1: Description of ACM Criteria

1) Acute Care Utilization	2) Functional Decline	3) Nutritional Decline	4) Performance Scale	Plus Surprise Question Validation
2 hospitalizations in the last 12 months <i>or</i> 1 ER visit & 1 hospitalization in the last 6 months <i>or</i> 2 ER visits in the last months	New, irreversible dependence in at least 1 ADL in the last 3 months	Involuntary lean body weight loss $\geq 5\%$ in the last 3 months	PPS ≤ 60 <i>or</i> KPS ≤ 60 <i>or</i> ECOG ≥ 3	Would you be surprised if the patient died in the next 12 months?

Each criterion in each category in itself is correlated with increased 1-year mortality risk.⁶ The surprise question alone is a strong validating tool. In a recent meta-analysis in April 2017⁷, for the outcome of death at 6 to 18 months, the pooled prognostic characteristics of the surprise question were sensitivity 67.0% (95% confidence interval [CI] 55.7%-76.7%), specificity 80.2% (73.3%-85.6%), positive likelihood ratio 3.4 (95% CI 2.8-4.1), negative likelihood ratio 0.41 (95% CI 0.32-0.54), positive predictive value 37.1% (95% CI 30.2%-44.6%) and negative predictive value 93.1% (95% CI 91.0%-94.8%). To maximize the specificity of a one-year prognosis, we propose individuals meet two of the four categories above plus the surprise question to become eligible for ACM services.

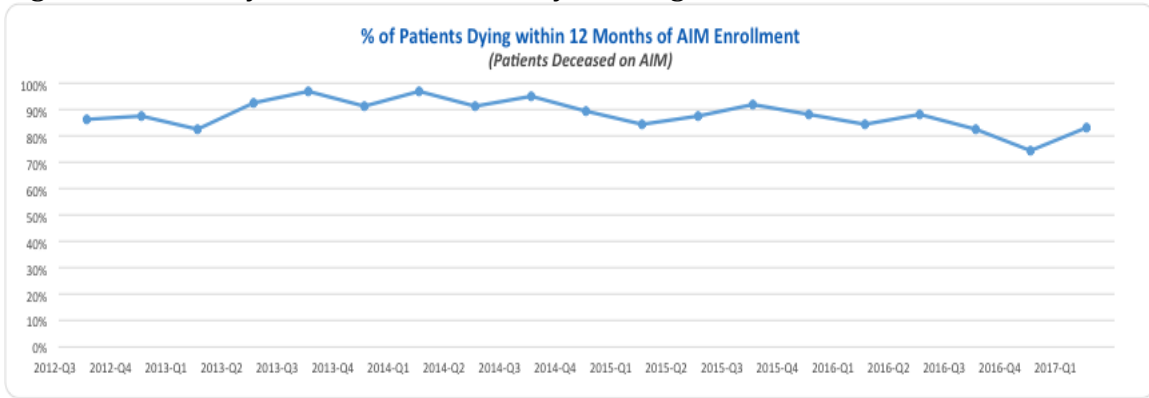
The HCIA Sutter AIM program, which demonstrated effectiveness through a large and diverse health system, utilizes similar criteria, but is less strict than what we propose. Eligibility under the Sutter AIM Model is determined by combining one criterion from three ACM categories with the surprise question. This model utilizes the ACM functional and nutritional criteria and some variations on the acute care utilization category: 2 or more hospitalizations in the last 6 months or 2 or more ED visits in the last 3 months. Figure 2 shows the comparison between the ACM and AIM eligibility criteria.

Figure 2. ACM and AIM Eligibility Criteria



From July 2012 to March 2017, the AIM program served and discharged 14, 832 patients. The program also underwent a dramatic expansion to test scalability for the HCIA. Despite the extraordinary expansion, the accuracy of the clinical predictions remained relatively stable. 88% of AIM patients died within 12 months of enrollment. Only 6.8% of patients were discharged because their conditions have improved significantly that they no longer qualify for the program. Figure 3 shows the accuracy of the AIM eligibility criteria during the 5-year time frame. The ACM criteria are even more conservative than the AIM criteria.

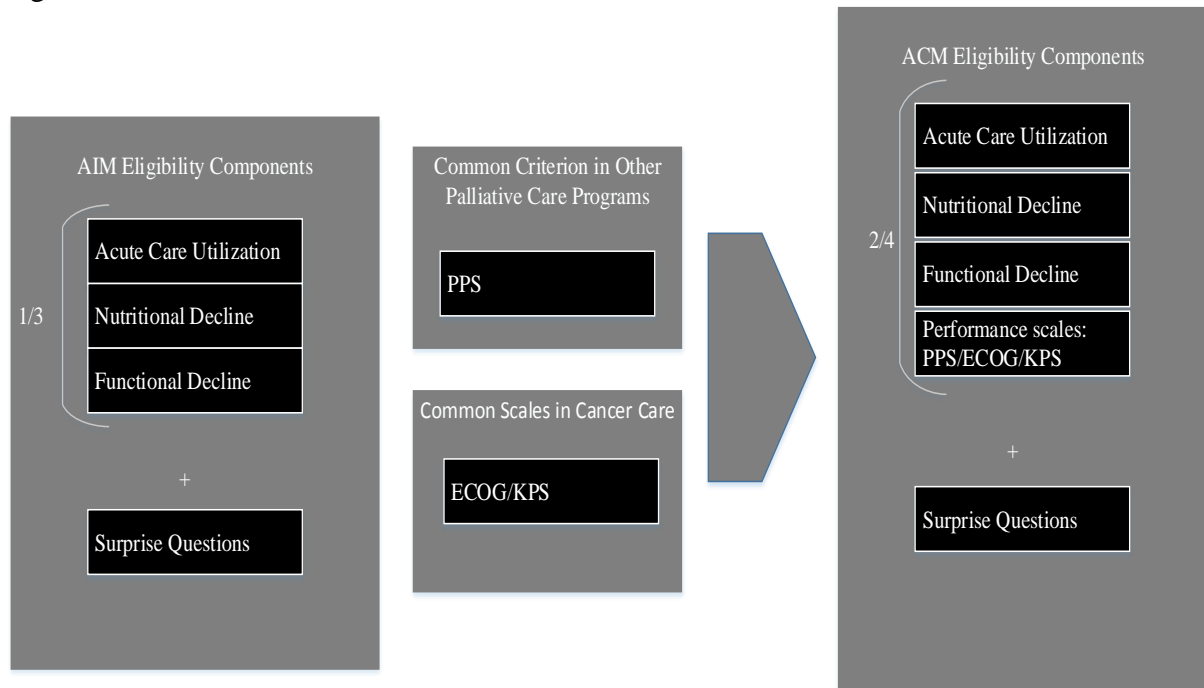
Figure 3. Accuracy of AIM Criteria for 1-year Prognosis



Aspire Health is another large program that applies the ACM services. To assist in this report, Aspire ran an analysis on a sample of more than 1,000 patients using criteria from 2 of the 5 ACM eligibility categories: acute care utilization and PPS performance score. The Aspire Model shows that this combination produces a 1-year mortality rate of 51%. Thus, the PPS scale or equivalents (KPS/ECOG) provides a strong additional criterion.

The ACM eligibility determination process builds on the successful Sutter Health AIM model and provides additional criterion component that are widely used by other similar models (Performance Scales). The ACM combines tested criteria and is stricter in the eligibility determination process to increase the accuracy of the 1-year prognosis over time (Figure 4).

Figure 4. ACM Criteria Context



c. Describe all of the different ways allowed to identify participating beneficiaries. For example, the proposal states on page 2 that:

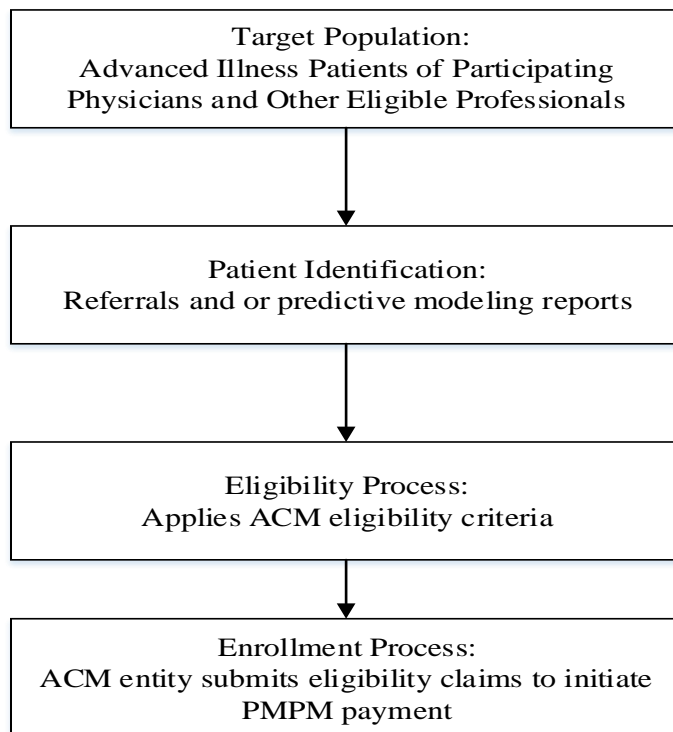
“The ACM may rely on referrals from participating providers or predictive modeling tools for assistance with patient identification.”

In addition, Table 1 states: “To be considered for ACM eligibility, beneficiaries must meet 2 of the following 8 criteria.” Why were these criteria selected and how do they contribute to predicting patient death within 12 months?

We clarify that beneficiaries must meet the ACM eligibility criteria, in order to be enrolled. Please refer to response 1b above for explanation and rationale for the ACM eligibility criteria.

As for the patient identification process, ACM entity can utilize any effective method to identify beneficiaries that may meet the ACM eligibility. Such methods may include: (1) referrals from physician offices, (2) referrals from hospitals or other providers or (3) use of algorithms. However, regardless of the identification process, the ACM entity must have supporting documentation of eligibility for each enrollee. Figure 5 depicts a patient flow from identification to enrollment.

Figure 5. Patient Identification and Enrollment Process



To the extent possible and over time, we recommend that the CMS develops a specific claims code for the ACM claims that could track eligibility criteria. Such enhancement would allow CMS to develop a deeper understanding of the clinical characteristics of the ACM population than otherwise possible. Such monitoring would allow CMS to enhance the evaluation, risk-adjustment, and any adjustment of the eligibility criteria.

2. Page 13 of the proposal states, “to date, state-of-the-art predictive algorithms are capable of identifying under half of the eligible population, while clinical criteria can yield 80-90 percent accuracy.” [Emphasis added.] Are these the same criteria referenced in Table 1? If not, please provide the clinical criteria referred to in this sentence and evidence of their 80-90 % accuracy in predicting death in the next 12 months.

Yes, the clinical criteria refer to the ACM eligibility criteria. Clarification and rationale for the ACM eligibility criteria are described in the response to question 1 above.

3. How will the program be described to potential participants? Will the program disclose to the potential enrollee that the program is for individuals in the last 12 months of their life and that the beneficiary’s provider has attested that such is the case for the potential enrollee?

One of the primary goals of the ACM services is to coordinate with the patient’s physicians and other clinicians to help patients understand their illness and its trajectory. This is a longitudinal and iterative process over time. Until a patient is at a terminal phase, the focus is on helping patients understand their disease process and how to manage their health. Advance care planning discussions in the early phase reflect the stage of illness, and discussions and goal planning focus on future “what if” scenarios. As patients enter into the terminal illness phase, advance care planning goals are revisited and enacted upon, ideally under the trusted support of an interdisciplinary team such as the ACM. Furthermore, patient’s goals may evolve, reflecting changes in patient’s understanding and preferences. Therefore, given the complex nature of prognostication we recommend, rather than using prognostic terminology, that the ACM program be described to potential participants in a person-centered context that includes the following key concepts:

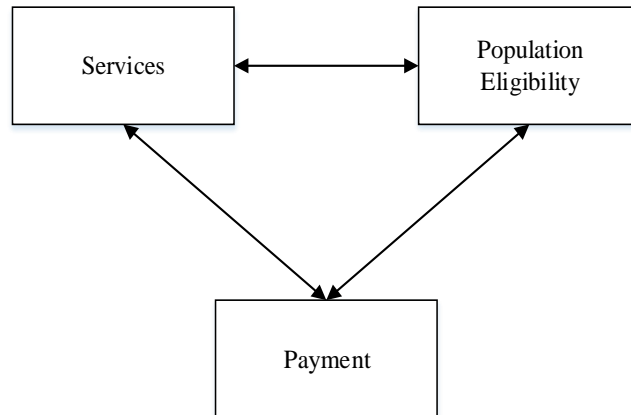
- The ACM is a comprehensive approach to care for beneficiary with advancing illness.
- The ACM provides a team of clinicians and non-clinicians who works closely with your physicians and others to provide additional support to you.
- Because your physician has adopted the ACM in their practice, you have access to these additional services.

This communication approach has been applied to successfully to other Medicare pilots including the Sutter AIM program.

4. Would this PFPM also work for patients with a longer predicted life? If not, why not?

As described in the response to Question 1, the ACM is specifically designed to address the unique challenges and needs of individuals in the last year of life. The services, payment methodology, and population eligibility are intertwined to create an integrated model (Figure 6).

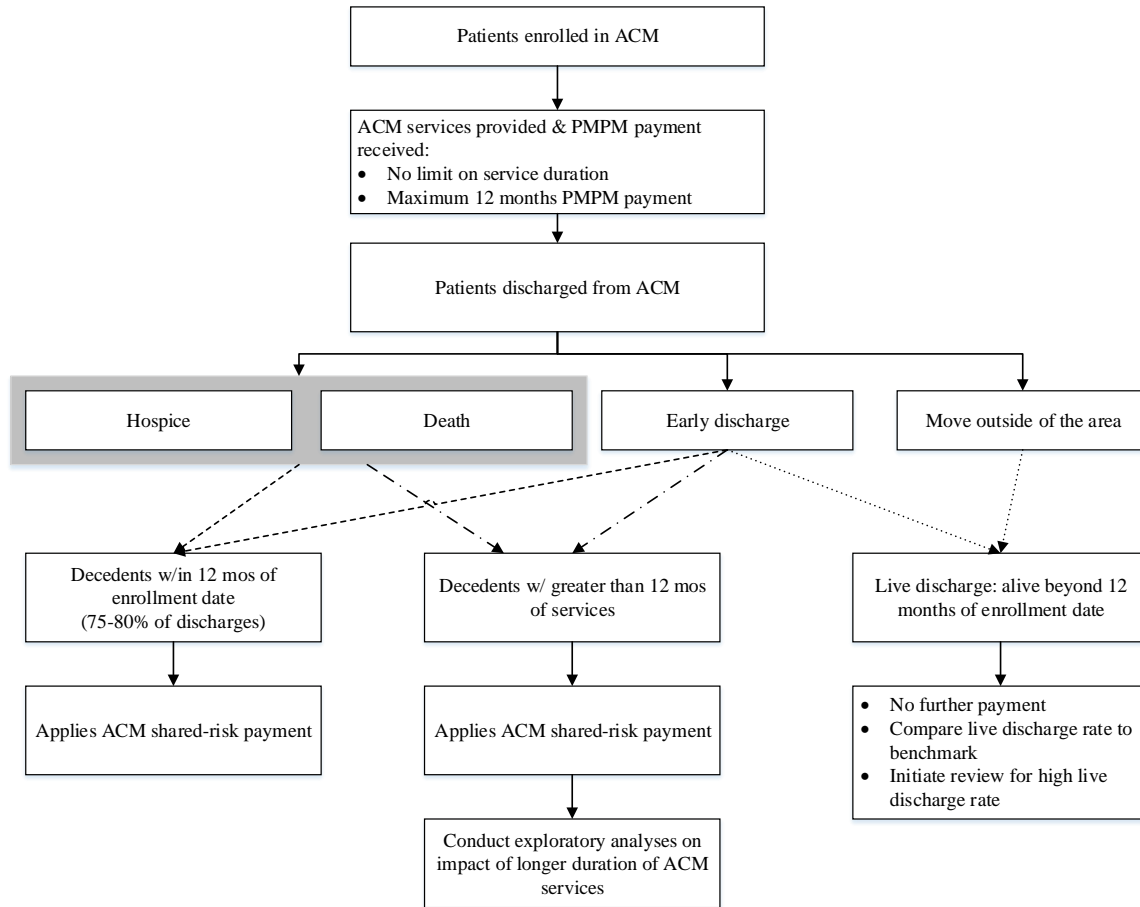
Figure 6. Inter-relationship between ACM components



ACM services in theory could benefit patients with a longer predicted life. For example, patients with a 18-24 month prognosis may benefit from early interventions such as care coordination, symptom management and initial advance care planning. However, the evidence base is not as strong for such application. Secondly, there isn't an available, accepted framework to predict prognosis beyond 1 year that differentiate those with a 18-24 month prognosis from longer length such as 3-5 years.

In our proposal, we anticipate that a reasonable proportion of patients (15-20%) may indeed outlive their one-year prognosis estimate due to the imprecise nature of prognostication. While the ACM has accountability for care in the last year of life and PMPM payment is fixed to 12 months, we provide flexibility for the ACM program to enroll patients for longer than 12 months at no additional cost to CMS in order to begin building evidence for such potential application. Some of these patients may indeed get better as a result of the ACM services while other may simply have an inaccurate prognosis assessment. The ACM program may choose to follow these patients (receiving only fee-for-service payments) who they expect will decline and ultimately will need the ACM in the near term or dis-enroll them from the program. For those patients that are being followed for longer than 12 months, the ACM provides an opportunity to understand the broader impact for patients with a longer predicted life. This approach maintains the core focus of the ACM, while providing the necessary and flexible pathway to test spreading the ACM to a longer time-frame (figure 7)

Figure 7. Patient pathways and relationships to payment



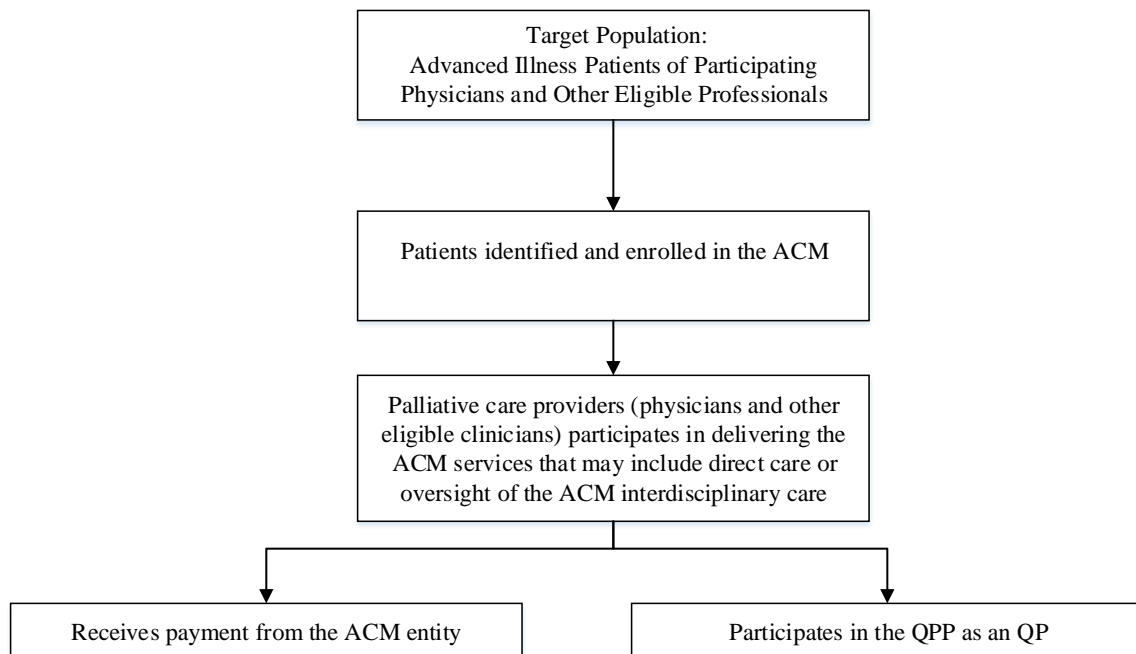
Alternatively, regardless of prognosis, certain patients with serious chronic illness may need intermittent support such as symptom management. Within this context, these individuals may also need other forms of population health including chronic disease management where elements of the ACM are deployed on an as needed basis. Models exist where such development is occurring and may expand as the ACM becomes widely used. Two models that target serious chronic illness high-risk populations are the Comprehensive Primary Care Plus and Independence at Home. We anticipate that additional models will also be proposed through the PTAC to expand payment and delivery options. Both of these models are based on a primary care chassis and future options may create more flexibility for specialty focus while maintaining coordination with primary care. For example, a prevalent symptom management need for serious chronic illness is pain. Pain clinics that utilize the palliative care resources may benefit from establishing a PFPM with such focus. Alternatively, there could be an expansion of the current care management codes to include palliative care management. Such development would support payment for palliative team-based care that can be deployed on as needed basis for wide-ranging patient profiles. Such development and testing must ensure that there is a mechanism to evaluate the impact of such intervention, including the ability to understand the target population.

SECTION II. Questions about payment methodology:

13. The proposal (p. 11) states that, “The ACM consists of PMPM payment and phased-in two-sided risk. The alternative payment replaced FFS payments for palliative care providers....” [Emphasis added]. Please identify the palliative care providers who will no longer receive FFS payments under this model, especially as the abstract states, “The PMPM will cover care management and ambulatory care provider E&M visits.” Would the patient’s current primary or specialty care providers (e.g. oncologist) no longer receive payments for E&M visits? Would this payment model replace payment to a home health agency serving the patient? Please identify all provider types whose payments would be replaced by the new PMPM and share savings/ risk arrangements.

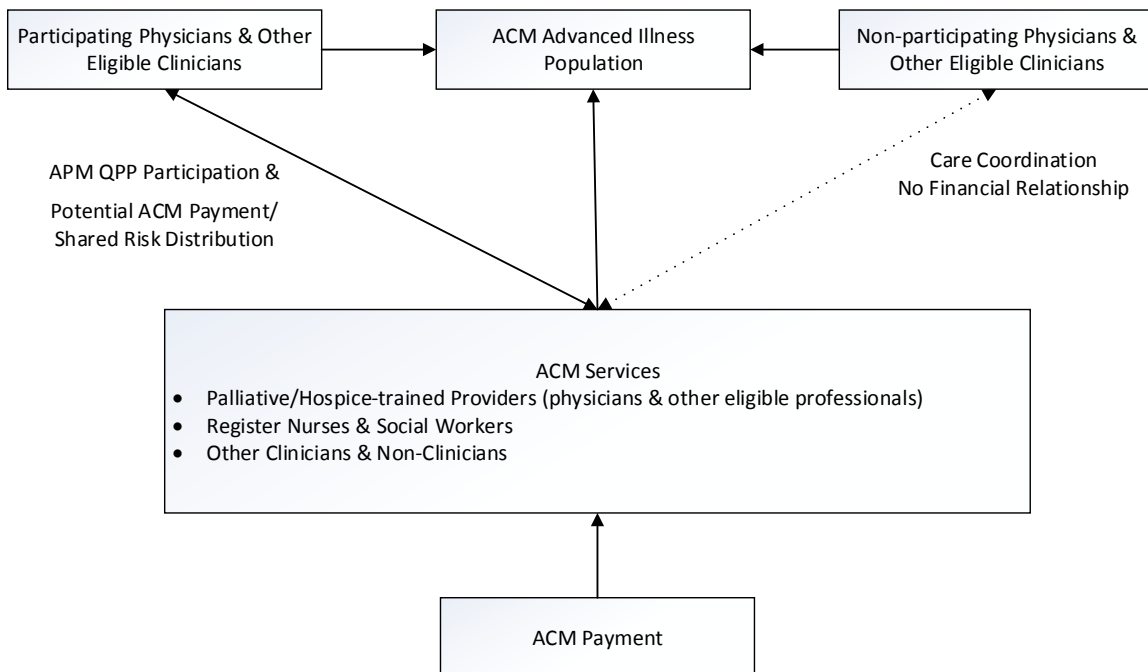
The ACM would replace FFS E&M payments for palliative care providers only. These providers will be pre-identified by the ACM entity, and they will not bill for E&M payments during the ACM enrollment. Figure 8 depicts the role of the palliative care provider.

Figure 8. Role of palliative care physicians and other eligible professionals in the ACM



Other providers such as primary care and other specialists will continue to access the payments that are available for them. The ACM will coordinate with the patient’s providers, including participating and non-participating providers, as described in our response to PRT questions regarding the ACM components (Q5-12). By virtue of participating in the ACM, participating providers such as primary care or treating specialists, will gain the added benefits associated with participating in an advanced APM in the QPP. Additionally, the ACM entity may share risks with these providers (Figure 9).

Figure 9. Relationship Between Physicians and Other Eligible Clinicians within the ACM

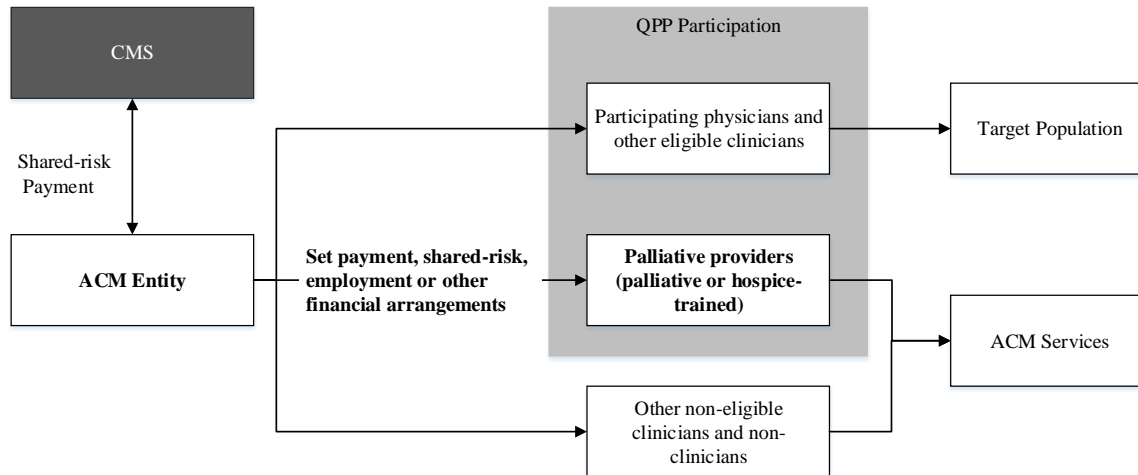


Furthermore, the ACM does not replace other existing reimbursable home-based services such as home health or hospice. Rather, the ACM provides an opportunity to clinically integrate and become financially aligned with post-acute services. We anticipate that there would be natural collaboration between ACM, home health and hospice services to improve efficiency and coordination.

14. How are incentives shared with all provider types whose fee is replaced by the PMPM? What is the split between the ACM entity and the different provider types?

The ACM entity has flexibility to distribute payments and share incentives for the services and organizations involved. Palliative care providers are the only type of physicians or other eligible professionals whose payment is replaced by the PMPM. Their payment and incentives can be set-up in a variety of ways (Figure 10). Payments and incentives can be in the form of a set rate, shared-risk or other financial arrangements.

Figure 10. Financial relationship between palliative care providers and the ACM



15. Page 4 of the proposal discusses a new partial AAPM incentive payment.

a. What is a partial AAPM? Is this defined differently than under MACRA?

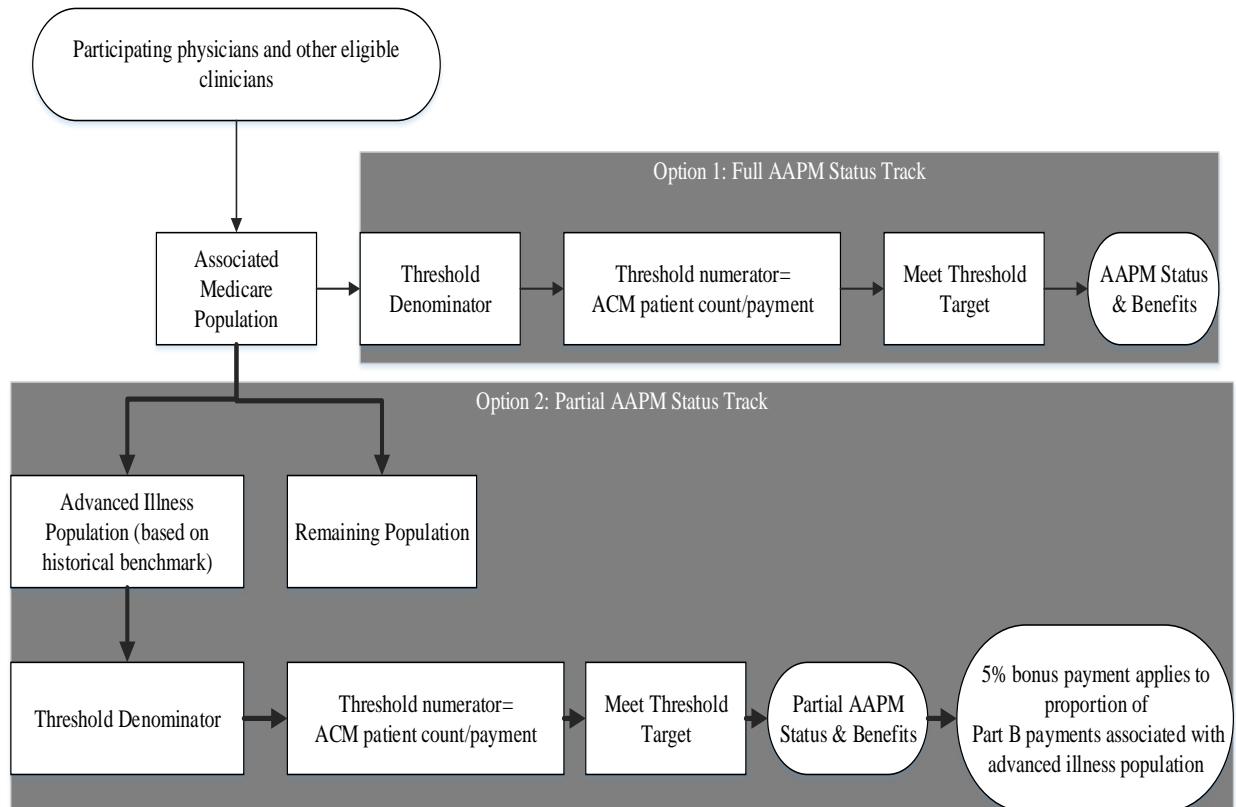
Please provide an example of how this would operate.

We believe a partial AAPM fits within the MACRA’s rules and provisions. MACRA defines the denominator for the QP threshold to be based on “attribution-eligible population”. In the case of an ACO, the attribution-eligible population is the Medicare FFS population. In the case of the OCM, the attribution-eligible population is the subset of Medicare FFS cancer patients that meet the OCM eligibility criteria rather than all Medicare FFS cancer patients. The ACM population represents only about 4% of the Medicare population. If we use the ACM population as the denominator, then the ACM would provide a short-cut for physicians to achieve AAPM status, by simply aligning and focusing on the ACM as the sole APM effort. We believe such an approach would run counter to the threshold requirement whose goal is to incentivize QPs to expand the attributed population. Therefore, we propose two possible ways to define the denominator populations that are consistent with the QP threshold definitions and provide a balanced path for physicians and other eligible clinicians: full or partial AAPM status and benefits.

In the full AAPM definition, the ACM threshold denominator represents the Entity or clinician’s overall Medicare FFS population. In the partial AAPM status, we propose that the denominator is based on the ACM eligible population only. In this scenario, if

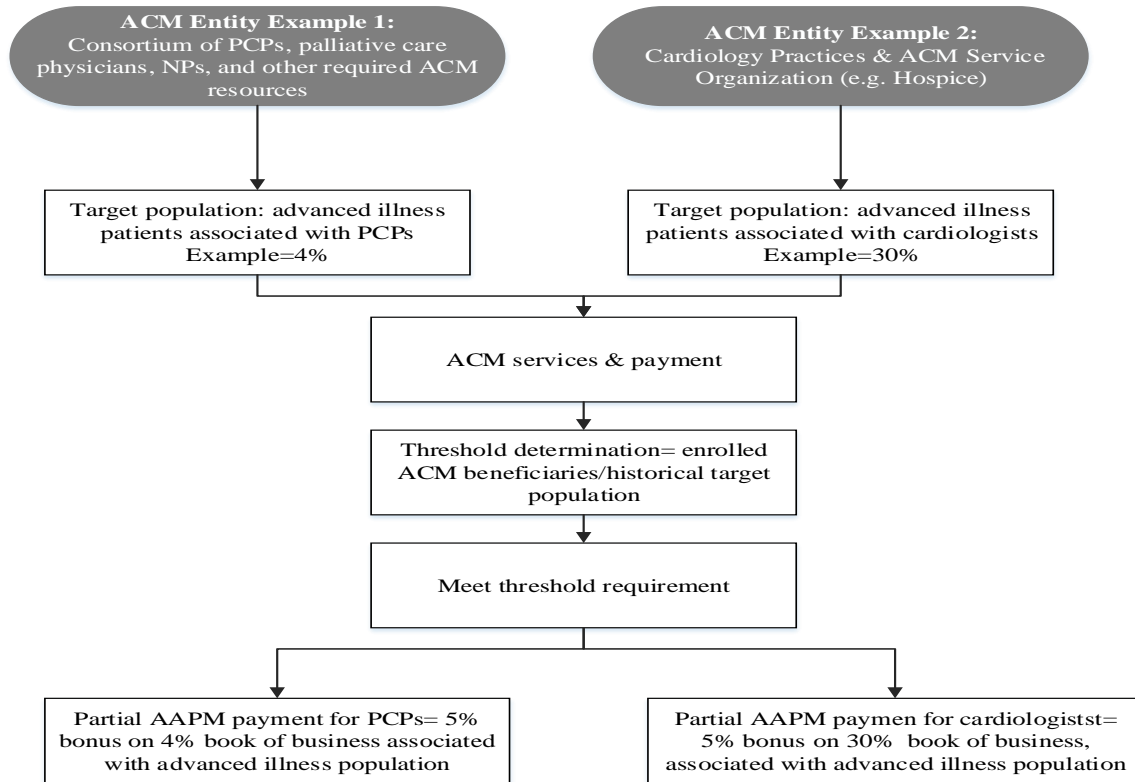
the appropriate threshold proportion is achieved, then the individual QP or Entity would have partial AAPM status and benefits. Quality reporting requirements could be partially waived and financial incentives proportionally applied. For example, the 5% AAPM bonus payment could be applied to the advanced care proportion (patient count or part B payment) of the overall Medicare FFS business (Figure 11) vs. the overall Medicare FFS business.

Figure 11. Full and Partial AAPM Determinations



We anticipate that the ACM partial AAPM option would be utilized for individual QP or Entity where the ACM is the only AAPM. We provide two examples of ACM Entities that may utilize the ACM partial AAPM, as shown in figure 12.

Figure 12. Examples of partial AAPM entity and calculations



16. Page 12 states:

“The ACM shared-risk model will encompass total cost of care in the last year of life (including PMPM fees) and include a 75-85% shared savings and shared loss rate, 30% total savings limit, 10 % total loss limit and 4 % total risk and minimum loss rate.” Please explain what these numbers mean and provide examples of how they would be implemented. Describe how the ACM entity, clinical team, primary care provider and any other treating providers would be affected by either savings or losses.

The ACM has a ramp-up phase to two-sided risk where the first phase applies the shared savings component and 4% total risk or minimum loss rate. The range for the shared-savings and shared loss rates (75%-85%) represents the spectrum of performance on quality scores with the lowest savings rate for minimum quality performance score and maximum savings rate for maximum performance score. The reverse logic is applied to shared loss rates, where high quality score will result in the minimum shared loss rate. The 4% total risk or minimum loss rate represents the proportion of spending that CMS and the ACM entity have full risk. Shared savings and shared losses are triggered once spending is outside of this range (spending target $\pm 4\%$). If the ACM qualifies for shared savings, the payment is capped at 30%, which represents the total savings limit. If the ACM is subject to shared losses, the repayment back to CMS is capped at 10%, which represents the total loss limit.

We provide a series of diagrams to illustrate how the payment model would operate. To begin, a spending target is determined for the ACM entity based on the historical performance of participating physicians and other eligible clinicians as illustrate in Figure 13. Figure 14 illustrates how the ACM shared risk model would be applied, in an example where the ACM entity achieves shared savings and maximum quality scores. In this example, we make the assumption that the ACM Entity is made of up a hospice organization who employs the palliative care physician and resources needed to operate the program. The hospice organization collaborates with 25 primary care physicians. This entity has a projected patient volume and target spend based on the calculations depicted in Figure 14, Spending Target Determination. Continuing from the example provided in Figure 14, we illustrate how the ACM payments could potentially be distributed and how a partial AAPM is applied, based on a financial arrangement example between the ACM entity and participating physicians in Figure 15.

Figure 13. Spending Target Determination

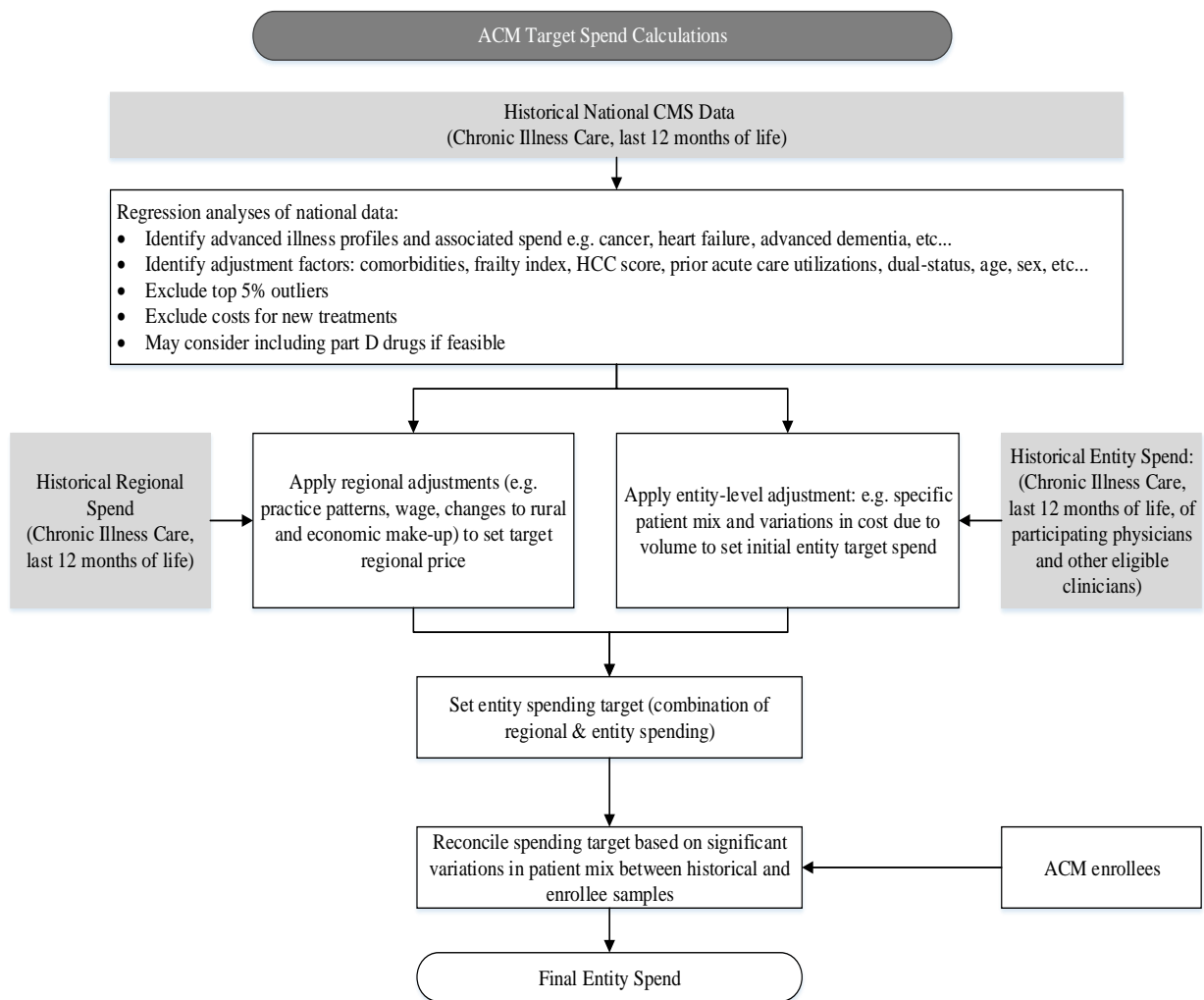


Figure 14. Example of the ACM Shared-Risk Calculations

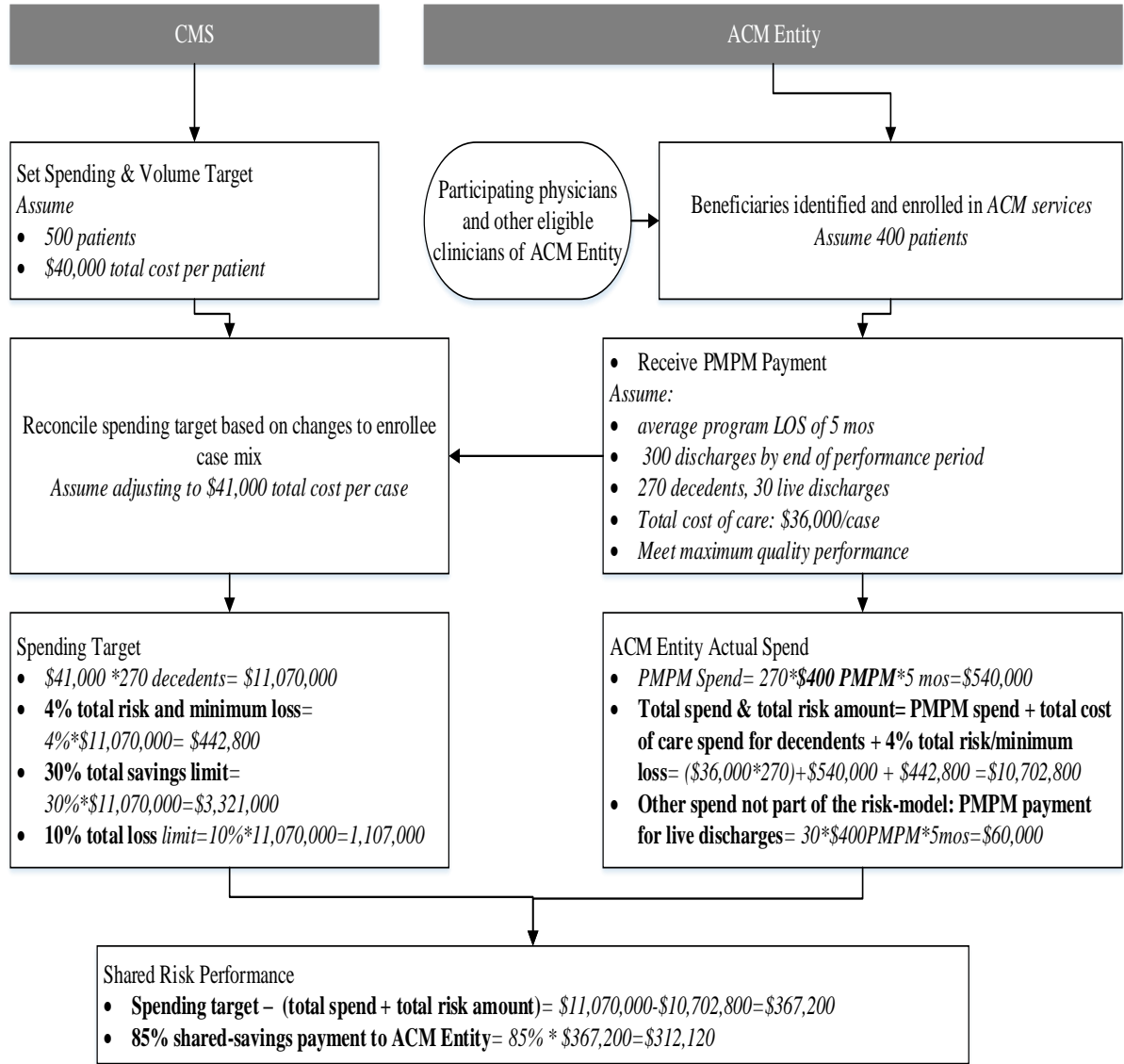
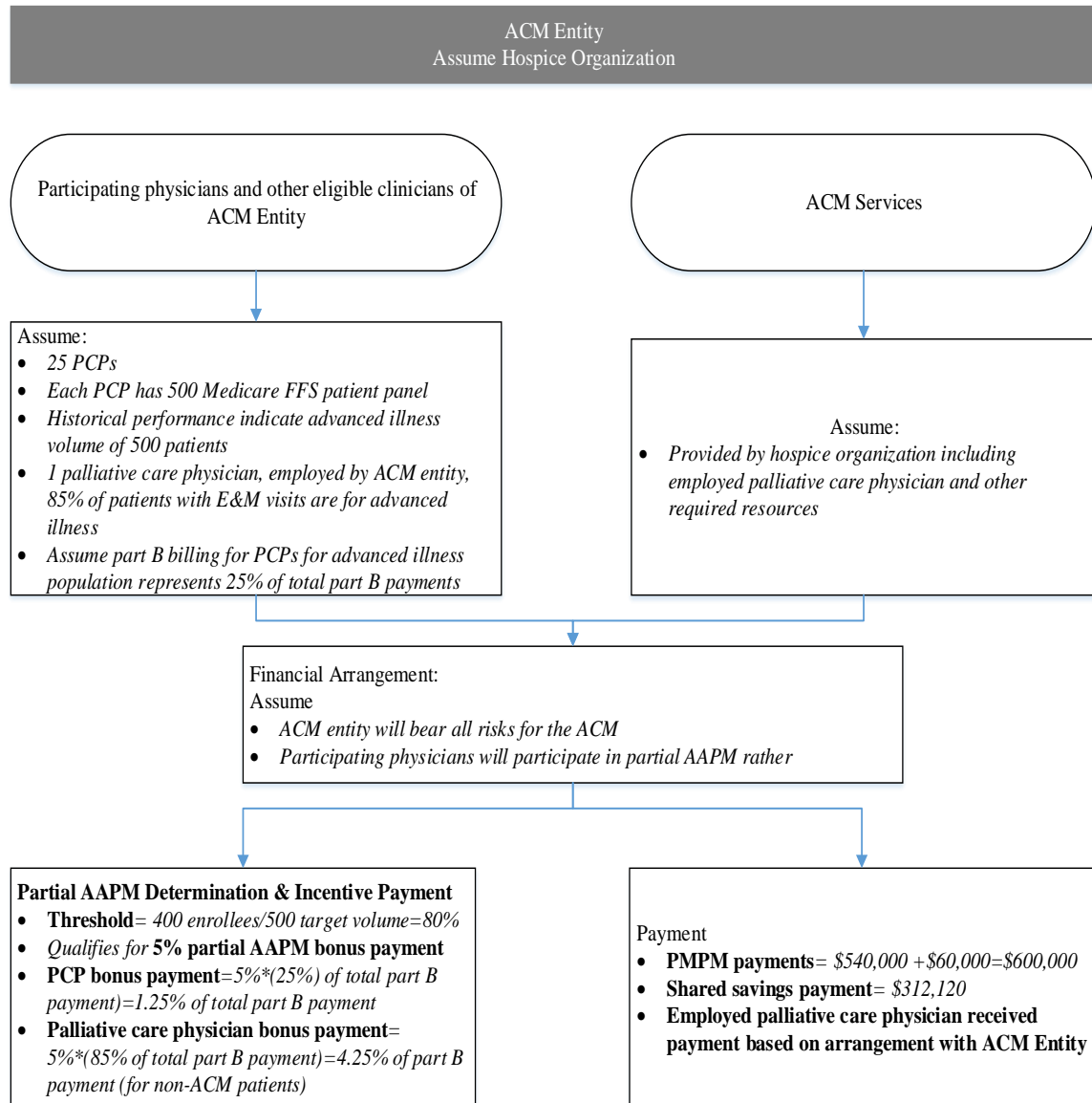


Figure 15. Examples of the financial calculations between physicians and health care organizations involved in the ACM



17. Please explain the rationale and calculations leading to a \$400.00 PMPM.

The rationale for the PMPM rate is to cover the direct costs associated with delivering the ACM services to a target population. Some patients may need more services than other and the PMPM rate represents the average cost. The \$400 PMPM is derived from surveying the direct cost of the ACM services from existing programs such as AIM, Aspire Health, Northwell Health, Aetna, Priority Health, Sharp Health and others. The PMPM payment does not cover the full cost and recognizes that ACM entity must make additional commitment.

18. Please provide examples of how both the spending target and risk-adjusted actual spending will be calculated. In doing so, show how the risk adjustment affects the calculation of savings or losses.

We provide a framework for CMS to establish a financial model to determine the spending target with risk adjustments in our response to Question 16 above, Figure 14, elaborating on the framework in our proposal. The goal of the financial modeling is to ensure that the spending target represents usual care expenditures for the advanced illness population that will instead receive the ACM services. We propose adjustments to account for cost differences associated with regional and ACM entity- specific factors. For example, regional spending for advanced illness in the Manhattan metropolitan area significantly exceeds the Portland, Oregon metropolitan area, although both regions are predominantly urban. Practice patterns also can significantly affect costs. Regional adjustment would account for why a regional spending target is different than a national spending target. Specific patient mix adjustment at the Entity level is also needed. An ACM entity involving cardiologists would serve advanced cardiac patients with or without other advanced condition co-morbidities. Their cost would be different than another ACM entity in the same region that serves advanced illness patients of primary care physicians where advanced cardiac conditions represent a proportion of the overall population. Patient volume can also affect pricing. There would be greater variation in costs between a small sample of lung cancer patients than with a larger sample of the same population. Adjustments would need to be made to factor in different pricing estimates for small vs large sample. We provide an example of the spending target and its application to determine the shared risk in Figure 13-14, in Question 16 response.

Our risk adjustment framework is based on existing CMS APM risk adjustment models including BPCI and OCM. We propose specific elements for the risk-adjustment based on our collective experience of designing and evaluating private programs such as Aetna Compassionate Care and Sutter AIM. Outlined in the proposal, Diagram 2 Advanced Illness Episode Modeling, these adjustment factors include:

1. Year 2 prior to death: age, sex, total cost of care, number of hospitalizations, SNF days, and home health episodes
2. Last year prior to death: HCC score, HCC count, primary advanced illness HCC (e.g. advanced cancer vs. dementia), and dual status

We anticipate that in our proposed regression analyses of the CMS national data, CMS will be able to detect other variation factors that should be added to the risk adjustment framework.

SECTION III. Questions about health care quality and quality measurement:

19. How can patients and the Medicare program be assured that there is no stinting on treatment (“curative”)-oriented care, especially as the core set of metrics are focused on the palliative aspect of the model, and the model would discontinue PMPM after 12 months? See p. 6: “Most of the quality metrics being proposed will

be determined by advanced illness beneficiaries and their family caregivers rather than by clinicians.” Since the model will offer “curative” care (see abstract, and pages 2 and 3), what curative care metrics will be used? How will the model assure the inclusion of sufficient measures of the appropriateness, effectiveness, and outcomes of curative care; so that the team does not focus on palliative care at the expense of the treatment of the underlying illnesses?

Patients continue to have access to their treating physicians under the ACM. Also, the ACM is required to share and coordinate their care plans with treating physicians (Access Domain: Evidence of care coordination with treating provider monthly). Furthermore, the ACM must attest whether care/treatment provided is consistent with patient’s preferences. Given that beneficiary, family members and treating physicians all play pivotal roles in determining the care, it would be extremely difficult for the ACM to stint on treatment-oriented care. In addition, we propose under the evaluation section of the proposal that CMS collaborate with ACM entities to conduct prospective evaluation to determine survival rates between ACM beneficiaries and usual care. Thus, there are safeguards to address theoretical concerns that the ACM can stint on treatment-oriented care.

To expand, we would like to add several additional components to encourage the use of evidence-based person-centered care. First, we would like to add one additional measure centered on curative treatment: Attestation that the ACM team supports and reinforces the use of evidence-based treatments by treating providers. Second, we propose that CMS conduct an initial evaluation of the ACM entity by month 6 of operations to audit the ACM entity’s operational plan, including ACM care guidelines. Third, we propose that a family member survey be conducted after the patient dies to assess the quality and care experience.

20. The proposed measure set includes measures derived from claims data, clinical data and patient surveys. What are the data collection and data quality methods proposed to ensure adequate and reliable data?

We propose that CMS supports the ACM entity in collecting and analyzing data as much as possible. Claims-based measures are proposed to be analyzed and reported by CMS based on already available data in the CMS claims system. For measures where the data source is either from EHR or claims, the options for claims data source is provided to the extent that CMS can provide a specific ACM encounter code and sub-codes to identify ACM activities and specify presence of required care processes (e.g. person-centered care goals documented in care plan, care/treatment consistent with preferences, etc.). Alternatively, ACM entity must demonstrate that these care process measures are captured and reported from the EHR where audit can be easily conducted. A few quality outcome measures are proposed to be assessed by the beneficiary or their representative family member through survey that would initially be conducted by the ACM entity with longer term plan for the survey to be incorporated into CMS surveys. We also propose

that the ACM entity develops a continuous improvement and quality assurance program. We would require that the ACM entity audit the reported measures and submit its reports to CMS as part of the quality assurance program.

21. Page 9 of the proposal states:

“We recommend that ACM entities have the option to pilot their own quality survey topics to generate a broader testing of new person-centered quality metrics.”

The PRT notes that the quality measurement community is striving to achieve standardization of quality measures to reduce measure variation and provider burden.

- a. Would the proposed new quality surveys be a substitution for the survey items in Table 5, or additions to the survey items listed in Table 5?***
- b. Regarding the five “ACM Beneficiary & Family Caregiver Survey Template” questions on page 11 (Table 5), please identify the source of these questions, and the results of the psychometric testing of these questions.***

We propose a quality survey template to measure the survey items in Table 5 of the proposal. The quality survey template is derived from existing programs including AIM, Aspire and Aetna, and wording of the survey questions mirrors the CAHPS surveys. Given that the ACM is a new care delivery model, existing and standardized surveys do not exist. We provide a template as well as propose that ACM entities and the industry have the opportunity to test different surveys in the first few years in order for CMS to establish an effective survey.

22. The proposal on page 15 states, “we recommend waivers . . . [of]...conditions-of-participation (CoPs) requirements for hospice and home health for the provision of ACM services.

- a. Please list the conditions of participation that you believe should not apply to home health providers providing services to ACM enrollees and explain why.***
- b. Please explain why you want waivers from hospice conditions of participation. The proposal states that when enrollees are admitted to hospice, they will be discharged from the ACM program. Why, then does the ACM program need waivers from hospice CoPs?***
- c. Will the ACM model’s palliative care services differ from the palliative care services provided through a hospice? If so, how?***

Both home health agencies and hospices may serve as the ACM entity and/or provide resources to deliver the ACM services. While these organizations can furnish ACM services and meet all home health or hospice conditions of participation, it would be helpful if CMS can provide clarifications or waivers that are consistent with other CMS APM waivers to facilitate the efficient delivery of ACM services by home health agencies or hospices. ACM services are not home health or hospice, therefore, tying these services within a home health or hospice conditions of participation could be unnecessary. We also propose that these are distinct programs even if they are being provided under the same organizational structure.

Section IV. Overall:

23. Please describe how this model would operate from the patient's perspective, including (but not limited to):

- a. How would the patient be informed about the program?***
- b. How would the patient be selected into the program?***
- c. What information would the patient be given at the time of their enrollment?***

The ACM will serve advanced illness patients of the participating physicians and other eligible professionals. These patients are informed of availability of the ACM service by their physicians and ACM entity once they are identified and meet the eligibility criteria. Information given to patients at the time of enrollment will focus on introducing the additional services that they are eligible to receive. As provided in the response to Question 3, the ACM program can be described to potential or active participants in a person-centered context that includes the following key concepts:

- The ACM is a comprehensive approach to care for beneficiary with advancing illness,
- The ACM provides a team of clinicians and non-clinicians who works closely with your physicians and others to provide additional support to you, and
- Because your physician has adopted the ACM in their practice, you have access to these additional services.

Additionally, any patient financial responsibility will be communicated, such as Medicare co-payment. We propose that CMS waive co-payment responsibility for this program. Patients have the choice to not utilize the services, in which case they will not be enrolled in the program.

- c. Would the program change the patient's relationship with their pre-existing primary care provider and specialists? If so, in what way? Would the ACM clinicians supplement the patient's primary care and specialty clinicians or would they replace them? Would patients have a say in this? How would the patient be informed of any changes in these providers' roles?***
- d. Would the patient receive a copy of the unified care plan?***

- e. Who would be the person identified to the patient as responsible for managing their care? Would this person be different for the management of their palliative care and the management of the treatment of their illness?*

The patient's relationship with their pre-existing primary care provider and specialists will remain unchanged. The ACM clinicians supplement and augment the care furnished by the patient's primary care and specialty physicians. As such, all clinicians involved in the patient's care will have responsibility for the care that they deliver. The ACM clinicians will be identified to the patient as additional members of the patient's care team. The ACM, in particular, will focus on coordinating their services with the patient's usual care team and be proactive in supporting patient's care needs. As noted in table 5 of the proposal, ACM entity is required to update the ACM care plan at least monthly and will share the updated plan with the patient. Measuring and reporting this process is required under the ACM Quality Monitoring Program.

24. Please describe how this model would operate from treating providers' perspective, including:

- a. What would be the role of the patient's primary care provider in the model? What is his/her relationship to the members of the patient's ACM team?*
- b. Would the program change the patient's relationship with their pre-existing primary care provider and specialists? If so, in what way? Would the ACM clinicians supplement the patient's primary care and specialty clinicians or would they replace them?*
- c. How would the model's clinical team interact with primary care providers who choose (if possible) to be part of the ACM model?*
- d. How would the model's clinical team interact with primary care providers who do not choose to be part of the ACM model?*

The primary care provider role in the patient's care remains unchanged in the ACM. Supporting the PCP-patient relationship is pivotal to the ACM's success. Similarly, specialists have an increasing presence in the patient's care as they reach the advanced illness phase, so similar support for this relationship is needed. The goal of the ACM is to address this critical need by coordinating care and enhancing communication among the patient's physicians. As demonstrated in the AIM program, the ACM can increase clinical integration by strengthening the communication and relationships among physicians as well as other sectors e.g. hospital and post-acute care.

Physicians who choose to be part of the ACM model are committed to the ACM goals and approach. As such, they will be naturally responsive to coordinating with the ACM so that care coordination and care management becomes a shared effort between the ACM clinicians and these physicians. Furthermore, these physicians may strive for structural integration including operating on a shared EHR or registry. Therefore, physician's participation in the ACM improves its efficiency.

To improve care of advanced illness, the ACM must coordinate with the patient's physicians, even when they are not part of the ACM. Physician's participation creates greater benefits, but significant opportunity remains to coordinate with physicians who choose to not participate in the ACM, as illustrated by the AIM program, which delivers services to employed and independent physicians.

25. The proposal included as a reference an article describing Aetna's Compassionate Care program (Spettell, et al. "A comprehensive case management program to improve palliative care," J. Palliat Med 2009; 12:827-832). This article was very informative, but we note the data is now a decade old. Please provide more recent data, if available. Also, please describe if you can what information was given to patient candidates for the Aetna program and their families at the point of enrollment.

We provide two sets of data provided by the Aetna program to bridge the results published in 2009 to the present. 2012 outcomes include the following:

- 82% reduction in acute inpatient days,
- 77% reduction in emergency room visits,
- 86% reduction in intensive care unit days,
- 82% of engaged decedents choose hospice, and
- \$12,924 mean savings per member engaged

Most recently, Aetna reports the following additional outcomes for 2014-2015 participants:

- Members engaged in Compassionate Care had 13% lower total medical costs in the last 3 months of life compared to those who were not engaged. This difference was driven by a 15% reduction in inpatient admissions and a 14% reduction in emergency visits,
- Members engaged in Compassionate Care were 36% more likely to use hospice than those who were not engaged, and
- Hospice duration was 27% longer for those engaged in ACCP.

¹ Medicare Spending at the End of Life: A Snapshot of Beneficiaries Who Died in 2014 and the Cost of Their Care. (2016). The Henry J. Kaiser Family Foundation. Retrieved 20 April 2017, from <http://kff.org/medicare/issue-brief/medicare-spending-at-the-end-of-life/>

² Dartmouthatlas.org. Retrieved 20 April 2017, from <http://www.dartmouthatlas.org/>

³ Teno JM, Gozalo PL, Bynum JPW, et al. Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009. *JAMA : the journal of the American Medical Association*. 2013;309(5):470-477. doi:10.1001/jama.2012.207624.

⁴ Ruiz, S., Snyder, L., Rotondo, C., Cross-Barnet, C., Colligan, E., & Giuriceo, K. (2017). Innovative Home Visit Models Associated With Reductions In Costs, Hospitalizations, And Emergency Department Use. *Health Affairs*, 36(3), 425-432.

⁵ Atkinson T, Andreotti C, Saracino R, et al. The level of association between functional performance status measures and patient-reported outcomes in cancer patients: a systematic review. *Supportive Care In Cancer* [serial online]. December 2015;23(12):3645-3652. Available from: Academic Search Alumni Edition, Ipswich, MA. Accessed April 20, 2017.

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Physician-Focused Payment Model Technical Advisory Committee
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August 30, 2017

Dear PRT and PTAC Members,

Thank you for your very thoughtful feedback on our proposal. We are deeply appreciative of PTAC's recognition of both the importance of and sensitivities around providing advance illness care services. We recognize that patients with advanced illness are an extremely vulnerable and underserved population and it is critical that all aspects of our model be well thought through in order to ensure this population is protected and provided the highest quality care. Prior to the full PTAC meeting on September 7th, we would like to provide you with five additional clarifications and minor modifications to our proposal based on the very helpful feedback provided by the PRT.

- **Patient Education:** For clarity, we believe it is critical that patients are fully informed about the model prior to enrolling in the program. Specifically, we believe patients must be informed about details such as the additional palliative care services that will be provided as well as how providers will be compensated for the services prior to enrolling in the program. On the PRT's question around when patients should be informed that a clinician has determined they may have less than a 12-month life expectancy, we would propose that this occur within the first 90 days after program enrollment. We believe this 90-day timeframe would be an appropriate balance between giving palliative care clinicians time to build a relationship with the patient and their family while also ensuring that patients were informed of their prognosis in a timely manner.
- **Quality Metrics:** Our primary reason for submitting our proposal is to improve the quality of care for patients facing an advanced illness, and we are deeply aligned with PTAC's belief that quality of care be both robustly measured and monitored. In our initial proposal, we included a number of quality metrics that were not tied to utilization including:
 1. Frequency of symptom control (collected via patient / family survey)
 2. Frequency of decision support (collected via patient / family survey)
 3. Responsiveness to emergent medical issues (collected via patient / family survey)
 4. Confidence in managing illness (collected via patient / family survey)
 5. Composite patient satisfaction score (collected via patient / family survey)
 6. Visit within 48 hours of hospital discharge (collected via claims)
 7. Evidence of advanced care planning within 14 days of enrollment (collected via claims / EMR)
 8. Person-centered care goals documented in routine care notes (collected via EMR)
 9. Care/treatment consistent with preferences (collected via EMR)

Furthermore, in our follow-up to the PRT questions on April 25th, we proposed three additional measures to support quality: (1) attestation that the ACM team supports and reinforces the use of evidence-based treatments by treating providers; (2) a family member survey conducted after the patient dies to assess the quality and care experience (expanding on the hospice family member survey - planning for this survey has already begun by industry experts in anticipation of the ACM); and (3) that CMS conducts an initial evaluation of each ACM entity by month six of operations to audit the ACM entity's operational plan including care guidelines.

To further ensure quality, we are proposing four additional enhancement to the quality initiatives discussed above. First, we are proposing to add four more questions to the patient and family satisfaction survey. As background, the initially proposed survey utilizes the CAPHS question templates for responsiveness to care and overall satisfaction as well as relevant quality topics (e.g., symptom control, adequate support for decisions, confidence in managing illness) that were adapted from the validated Patient Activation Measure survey (PAM), tested by CMMI Sutter AIM program, and widely utilized by other ACM programs. Leveraging ideas from the American Academy of Hospice and Palliative Medicine, we believe four additional questions that should be added to the survey to measure patient engagement in shared-decision making are:

1. Was the information presented in a way the patient could understand;
2. Did the healthcare professionals communicated in a sensitive manner;
3. Were the seriously ill person and family allowed to ask questions; and
4. Was the patient able to make a decision without feeling pressured by the health care team to make a decision that they did not want?

We believe adding these four questions will enhance the survey's ability to measure patient engagement in shared decision-making.

Second, there are current efforts being led by NCQA and the National Consensus Project to create new national quality standards for home-based advance illness care, and we recommend that these quality standards be incorporated into the quality metrics in the APM when the standards are published (likely in 2018 or 2019).

Third, we agree we could potentially improve quality by requiring that the lead advanced illness clinician for each ACM entity have a formal palliative care certification (rather than just three or more years of experience in palliative care or hospice, as we initially proposed in our questions submitted on April 14).

Finally, in Appendix I we have clarified in detail how the quality metrics would work as they relate to payment. As you will see, we are proposing four quality metrics on which payment would initially be based. None of these metrics are related to utilization, and we are proposing to require 100% provider attestation that patient care plans are aligned with patient goals in order to be eligible for any shared savings, thereby ensuring patient preferences are always protected.

- **Prognostication & Patients Enrolled Longer Than 12 Months:** The PRT raised several concerns related to the ability to accurately prognosticate, especially for non-cancer patients. While we agree that prognostication is imperfect, both our experience and review of the literature suggests that national best practice for prognostication for both cancer and non-cancer patient is based on a combination of multiple inputs including objective measures such as prior utilization, function status and functional decline as well as the subjective judgement of individual clinician prognostication. We believe the review of literature by Social & Scientific Systems supports this view in their finding that *“prognostication tools were found to aid physician’s predictions and boost physician’s confidence in their predictive ability. These tools primary focused on patient function impairments, or combinations of functional impairments, patient ability to perform, and clinical measures.”* We believe the eligibility criteria in our proposal deeply align with this observation and represent the best patient identification criteria currently available. Specifically, our eligibility criteria require that patients must have a combination of at least two factors noted in the literature review (e.g., recent acute utilization, low functional status, recent functional decline and/or recent nutritional decline) plus clinician prognostication.

That said, we know that any method of prognostication will be imperfect and, therefore, must design the model to account for this, with a specific focus on patient who live longer than 12 months after being enrolled in the model. In our initial proposal, we prioritized limiting the financial risk to CMS by limiting the PMPM payment to ACM entities to a maximum of 12 months. We fully appreciate the PRT’s concern that capping the PMPM at 12 months may not provide sufficient incentives for all ACM entities to care for patients after this 12-month period. Therefore, we propose to address this concern by removing the PMPM 12-month cap so that the PMPM would be available for any duration of ACM services.

However, to ensure this does not place additional financial risk on CMS, we are proposing that for the purposes of measuring savings, all PMPM payments received by the ACM entity be counted as a cost in the risk performance calculation. Specifically, as outlined in Appendix II, savings would be measured by comparing total cost for ACM enrollees in the last 12 months of life plus all PMPM payments to the ACM entity for ACM enrollees who passed away to the projected last 12 month of life cost baseline for those ACM enrollees. As a result, if an ACM entity received 16 months of PMPM payment, all 16 months of PMPM payment would be counted as a cost for the purpose of the comparison to the baseline. We believe this thoughtful modification to our proposal achieves multiple goals including: (1) providing additional protection to ensure that vulnerable patients who live longer than 12 months continue to be provided the ACM services; (2) incentivizing ACM entities to identify appropriate patients (as all PMPM fees they receive will be counted in the reconciliation for which they are at risk); and (3) protecting CMS from excessive financial risk, as providers will still be responsible and at risk for the entire cost of the PMPM they receive.

- **Measuring Savings:** Based upon feedback from the PRT, we have worked with external actuarial experts over the past three weeks to clarify and add additional detail to our proposal for measuring savings. Appendix II contains additional clarifying detail on how we propose to execute our savings methodology. As you will see, much of the additional detail is based

on the methodology used in the CMMI Independent Evaluation of the HCIA Sutter AIM Program.

- **Hospice Participation:** As outlined in our initial proposal, we believe that the ACM model is distinct from MCCM in that ACM includes a broader patient population, flexibility for different provider organizations to collaborate and participate in the model, and advanced APM eligibility. However, we recognize the potential confusion that could exist between individual hospices being able to participate in both the ACM and MCCM demos. There are three ways we believe CMS could address this issue including: (1) allowing MCCM providers to participate in both the MCCM and ACM programs simultaneously; (2) allowing MCCM providers to only participate in either the MCCM or ACM program but allowing MCCM providers the option to transition from MCCM to ACM if they so choose; or (3) prohibiting MCCM providers from participating in the ACM demo during the initial demonstration period.

In closing, we are deeply appreciative of PTAC's recognition of the needs of patients facing an advanced illness and believe that our model – with the above modifications based on the PRT's feedback – represents a very thoughtful way to increase access to advanced illness services for some of our nation's most vulnerable patients. While we would certainly learn as the model was implemented and identify ways to improve the model, we believe this is such a critical need that serves the best interest of patients – and our country – that we get started right away.

We are very grateful for PTAC's review of our proposal and are looking forward to the full committee meeting on September 7th.

Best,

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Appendix I:

Quality Metrics Tied to Payment

We propose that the four metrics on the following page be initially tied to payment. We propose that ACM entities be required to achieve 100% on Metric 1 in order to be eligible for any shared savings payment. We then propose shared savings and losses be tiered based on performance on Metrics #2-4. As the program matures, additional metrics could be tied to payment.

Shared Risk Rate	Quality Performance
1. 85% shared savings/75% loss	Metric 1: Qualifying status Metric 2-4: Score 2 for one metric; score 1 or greater for other two metrics
2. 80% shared savings/loss	Metric 1: Qualifying status Metric 2-4: Score 1 or greater for all three metrics
3. 75% shared savings/85% loss	Metric 1: Qualifying status Metric 2-4: Score 1 or greater for two of three metrics
4. Below shared savings threshold	Metric 1: Non-qualifying status Metric 2-4: Score 0 on two or more of the three metrics

Appendix I:

Details on Four Quality Metrics Tied to Payment

Metric 1: ACM provider attestation that patient's care plan is consistent with preferences: Yes/No	Source: EHR documentation or ACM CMS code Frequency: 30 days after enrollment and at discharge
	Performance Tiers: Qualifying status: 100% Non-qualifying status: less than 100%
<hr/>	
Metric 2: Evidence of advanced care planning within 14 days of enrollment: Yes/No	Source: EHR documentation or ACM CMS code Frequency: 14 days after enrollment
	Performance Tiers: Score 0= less than 80% Score 1= 80% Score 2= 85%
<hr/>	
Metric 3: Attestation that the ACM team supports and reinforces the use of evidence-based treatments by treating providers: Yes /No	Source: EHR documentation or ACM CMS code Frequency: 30 days after enrollment and discharge
	Performance Tiers: Score 0= less than 90% Score 1= 90% Score 2= 95%
<hr/>	
Metric 4: On a scale of 1-10, please rate your overall satisfaction with the care that you received from your Advanced Care Team?	Source: Third-party patient satisfaction survey Frequency: 180 days after enrollment or at discharge (whichever comes first)
	Performance Tiers: Score 0= less than 7.5 average score Score 1= 7.5 average score Score 2= 8.0 average score

Appendix II:

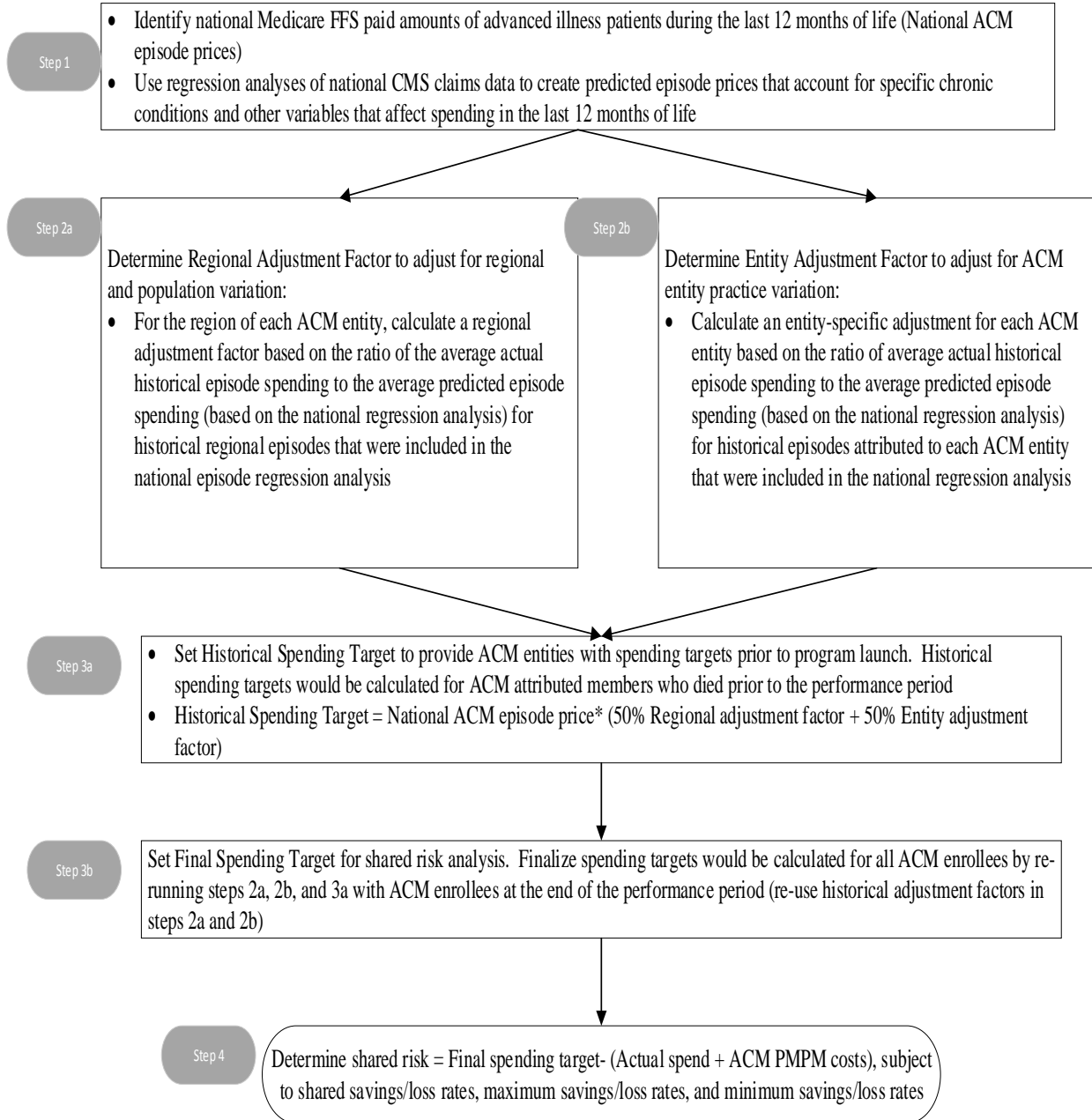
Detailed Payment Methodology

We appreciate the PRT comments regarding the need for more specifications of the ACM shared risk analysis methodology to ensure feasibility. On the following pages, we provide further details of the shared risk analysis methodology, starting with a methodology overview diagram followed by a detailed description of each step of the methodology. As you will see, the methodology is based on a national regression analysis, similar to the methodology used for the CMMI independent evaluation of the Health Care Innovation Award (HCIA) Sutter Advanced Illness Management (AIM) program. The results of the ACM national regression analysis would be combined with regional level and ACM entity-level adjustments to calculate spending targets for ACM entities.

We also provide a letter of support for our payment methodology design from the American College of Surgeons (ACS). This is of significance as the ACS has developed a PTAC approved Episode Grouper for Medicare (EMG) to determine expected spend for various APM care episodes. In their review, the ACS believes the ACM payment methodology is a viable design that can be operationalized through the EMG for example.

Appendix II:

ACM Payment Methodology Overview



Appendix II:

Step 1: National ACM Episode Price

Step 1: Identify national Medicare FFS average prices of advanced illness patients during the last 12 months of life (National ACM Episode Prices) using regression analyses of national CMS claims data

Data Source: National historical Medicare FFS claims (Part A & B); include part D if feasible. Part A & B spending amounts would be normalized using the CMS Payment Standardization Methodology to eliminate geographic differences in Medicare payment rates.¹ Similar to the CMS Oncology Care Model (OCM), Part D spending amounts could be limited to non-capitated payments, namely 80% of the Gross Drug Cost Above Out-of-Pocket Threshold and Low-Income Subsidies.

Population: The goal is to include as many decedents who had chronic illness as possible in the historical regression analysis. Specifically, we propose including all decedents who had one or more of the 11 chronic illness diagnoses in Appendix III (as determined by an individual having at least 3 claims in the last 12 months of life for any of the individual 11 diagnoses). The 11 diagnosis categories consist of the 9 chronic conditions from the Dartmouth Atlas that represent 90% of decedents plus other nervous system diseases (such as ALS and MS) and HIV/AIDs.

Benchmark Timeframe: The goal is to use multiple years of data to increase the sample size but also to weigh recent data more heavily in order to reflect recent national trends. Specifically, we propose to construct 12-month episodes for beneficiaries who die during a 3-year historical period, which will require analyzing four years of claims data that cover 36 rolling 12-month periods. For the regression analysis, we will weigh more recent episodes more heavily, with weights of 60% for episodes ending in the most recent year, 30% for episodes ending in the second most recent year, and 10% for episodes ending in the third most recent year.

Analysis: Using a methodology similar to the CMMI independent evaluation of the HCIA Sutter Aim Program, conduct a regression analysis to determine average price estimates based on national CMS FFS data. The independent variable in the analysis would be total Medicare paid amount in the last 12 months of life. Spending in episodes in the first two years of the historical benchmark timeframe would be trended to the final year based on changes in average paid amount in the last 12 months of life for each chronic condition. Dependent variables in the regression would include:

1. **Primary Diagnosis:** The primary diagnosis would be one of the 11 diagnosis categories from Appendix III. The primary diagnosis would be determined by the diagnosis category that appeared on the highest frequency of claims for an individual patient in the last 12 months of life.

¹ <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FOnetTier4&cid=1228>. Accessed 8/24/2017.

2. Individual Comorbidities: 11 diagnosis categories from Appendix III plus hip fracture (M80, M84, S32, S72, S79) and anemia (D50-D53, D55-59, D60-D64) as determined by an individual having three or more claims for each of the individual diagnoses during the last 12 months of life
3. Hierarchical Condition Category (HCC) score during the last 12 months of life
4. Total Medicare cost during months 13 to 24 prior to death
5. Hospitalizations during months 13 to 24 prior to death
6. ED visits during months 13 to 24 prior to death
7. SNF days during months 13 to 24 prior to death
8. Home health episodes during months 13 to 24 prior to death
9. Dual-status during the last 12 months of life
10. Age at death
11. Gender
12. Part D coverage, if Part D spending is included
 - Spending in the last 12 months of life would be capped at the 95th percentile of spending for each of the primary chronic conditions
 - Exclude significant new treatments from analysis, identifying new treatments as currently identified in the Comprehensive Care for Joint Replacement (CJR) model

Output:

- Target National ACM Episode Price for each decedent; this information could be presented through an episode pricing table based on primary diagnosis with adjustment factors for each of the other factors listed above

Step 2: Regional & Entity-Level Adjustments

Steps 2: Determine regional and ACM entity-level adjustments

Step 2a: Determine regional ACM adjustment factor

- Regional adjustment factor = average actual regional spending in last 12 months of life / average predicted spending in the last 12 months of life from regression analysis
- The population used to calculate the adjustment factor would be all beneficiaries who died in each region and who were included in the national regression analysis (i.e. had at least one of the 11 chronic illness diagnoses listed in Appendix III)
- Patients would be attributed to a primary diagnosis in Appendix III based on the diagnosis category that appeared on the highest frequency of claims for an individual patient in the last 12 months of life.
- Like with the regression analysis in Step 1, multiple years of data would be used to increase the sample size while weighing recent data more heavily in order to reflect recent national trends. Specifically, we propose to construct 12-month episodes for beneficiaries who die during three years of historical data and applying the same weights as in the regression analysis. CMS should define regional parameters based on its current best practices, such as using the MSSP regional definitions or each Hospital Referral Region (HRR).

- We propose using national ACM episode prices generated by the national regression analysis as the basis for regional adjustment rather than conducting regional regression analysis to determine regional ACM episode prices because advanced illness represents a small subset of the overall Medicare population and the national dataset would provide more data to determine the adjustment factors. That said, CMS may consider performing regional regression analysis to determine the regional episode price if it determines that there is sufficient data for all US regions.

Step 2b: Determine ACM-entity adjustment factor

- Step 2b. Entity adjustment factor = average ACM entity spending in the last 12 months of life / average predicted spending in the last 12), where the predicted spending is calculated based on the national regression analysis
- The population used to calculate the adjustment factor would be all beneficiaries attributed to each ACM entity who died the historical benchmark timeframe and who were included in the national regression analysis (i.e. had at least one of the 11 chronic illness diagnoses listed in Appendix III)
- Like with the regression analysis in Step 1, multiple years of data would be used to increase the sample size while weighing recent data more heavily in order to reflect recent national trends. Specifically, we propose to construct 12-month episodes for beneficiaries who die during a three-year historical period and applying the same weights as in the regression analysis.
- Each ACM entity would consist of all participating providers; attributed decedents would be all decedents with two or more evaluation and management (E&M) claims with a diagnosis code for one of the diagnosis categories in Appendix III that are billed by any of the individual ACM providers (e.g. primary care physicians or specialists) that are part of the ACM entity in their last 12 months of life.

Step 3: ACM Target Spend Calculations

Steps 3: Determine entity-level spending target

Step 3a: Set historical spending target

- We are proposing to provide ACM-entities with historical spending targets prior to program launch to help inform those entities as they enter the program.
- Historical spending targets would be calculated for ACM attributed members who died prior to the performance period using the formula National ACM Episode Price * (50% Regional Adjustment Factor + 50% Entity Level Adjustment Factor).
- Attributed decedents would be all decedents with two or more evaluation and management (E&M) claims with a diagnosis code for one of the diagnosis categories in Appendix III that are billed by any of the individual ACM providers (e.g. primary care physicians or specialists) that are part of the ACM entity in their last 12 months of life.
- ACM entities would receive claims-level and beneficiary-level information, including the assigned historical episode price for all attributed historical episodes.

Step 3b: Set final spending target

- The final spending targets would be calculated for each ACM enrolled member who died using the formula National ACM Episode Price * (50% Regional Adjustment Factor + 50% Entity Level Adjustment Factor) * Trend Factor and summed across all enrolled members
- The adjustment factors would be calculated from the historical episodes and would not be recalculated in this step
- The trend factor would capture changes in Medicare payment rates that occurred between the end of the historical benchmark timeframe and the performance year. It could be calculated similar to the update factors in CJR²
- ACM enrolled members would be all members for whom the ACM received a PMPM payment who had passed away
- As with the initial regression analysis, spending in the last 12 months of life would be capped at the 95th percentile nationally for each of the primary chronic conditions
- As with the initial regression analysis, new treatments would be excluded from the analysis, identifying new treatments as currently identified in BPCI

Step 4: Shared Risk Performance Analysis

Step 4. ACM Shared Risk Performance Analysis, at the end of the performance year

Shared Risk Performance: Final Spending Target - (Actual Spend for ACM Enrollees in Last 12 Months of Life + ACM PMPM Costs for All Deceased Enrollees)

- The final spending target would be the sum of the individual spending targets for each ACM attributed enrollee who died
- The actual spend in the last 12 months of life would be the total spend in the last 12 months of life (Part A and B as well as part D if the latter was included in the regression in Step 1) for each ACM attributed enrolled who died
- ACM PMPM costs would be the sum of all PMPM payments to the ACM entity for enrolled members who had died and were included in the reconciliation; the PMPM payments for ACM enrollees who were still alive would not be included in the shared risk performance analysis until those members passed away

Payment To / From ACM Entity: Determine the payment to or from the ACM entity by applying the payment model rules to the Shared Risk Performance; these rules include:

- 75-85% shared savings/loss rate based on quality
- 30% total savings limit
- 10% total loss limit, which exceeds the financial risk threshold of 3% of expected expenditures for qualification as Advanced APM
- 4% minimum savings/loss rate
- We propose that a minimum volume requirement should be set such that there is sufficient power to statistically detect a 4% difference in spending.

² See CJR Final Rule update factor methodology (80 FR 226 73341 – 73346. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-11-24/pdf/2015-29438.pdf>. Accessed 8/24/2017.

Appendix III:

ACM Proposed Diagnoses for Diagnosis-based Spending Target Determination

Condition Category	ICD 10 CM Codes	Exclusions
Malignant Neoplasm*	C00-C14, C15-C26, C30, C41, C43-58, C60-75, C7A-C7B, C76-96	
Diabetes w. End Organ Damage*	E08, E10, E11, E13	E08.319, E08.32X-E.08.33X, E08.41, E08.51, E08.65-E08.9, E10.319-E10.339, E10.41, E10.64-10.9, E11.319-E11.339, E11.51, E11.620, E11.64-E11.9, E13.319-E13.339, E13.41, E13.51, E13.64-13.9
Alzheimer's Disease*	G30.1-30.9	
Other Nervous System Diseases: Inflammatory & Other Degenerative Conditions	G10, G20, G21, G23, G35-G37, G60-65	
Heart Failure & Other Heart Diseases*	I01, I05-I09, I11-I12, I21-28, I31-52, I60-63, I65-I69, I71-73	I13.10
Cerebrovascular Diseases*	I60-I63, I65	
Peripheral Vascular Diseases*	I71-I82, I85	I73.00, I73.8, I73.9, I80
Pulmonary Diseases*	J43, J44	
Liver Failure & Other Diseases*	K72-K74, K75.9, K76	K73.8, K73.9, K76.0, K76.1, K76.9
Kidney Failure*	N18	N18.1-N18.3, N18.9
HIV/AIDS	B20	



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August 29, 2017

Physician-Focused Payment Model Technical Advisory Committee
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy
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Letter of Support – Coalition to Transform Advanced Care, Advanced Care Model

Dear Committee Members,

I write to express support for the Advanced Care Model (ACM) proposed by the Coalition to Transform Advanced Care (C-TAC), which is scheduled for consideration at the upcoming September meeting of the PTAC. I would strongly encourage the PTAC to recommend this model for testing.

The ACM seeks to increase coordination of care in an area of medicine that is costly and disproportionately fragmented. The C-TAC proposal is patient-focused and recognizes the team-based nature of care necessary to efficiently and effectively meet the needs of these vulnerable patients. The model is also designed to work in cooperation with other APMs and Advanced APMs which should help to ensure that improvements in care transitions and coordination extend beyond the providers involved in the ACM.

Furthermore, the C-TAC payment model has a feasible design that can also be implemented leveraging the Episode Grouper for Medicare (EGM) to identify all open episodes for a given patient, thus using this information for risk adjustment and refining cost expectations. With future collaboration, the ACM payment model could function efficiently with the ACS-Brandeis Advanced APM proposal previously recommended by the PTAC.

Thank you for your work in helping to move meritorious models into practice. The ACM model has great potential and I again encourage you to consider recommending the model for testing.

Sincerely,

Frank Opelka, MD, FACS
Medical Director for Quality and Health Policy
American College of Surgeons

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2
3 PHYSICIAN-FOCUSED PAYMENT MODEL
4 TECHNICAL ADVISORY COMMITTEE (PTAC)
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6
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9

10 PRELIMINARY REVIEW TEAM (PRT)
11

12 CONFERENCE CALL
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16 Monday, June 12, 2017
17 2:00 p.m.
18
19
20
21
22

23 PRESENT:
24

25 ELIZABETH MITCHELL, PTAC Committee Member
26 PAUL CASALE, MD, MPH, PTAC Committee Member
27 BRUCE STEINWALD, PTAC Committee Member
28 ANN PAGE, Designated Federal Officer
29 JANET PAGAN-SUTTON, PhD, Social & Scientific Systems, Inc.
30
31 Gary Bacher, Coalition to Transform Advanced Care (C-TAC),
32 Founding Member of Healthsperien
33 TOM KOUTSOUMPAS, C-TAC Co-Chair of the Board of
34 Directors; Founding Member of Healthsperien;
35 President and CEO, National Partnership for
36 Hospice Innovation
37 KHUE NGUYEN, PharmD, C-TAC Chief Operating Officer
38 MONIQUE REESE, DNP, C-TAC; Chief Clinical Officer of Sutter
39 Care, Advanced Illness Management (AIM)
40 BRAD SMITH, C-TAC; CEO, Aspire Health
41 KRISTOFER SMITH, MD, C-TAC; Senior Vice President of
42 Population Health; Medical Director of Northwell
43 Mark Sterling, JD, C-TAC Senior Strategic Advisor
44

45 P R O C E E D I N G S
46

[2:07 p.m.]

1 MS. PAGE: This is Ann. Elizabeth emailed
2 and can't join until 2:30.

3 MR. STEINWALD: Well, the first topic is
4 eligibility criteria and patient recruitment, and
5 we would like to hear from you a bit more about how
6 you develop those criteria, how well you think they
7 are as predictive of mortality within 12 months,
8 and, you know, kind of what other things you might
9 have considered, and how confident you are that
10 those criteria will result in a population of
11 patients that are appropriate for the model.

12 So if any one of you would like to kind of
13 start out that conversation, please do.

14 DR. NGUYEN: Yeah, Bruce, this is Khue
15 speaking here, and I'll just take a second here to
16 just introduce the three guests that will be
17 speaking with us, with me here, so that you have
18 some context to their contribution here.

19 So this is Khue Nguyen. I'm with C-TAC,
20 and I came to this work from having developed and
21 implemented the Sutter AIM program, and we are
22 currently involved and working with providers and
23 payers to implement the ACM. So the ACM for us is
24 really based on extensive experience, and I'll just

1 introduce the other three members and get to your
2 questions.

3 So Kris Smith is a senior vice president
4 of population health and medical director of
5 Northwell. Northwell is a large integrated health
6 delivery system, the largest in New York State. It
7 has a network of 22 hospitals. Kris developed the
8 advance known as Management and Health Corps
9 program, and he is currently an acting -- a
10 practicing physician, and so Kris will come from
11 the perspective of somebody who is in the field as
12 well as someone with a policy background.

13 We have with us also a leader from the AIM
14 program, the Sutter Health AIM program, and that's
15 Monique Reese, and she's the chief clinical officer
16 of Sutter Care at Home, and she leads the Sutter
17 Health AIM program. Sutter Health is also another
18 large leading integrated delivery system similar in
19 size, 20 or so hospitals with also a large network
20 of physicians, both employed as well as independent
21 physicians. And the AIM program has served over
22 20,000 patients in the last five years and has a
23 daily census of 3,000 patients.

24 We also have Brad Smith with us, and he is

1 the CEO of Aspire Health. It's the largest-growing
2 advanced illness care program in the country. It
3 operates in 23 states and contracts with national
4 as well as regional Medicare Advantage health plans
5 as well as ACOs. And this year alone, he expects
6 to serve at least 40,000 patients and has seen in
7 the past four years 30,000 patients alone.

8 And so, with that, Bruce, we were thinking
9 that it may be helpful -- and we know that you may
10 have other questions here, but would it be helpful
11 before we dive into the eligibility to just start
12 with the patient experience and just for us to have
13 an opportunity to share with you how we expect
14 patients and physicians to interact with the
15 program and start there and then get back to your
16 eligibility? Because I think if we provide that
17 context, it will allow us to build on that. Would
18 that be acceptable to you?

19 MR. STEINWALD: That sounds good to me.
20 Paul, what do you think?

21 DR. CASALE: That's fine, sure.

22 MR. STEINWALD: Okay. Go ahead.

23 DR. NGUYEN: Great. Thank you. So with
24 that, I am going to ask Kris Smith here to just

1 walk you through some actual patients here, along
2 with Monique.

3 MR. STEINWALD: Okay.

4 DR. SMITH: Great. Thank you, Khue. Good
5 afternoon, everyone. Thank you so much for taking
6 the time to speak with us. We're really excited
7 about this care model and this opportunity.

8 One of the reasons that I'm particularly
9 excited about it is I've been in the clinical side
10 of taking care of patients with advanced illness
11 for over a decade now, ever since I finished
12 residency. The only care that I've ever done is
13 care of the homebound frail elderly, which, as many
14 of you know, is a story of patients and families
15 who are in our communities, patients suffering from
16 unmet medical needs and symptom needs and families
17 suffering from unmet needs as caregivers and
18 providers for these patients.

19 And so, you know, when we came together as
20 a group a while ago now to kind of say how do we
21 take some of the learnings from some of the
22 hospice, the Medicare Choices, Independence At
23 Home, and propose the sort of next generation
24 advanced illness demonstration that we hope CMMI

1 would support, we really came at it thinking about
2 some patients.

3 So some of the patients that I was
4 thinking about as I was preparing to talk with you
5 today would be, for example, one of the patients
6 that I took care of for probably about -- I would
7 say about 15 months. She was a woman who had
8 advanced COPD from a lifetime of smoking, was
9 living in a two-bedroom apartment taking care of
10 her son who had a developmental disability, was
11 able to work but still required to be living with
12 his mother.

13 Slowly, over time, visits to the
14 hairdresser became, you know, too difficult because
15 she really didn't have the support to breathe. She
16 couldn't get to her pulmonologist, primary care
17 doctor, and so that's when we were called in to
18 help manage her care.

19 And so over the next 15 months, we
20 continued to work with her pulmonologist and with
21 her cardiologist and even her primary care
22 physician, but mostly over time we assumed the sort
23 of hub kind of management of that patient's care.
24 And, you know, she did quite well in terms of

1 stabilizing her decline and her breathing status.

2 But then, over time, it became clear that
3 she was really limited. She required oxygen, which
4 we got into the home. She required a hospital bed,
5 which we got into the home. All the while we were
6 having longitudinal conversations about her goals
7 of care. And in the last probably about, I'd say,
8 30 days of her life, we made the decision to bring
9 hospice in because her symptoms became a little bit
10 beyond the rate of response of our advanced illness
11 program, and we felt that having some nursing care
12 in the home would be beneficial, and so we were
13 able to bring hospice in.

14 And, you know, right in the last few days
15 of life, we were able to make the determination
16 that inpatient hospice was the best course for her,
17 and we brought her into an inpatient hospice, and
18 she was able to pass comfortably, surrounded by the
19 friends from her community, and we feel really
20 quite good about the suffering that was avoided
21 during that sort of 15-month period before she
22 passed. That's an example of how sort of the home-
23 based advanced illness program can really partner
24 with hospice.

1 And then other patients that I take care
2 of pretty regularly are patients that --

3 MR. STEINWALD: Well, I'm sorry. Let me
4 interrupt for a second because I'm curious. At
5 some point before she became eligible for the
6 hospice benefit, did anyone on her care team have a
7 prediction of how much time she had left?

8 DR. SMITH: Yes, so in programs such as
9 ours, we typically have conversations regularly
10 with where we think patients are in their illness.
11 But I guess if your question is did we sit down and
12 say, you know, "Mrs. Jones, we think that you have
13 three months to live," we tended to just talk
14 about, you know, "In a patient with your illness,
15 with your functional impairment, it's often the
16 case that we measure life in months rather than
17 years." So we have those conversations, and as
18 people have events, you know, like a
19 hospitalization or an ER visit, you revisit those
20 conversations.

21 Tell me a little bit about the genesis of
22 the question, and maybe I can answer it better for
23 you.

24 MR. STEINWALD: Well, the genesis has to

1 do with the first topic of conversation, is how
2 well the clinical criteria and the surprise
3 question will be predictive of the patient's
4 mortality within 12 months. That's the genesis.
5 So I was trying to link your example to the
6 question --

7 DR. SMITH: Yeah, so, you know, typically
8 we see -- and this is part of how the criteria was
9 generated. We see patients with multiple chronic
10 illnesses or the chronic illness has led to
11 functional impairment, meaning they can't get out.
12 We typically see that 40 to 50 percent of those
13 patients will die within the first year that
14 they're on program. So we find that that should be
15 pretty helpful to identifying a group of patients
16 who either may not yet be hospice-eligible or don't
17 want hospice, but also have, you know, substantial
18 burden of disease and need higher-intensity care
19 models.

20 MR. STEINWALD: Okay. So go ahead and
21 continue.

22 DR. NGUYEN: Yeah, I'm wondering here, to
23 add to Kris' answer, I'm thinking here maybe
24 Monique can also speak, because I think, Bruce,

1 Kris is speaking from a complex care to advanced
2 illness care management program where they're able
3 to follow patients two to three years out, all the
4 way to the last year; and while the last year is an
5 important focus, there is a pathway to that.

6 The AIM program is one that focuses on
7 advanced illness and utilizing the clinical
8 criteria to predominantly identify those with
9 advanced illness.

10 MR. STEINWALD: Okay.

11 DR. SMITH: Monique.

12 DR. REESE: And so one of the items, I
13 think, that I was going to share from a patient
14 story standpoint and maybe some of the process that
15 we went through, so from an advanced illness
16 management standpoint we actually started the
17 program probably seven, eight years ago, and
18 actually in 2012 to '15, we were part of a CMMI
19 grant. And the focus on that CMMI grant was really
20 the focus on -- one of the main things was how
21 could you scale a program caring for the seriously
22 ill in rural and urban areas. And so we were able
23 to scale between 2012 and '15, with the three
24 years' CMMI grant, and some of the findings that we

1 actually saw as we came through that, NORC did an
2 independent evaluation of that grant period for
3 CMS, and we were actually able to see that in the
4 last 30 days of life, when we added a comparison
5 group, that there was savings of over \$4,000 per
6 member per month.

7 And so I think when we look at that last
8 30 days of life, what we have seen with the
9 interventions is, you know, an improvement in the
10 symptoms managed, an improvement in the transitions
11 in regards to access to hospice, definitely
12 improvement in regards to pre- and post-
13 hospitalization and ED measures. So when we looked
14 at pre- and post-90 day, we had a reduction after
15 the intervention, and that's the referral to
16 interdisciplinary team, we saw a reduction in
17 hospitalizations around 60 percent. And that's
18 where we're sitting at currently right now.

19 And so when we looked at median length of
20 stay in hospice for inpatients, within Sutter
21 Health what we currently sit at is it's about 24
22 days that patients and families median length of
23 stay is; whereas, without AIM as an intervention,
24 it's around 15 days. So we do see improvement in

1 regards to actual for hospice for patients who are
2 identified earlier.

3 I don't know if that addresses your
4 question or not.

5 DR. NGUYEN: Yeah, Monique, I'll add to
6 that here on the eligibility here, Bruce. So the
7 AIM program, patients come to the AIM program by
8 referrals, and this is referrals from physicians,
9 referrals from the hospital, referrals from home
10 health, and patients are identified through these
11 referred sources. Once they're identified, the AIM
12 team does a clinical assessment and utilizes much
13 of the criteria that we're proposing in the
14 proposal.

15 And so returning back to the criteria,
16 there are four categories of clinical assessment:
17 one is acute care utilization; two is functional
18 status; three is nutritional status; and then four
19 is, you know, an objective measurement of
20 performance utilizing the three available
21 performance scales. And the AIM program utilized
22 much of these tools, much of these domains to
23 assess and determine if someone indeed has a one-
24 year prognosis. And we share with you some of that

1 data as part of our Q&A back to you. So that's
2 how the AIM program utilizes referrals.

3 Now, I'm sure Kris can add to this, that
4 when patients enter Kris' program, they may begin
5 three years out, and as they approach the last year
6 of life, the team does a clinical assessment of
7 that and tailors their advanced care planning based
8 on their understanding of where the patient's
9 prognosis is. And I think others -- Brad Smith can
10 also add to that as well.

11 MR. SMITH: Let me jump in on that. So,
12 Bruce, as background, we primarily identify
13 patients through administrative claims data that
14 Medicare Advantage plans have, and our customers,
15 partners, represent the vast majority -- almost
16 all, actually -- of the major Medicare Advantage
17 plans across the country. When we build predictive
18 models off of claims, about 50 percent of our
19 patients pass away within 12 months of
20 identification. When we take direct referrals --
21 and we use criteria very similar to those in the
22 ACM proposal to train and educate care managers and
23 physicians on those criteria -- it's closer to, you
24 know, 70 to 75 percent of those patients pass away

1 in a year. So while I don't think these criteria
2 are going to be 100 percent of members passing away
3 in a year, you know, I would definitely expect it
4 to be in that -- you know, definitely higher than
5 70, but probably not higher than 80 based on our
6 experience kind of range, if that's helpful.

7 MR. STEINWALD: That's helpful. Are you
8 routinely using what we are now calling "the
9 surprise question" to make that determination, that
10 is, the --

11 DR. NGUYEN: Yeah.

12 MR. STEINWALD: -- chief clinician would
13 say, "I would not be surprised if the patient
14 passed away within 12 months"?

15 MR. SMITH: We are.

16 MR. STEINWALD: You are.

17 MR. SMITH: We are, and we find that is
18 pretty predictive and would love Monique's thoughts
19 on this. What we typically find is typically when
20 we're training providers, we lead the training with
21 that question. We then describe more detailed
22 criteria, like those that are laid out, and then
23 sort of close the presentation with that question,
24 because what we find is if you say yes to -- or,

1 "No, I wouldn't be surprised" to that question, the
2 chance that you meet those other criteria is quite
3 high. But we've found the additional layer of
4 depth is helpful, but the surprise question is
5 definitely directionally correct.

6 DR. REESE: Yeah, that's what we're using,
7 too, from a Sutter Health AIM standpoint. So we
8 are using the surprise question, but we also are
9 wrapping up in regards to hospitalizations prior to
10 the admission, so number of hospitalizations, and I
11 think to Khue's point, kind of back to the
12 different domains and criteria we're looking at, we
13 are looking at, you know, functional status from a
14 PPS standpoint, nutritional status from your
15 albumin and so forth, and, you know, utilization
16 data.

17 So it's pretty comprehensive on the way
18 that we're identifying and looking at patients.

19 MS. PAGE: This is Ann. Can we move to
20 the proposed model? I just don't want to confuse
21 the Sutter Health model with the AIM model with the
22 ACM model that we're focusing on.

23 DR. NGUYEN: Yes, and I think much of what
24 the team has shared with you are elements of the

1 ACM, but it's good to clarify. And we wanted to
2 also just clarify here that what we asked the team
3 to share about their programs are elements that
4 match up to what we're proposing.

5 DR. CASALE: Just to follow up on that, so
6 in the proposal, you try and identify -- this is
7 Paul -- patients who are likely to die within 12
8 months.

9 DR. NGUYEN: Yes.

10 DR. CASALE: There's two questions. One
11 is -- and please correct me if I'm wrong -- it
12 seemed like in terms of the references that were
13 provided in terms of the ability to do that, that
14 the ability to do that in patients with cancer was
15 much better than those with other diagnoses. So
16 that's one question.

17 And the other is I'm still a little unsure
18 as to exactly how does the patient get into the
19 model. I know you talked about sort of the care
20 for the patient, but the trigger, what's going to
21 happen? Is it a conversation with that patient?
22 I'm trying to understand what gets them into the
23 model.

24 DR. NGUYEN: Right, right.

1 MR. SMITH: Khue --

2 DR. CASALE: So the first question was
3 around the cancer diagnosis being easier to predict
4 than non-cancer, and maybe -- I just want to make
5 sure if I'm correct in that. And then the second
6 is around how does the patient actually get into
7 the program, into this model.

8 DR. NGUYEN: Right. Kris, please add to
9 what I shared on the cancer patients. You're right
10 that for cancer patients it's a lot more
11 straightforward. For the most part, the team is
12 able to predict prognosis once they have an
13 understanding of the cancer and the stage of
14 cancer. One doesn't even have to look at these
15 various domains. So in some way cancer is more
16 straightforward because we just have more data on
17 staging and prognosis.

18 These utilization domains are really
19 created to target the other chronic conditions --
20 heart failure, COPD -- and so it is designed to
21 allow us to capture a variety of patient profiles.

22 MR. SMITH: And, Khue, this is Brad. Just
23 let me add a little more detail on that. What we
24 do, obviously cancer you can do in the sense it's

1 pretty binary. We have found for organ failure,
2 these criteria also work quite well, so CHF, COPD,
3 end-stage renal, end-stage liver. What we've found
4 is for dementia patients, many of the dementia
5 patients will not meet these criteria, and it's a
6 little bit harder to predict decline in dementia
7 patients than it is in organ failure patients or in
8 cancer patients.

9 DR. NGUYEN: Right.

10 DR. SMITH: This is Kris. That's been our
11 experience as well, that cancer is easy, organ
12 failure with proper functional status, surprise
13 question, recent utilization, you can identify a
14 group of patients that, on average, has a very
15 limited life expectancy. But I wanted to address
16 the question of how patients find their way into
17 programs like this. As Khue pointed out, we're all
18 --

19 DR. CASALE: I'm talking about a specific
20 model. I don't mean to interrupt. Just focus on
21 this model. I just want to make sure I understand
22 how a patient is going to -- will be enrolled in
23 this payment model.

24 DR. NGUYEN: Yes, so I'll start here,

1 Kris, and so let's just start with we have an ACM
2 entity, and we described here that the ACM entity
3 is made up of a team that deliver the core
4 services, so let's call that the "core team." And
5 it also consists of a network of physicians who
6 choose to participate in the model.

7 And so patients, the eligible population
8 of patients that can be enrolled in the program
9 will be advanced illness patients of those
10 physicians that choose to participate in the model.
11 So that's one filter.

12 The ACM entity has a variety of ways to
13 structure how they identify these patients. They
14 can use a predictive algorithm similar to what
15 Aspire used to help them identify a potential list
16 of patients and then assess those patients further
17 against these eligibility. Or they can also do
18 what Sutter Health and what Kris' program does,
19 which is rely on providers to identify these
20 patients and refer them into the program. So it
21 could be referral with or without the help of a
22 patient list.

23 Once the patient is identified, then the
24 ACM entity is responsible for applying the clinical

1 criteria, and that can be done by the physicians
2 that participate in the model or it can be done by
3 the core team. Likely it's going to be done by the
4 core team whose focus is on this population. When
5 the physicians participate in this model, they're
6 committed to the approach, the ACM care approach,
7 and they're committed to how patients -- to the
8 eligibility, and so it's going to be up to the ACM
9 entity to decide how it operationalizes in terms of
10 who does the eligibility assessment. But,
11 ultimately, the ACM is accountable to applying the
12 eligibility appropriately, and in our quality
13 assurance program that we propose as well as in the
14 evaluation, there is going to be a lookback to each
15 of these ACM entities, you know, to essentially do
16 a verification of their eligibility.

17 MR. STEINWALD: This is Bruce. Let me --
18 oh, go ahead, Paul.

19 DR. CASALE: Sorry. At the time of
20 enrollment, does someone sit down with the patient
21 and so they understand they're in this payment
22 model, that they're in this particular model?

23 DR. NGUYEN: Yes, yes. Yes, that's a best
24 practice, and that's what we expect out of these

1 ACM programs, is that patients will be introduced
2 to the service, and so patients will be introduced
3 to what are the additional services that they'll
4 get, who are the team members, how does the team
5 member relate to their existing provider. Kris
6 does this, Monique does this. When an AIM patient
7 comes into the program, you know, the care team
8 sits down with them, introduces the services,
9 orients them to how the care team is going to work
10 in collaboration and integrate -- and in
11 coordination with their treating physician, so
12 those are process questions -- those are process
13 orientations that the ACM team is going to
14 communicate.

15 MS. PAGE: And will the patient be told
16 that the program is only for 12 months, and after
17 that they will revert back, I guess, to either what
18 they had before or people can continue to pay --
19 continue to care for them, but they won't be paid
20 for these extra services?

21 MR. SMITH: This is Brad. That's correct,
22 but let me walk through a little bit more, and this
23 gets to a couple of your later questions around the
24 payment model. And I think, you know, what we've

1 proposed, I think, is relative -- I think it's
2 pretty thoughtful relative to, for example, how
3 we're contracting with MA plans today. So
4 specifically in this payment model, you're in for
5 12 months. You can receive the additional payment.
6 But in terms of the shared savings component,
7 you're in for any patient -- you're responsible for
8 that for any patient who you serve who then passes
9 away.

10 So if you identify a patient let's say 15
11 months out from death, you serve them for 12
12 months. There's three -- or you get the payment
13 for 12 months. There's then three months at which
14 point the patient passes away, and you're still
15 responsible for that total cost in the last 12
16 months of life.

17 What we believe this payment model does is
18 really hits a thoughtful balance between two
19 things. One, it limits the financial exposure of
20 the federal government in terms of paying for the
21 services for patients for 24 months. You can't,
22 for example, like in hospice, continue to get
23 recertified into the program. At the same time,
24 because you're holding that entity accountable for

1 total costs in the last 12 months, even if a
2 patient doesn't die during the 12 months they're on
3 the program, what we believe -- and I can speak to
4 what we would do as our entity, but what we believe
5 most of the ACMs, if not all of them, would do is
6 continue to provide services to those patients
7 during that period of time.

8 What it will really do is put appropriate
9 -- not pressure but encouragement on the programs
10 very early in that process to discharge patients or
11 to not accept patients under the program who really
12 don't have short life expectancies. So we really
13 think the payment model is really thoughtful in
14 terms of capping the financial exposure to the
15 federal government, while at the same time having a
16 very high likelihood that the patient will receive
17 services all the way up to their death without the
18 government having to pay for, say, 15 months of
19 services.

20 MR. STEINWALD: Elizabeth, did I hear you
21 join us?

22 MS. MITCHELL: You did. I'm sorry I'm
23 late.

24 MR. STEINWALD: I thought I heard

1 Elizabeth beep in. Maybe not.

2 MS. PAGE: I just want to make sure I
3 understood what you said correctly. So if you
4 begin to serve somebody who's in the last 15 months
5 of life and they die at -- or the program only
6 extends for 12 months, did you say that the ACM
7 would be -- the entity would be accountable for the
8 cost of care through the 15 months, through death?

9 MR. SMITH: So the payment model is based
10 on total costs in the last 12 months of life. So
11 you'd actually be -- technically the reconciliation
12 would happen on those nine months they were in the
13 program plus the three months that they -- I
14 shouldn't say "in the program" because they're
15 likely to be in the program. The nine months you
16 were getting compensated additionally for, and then
17 the three months for which there wasn't additional
18 compensation. And so what it does is it really
19 encourages the programs, without an additional cost
20 to the federal government, to continue to provide
21 these services up until a patient passes away.

22 DR. NGUYEN: Yes, so for that 15-month
23 patient, the ACM is accountable for the last 12
24 months of life in terms of the shared risk, shared

1 savings. The PMPM payment is also capped at 12
2 months, but we also propose here that for patients
3 -- the ACM has the flexibility and the option to
4 monitor and care for patients beyond 12 months if
5 they so choose, especially those patients where we
6 anticipate that they may have 15 months and it can
7 be -- the patient will come back to the program
8 again within a short period of time. We anticipate
9 that the ACM will want to hold on to those patients
10 and continue to support them because their need
11 will resurface. And so it has that flexibility of
12 continuing to care for patients, but being
13 accountable for the last year.

14 DR. SMITH: Khue, this is Kris again.
15 That was part of what we thought was, you know, a
16 good part of the design, is because you're going to
17 share in savings that are related to the last 12
18 months of life, you would probably be very hesitant
19 to discharge a patient who has been with you for 12
20 months, it looks like they have, you know, a few
21 more months most likely, because to release them
22 from the program means that they would probably go
23 back to their pre-program utilization profile of
24 bouncing back and forth from hospital to rehab to

1 home. And so you'd really be -- even though you
2 weren't getting those up-front payments, you'd be
3 incentivized to keep that patient on board or get
4 them into hospice because as the AIM program and
5 many programs have shown, the substantial cost
6 savings are in those last 90 days of life, and so
7 you wouldn't want to release the patient back into
8 an old care model that wasn't serving them well.
9 So as Brad is saying, we're trying to balance not
10 having an endless new benefit and encouraging
11 providers to do the right thing without being sort
12 of too prescriptive.

13 MR. STEINWALD: Okay. I want to ask that
14 question on sort of -- I'm going to restate what I
15 think I heard, and then you can tell me if it's
16 accurate. So it sounds like the patients would be
17 drawn from a larger population of patients,
18 probably with multiple chronic conditions that are
19 already being cared for by essentially the same
20 provider group who would be providing services
21 during -- when the model would -- when the patient
22 would enter the model? Is that true? So that they
23 would be drawing -- identifying the patients from a
24 larger population of patients who they believe

1 would meet the eligibility criteria, and then it
2 would be determined whether they did, in fact, meet
3 the eligibility criteria. Is that accurate?

4 DR. NGUYEN: Yeah.

5 DR. SMITH: I think that's one of two
6 scenarios. So one would be that you're an
7 integrated delivery system, and your PCPs and your
8 oncologists, et cetera, would be referring into a
9 program like this set up by that integrated
10 delivery system, right?

11 Another opportunity would be, you know, an
12 organization that was independent of that providing
13 these services who would essentially go around to
14 non-owned PCP specialists -- this is especially
15 important in rural areas, right? -- individual
16 physicians to educate and generate those referrals
17 into the program.

18 So it may be that the delivery mechanism
19 and the referral base are part of the same
20 institution, but the model is also flexible enough,
21 especially for rural areas, to allow referrals from
22 multiple referral sources into a single program.

23 MR. STEINWALD: Okay. Thank you. That's
24 helpful.

1 DR. NGUYEN: Yeah, and here it consists of
2 -- the model consists of a group of physicians who
3 agree to participating, and so Brad is right, that
4 that group of physicians could be in an integrated
5 delivery system or it could be a network of
6 independent physicians who come together with a
7 service provider to structure the ACM. But it is
8 based off of a group of physicians, and the
9 population is drawn from that group of physicians'
10 population.

11 MR. STEINWALD: Okay. Paul, do you have
12 any more --

13 DR. NGUYEN: Did we get to -- I'm sorry,
14 Bruce.

15 MR. STEINWALD: I'm looking at our topic
16 questions and trying to see if they've all been
17 addressed, I mean, all of the first ones about
18 eligibility and recruitment and patient experience.
19 Ann, what do you think? Should we move on?

20 MS. PAGE: Yes. I think we're on to the
21 care coordination question.

22 MR. STEINWALD: Okay.

23 DR. NGUYEN: Yeah, can I ask, Ann, did you
24 feel that we answered your question around the 12

1 months?

2 MS. PAGE: I guess, you know, I heard --
3 and I'll just restate quickly -- that if a person
4 lives longer than 12 months, the ACM would be
5 accountable for all costs leading up to death.

6 DR. CASALE: Well, for the 12 months up to
7 death. So if they live -- it's just the last 12
8 months, so if they live 15, 16, or 17, it's my
9 understanding -- do I have that right? It's the 12
10 months up 'til death.

11 MR. SMITH: That's correct, and we picked
12 that theory because that's where there's a
13 concentration of cost and all patients will go
14 through that period. But, yes, that's correct.

15 DR. CASALE: Okay.

16 MS. PAGE: I guess to clarify, even if
17 they enrolled in hospice?

18 DR. NGUYEN: Yes.

19 MR. SMITH: Yes, that's a very important
20 part of the model, actually. It's because many
21 times hospice is both an appropriate and most cost
22 reasonable method of care. The patient -- you
23 know, both the hospice cost would be in the cost of
24 the patient delivery, but, yes, they would stay in

1 all the way through death. What this would
2 encourage is appropriate utilization of hospice by
3 the ACM program.

4 DR. NGUYEN: Yeah, if you stop the payment
5 once patient enters hospice, you could create
6 potentially negative consequences or cost shifting
7 from one bucket to the next if they're not tied
8 together. And so we saw that care needs to be
9 coordinated from ACM to hospice, so from a delivery
10 we believe that it needs to be a continuum of care
11 and also --

12 MR. STEINWALD: But I thought --

13 DR. NGUYEN: -- from a payment -- yes?

14 MR. STEINWALD: Your proposal I thought
15 said that the patient would participate up to the
16 point of death or discharge to hospice. I thought
17 they were treated much the same as far as the model
18 is concerned.

19 MR. SMITH: That's right. Let me clarify
20 --

21 DR. NGUYEN: Yeah.

22 MR. SMITH: Yeah, let me clarify Khue's
23 comments. So the PMPM \$400 payment stops at three
24 points: it stops after 12 months no matter what;

1 it stops at death; or it stops when you go to
2 hospice. Any of those three things would stop the
3 \$400 PMPM.

4 MR. STEINWALD: Right.

5 MR. SMITH: What you're responsible for as
6 an entity in risk is the total cost the last 12
7 months of life, so if a patient was in hospice, you
8 would not receive the PMPM for that. But you would
9 be at risk for that period of time because
10 presumably it's in the last 12 months of life. But
11 you would not be receiving the PMPM.

12 MR. STEINWALD: Got it. Okay. That does
13 raise a question, though, about how you determine
14 what your savings, if there are any, are when
15 there's nothing in a claims database that tells you
16 when the patient has 12 months left to live, nor is
17 there a code for a prognosis for that. I'm
18 wondering how you then make a determination of,
19 okay, what would have happened to this patient if
20 they weren't in the model, both clinically and
21 economically?

22 MR. SMITH: Yes, this is Brad. I'll take
23 a first shot at the economic, and, Khue, if you
24 want to do it from the clinical. But what's unique

1 about this patient population is that the vast
2 majority of them will die within 12 months and
3 almost all of them will die within, let's say, 18
4 months or something like that. And so you have
5 this very finite endpoint from which
6 retrospectively you can count backwards. Right?
7 So you will know for every patient in that group
8 what their last 12 months were in a definitive way.

9 The model then -- and Khue can talk
10 through it more -- proposes essentially building
11 that cost curve, if you want to think of it that
12 way, on an index adjusted by region basis for other
13 patients who were not in the model who would have
14 otherwise qualified for the model. So I think it
15 really takes in this sort of this uniqueness of
16 this patient population, which is there's this very
17 definitive endpoint, death, from which you can
18 count backwards. But, sorry, Khue, I didn't mean
19 to interrupt you.

20 DR. NGUYEN: Yeah, so, you know, the
21 clinical criteria is a way for us to get to
22 prognosis and, you know, we have Paul, our
23 cardiologist -- a clinician can do a much better
24 job of assessing prognosis than what claims data is

1 able to do. And, therefore, that's why we have
2 these clinical criteria to get us to a high
3 prognostic determination. And so that's how
4 patients come into the program. And Brad is right.
5 If we could think of these patients -- if we could
6 think of the ACM as like bundles and bundles, we
7 can -- you know, we can clearly detect an episode
8 of care, whether that's a 30-day post-
9 hospitalization, that's very clear.

10 In the case of the ACM, it's also very
11 clear, we can look back -- we can look back at an
12 ACM prior history and look at the decedents and
13 determine that historical episode benchmark, and
14 that's how we propose to do the evaluation, is to
15 really use decedents as a way of determining and
16 reconstructing that one-year episode of care and
17 using that as a baseline benchmark to then apply
18 those patients that are being seen by the program.

19 So the analysis will really be a time
20 series in the sense that the benchmark, the
21 baseline, will be based on prior years prior to the
22 start of the program, and then compared to the
23 performance period when patients are enrolled in
24 the program. And in each case, it will be looking

1 back at decedents and their utilization in that 12
2 months.

3 MR. STEINWALD: Would you try to match on
4 diagnosis and multiple diagnoses, other patient
5 demographic characteristics that are measurable?

6 DR. NGUYEN: Yes, yes. Yes, so we lay out
7 the matching construct, conceptual model, and we
8 anticipate that CMMI can also lend their experience
9 to this. But in our Q&A, we provided a way of how
10 to construct that evaluation, and we propose that
11 patients would be matched by age, diagnosis,
12 frailty index, case mix, a variety of measures
13 based on our own experience of what we know
14 differentiate between two patients.

15 MR. STEINWALD: Okay. I apologize for not
16 remembering that.

17 MS. PAGE: And one last question. I think
18 we almost touched on it, but since we're going to
19 get off the eligibility and recruitment part, I
20 just want it to be clear. Would the patients be
21 told that this is a program for people, you know,
22 thought to be in the last 12 months of their lives?

23 DR. NGUYEN: Yeah, so I think here we -- I
24 think we're -- you know, I think that the program

1 will have to provide a high-level description of
2 what we're trying to achieve here, and that has to
3 be public and available.

4 At the same time, we also need to -- this
5 is a very difficult phase of their illness. This
6 is the reason why we formed the program, is to help
7 patients and providers walk through this transition
8 from curative to comfort care. And so there is
9 what one has to communicate around what are we
10 trying to achieve with such a program, and then
11 there is what do you actually communicate to
12 patients when they come into the program in a way
13 that helps them. And I think that both will need
14 to be considered.

15 I was talking to Kris Smith about this,
16 and, you know, Kris talks about, "Well, when I meet
17 with a patient in hospice, I don't ever say you
18 have terminal illness; you have a prognosis of six
19 months left." And so, you know, we're actually
20 talking about a patient population that is not as
21 aware as the hospice population so there has to be
22 even more attention and care to how we communicate
23 and help patients get to that level of
24 understanding, and that's the whole reason why this

1 program is formed as well.

2 Kris, do you want to add to that?

3 DR. SMITH: Yeah, you know, when Khue
4 introduced me earlier, one of the things she didn't
5 mention was I'm boarded in hospice and palliative
6 care and have been working with our palliative care
7 inpatient teams and our hospice organization quite
8 a lot over the last six years at Northwell. And,
9 you know, clinically, when I talk with patients who
10 I bring into our advanced illness program, I don't
11 typically start the conversation with, "You have
12 less than 12 months to live." I typically start
13 the conversation with, you know, "You have a
14 serious illness, and that serious illness is
15 probably going to limit your life expectancy." But
16 over the course of the first couple of visits in
17 that first month, we can get down to the real, you
18 know, finer details of what that means. But as
19 Khue said, it's often -- often families haven't
20 been counseled properly prior to a conversation
21 with me about where they or their loved one is in
22 their illness.

23 And so, you know, it's an art to try and
24 find a way to partner with patients and families to

1 get to that point where you can have those honest
2 conversations. I don't want to be thrown out of
3 the home or the room of a patient who needs my help
4 because I shocked them with, you know, a definitive
5 expectancy around how long they have to live.

6 DR. CASALE: This is Paul. I understand
7 all that, and I think, however, this is a payment
8 model, and so there will be additional payments
9 related to their care.

10 DR. SMITH: Right.

11 DR. CASALE: And so, you know, there will
12 be -- so there will be some transparency around
13 that. So I suspect that --

14 DR. SMITH: Yeah, and we've had good
15 experience, so in the Independence At Home
16 demonstration, which is not quite 12 months to live
17 but probably more like 24 to 36, but even within
18 that program, while we don't get up-front payments,
19 we do have the opportunity for shared savings. And
20 we do have to inform every patient that they are
21 being enrolled into a program that is a CMMI
22 demonstration. And, you know, we have to give them
23 the paperwork. We don't have to get them to sign
24 anything, which I think was the right decision, but

1 we do have to give them paperwork and talk to them
2 about it. And, you know, it leads to good
3 conversations, not something that has been really a
4 problem.

5 MR. STEINWALD: Go ahead.

6 MR. SMITH: I was going to say to put a
7 more fine point, I think this would be something
8 we'd be excited to work -- have the chance to work
9 with CMMI on, and I think our recommendation based
10 on our collective experience would be that you'd
11 have to clarify that the patient has an advanced
12 illness; you have to clarify for them that advanced
13 care planning is part of what the services will be.
14 I think our recommendation would probably be that
15 you don't have to mention the 12-month piece, but
16 that's something we'd obviously, you know, want to
17 work through with you all, because as was mentioned
18 several times, there are pros and cons to that.

19 DR. NGUYEN: Yeah, and patients will come
20 -- I think all of the programs here can say that a
21 higher percent of patients will come to understand
22 their prognosis or, you know, the limited time that
23 they have. So that information will be thoroughly
24 explored as part of the ongoing advanced care

1 planning. So this won't be a -- you know, patients
2 will -- part of the job is to help patients develop
3 that awareness.

4 MR. STEINWALD: This is Bruce. Say a
5 little bit more. You used the phrase "the
6 transition from curative to comfort care."
7 Patients in the model will still be eligible for
8 Medicare fee-for-service benefits, and yet they
9 will be managed by a care team that is well aware
10 of the need to make that transition go as smoothly
11 as possible. How do you accomplish that? We talk
12 a lot about silos in medicine, and this patient
13 population often suffers from medicine being
14 siloed. How do you break down the silos and make
15 that transition as smooth as it can be?

16 DR. NGUYEN: Yeah, yeah, and you hear it,
17 and the story that Kris talks about where he talks
18 about the two patients and his team very much
19 initially were focused on helping patients manage
20 their condition. And so this care team, in order
21 to achieve the kind of outcomes that Kris and
22 Monique and Brad are achieving, the way to get to
23 that is to coordinate and to engage with the
24 physicians. And so the model naturally motivates

1 and incentivizes the clinicians to coordinate
2 because that's how you can prevent
3 hospitalizations. And for many of the patients who
4 first come into the program, very much the focus is
5 going to be around disease management. It's mainly
6 about coordinating the care that they need at that
7 moment and very likely most patients come into this
8 program not yet ready for hospice or not yet
9 eligible for hospice.

10 And so part of the work will be around
11 disease management and care coordination, and as
12 the team comes to understand the patients'
13 preferences, their values, and how that changes
14 over time, then they facilitate a care plan that
15 aligns with that, and that's why it's important to
16 have that ongoing relationship and engagement with
17 the patient's physician, because they'll have to be
18 -- just as much as patients have to move through,
19 physicians will have to be kept informed and be
20 ready to make these additional changes to the way
21 they treat patients.

22 MR. STEINWALD: Could you say a little
23 more about the care coordination team, what kinds
24 of training and expertise and credentials you

1 expect to have, how standardized do you think that
2 would be or how variable it could be across
3 different parts of the country and different
4 systems?

5 MR. SMITH: So this is Brad. I could take
6 the first shot at that. So what we have found is
7 really unique. As Khue mentioned, we're in 23
8 different states, and we have, as was proposed in
9 the ACM model, palliative care physicians leading
10 these teams, and what we have found is a core
11 competency of palliative care physicians is this
12 physician-to-physician communication. So being
13 able to call an oncologist and talk about, "Hey, we
14 were just with Ms. Jones at her [unintelligible],
15 and I'll tell you what we heard from her and her
16 daughter," et cetera.

17 And so we believe that this physician-to-
18 physician communication that's leading the team is
19 very scalable across the country and will help
20 ensure coordination. In our experience, we are not
21 part of an integrated delivery system. We are
22 coming in with Medicare Advantage plans, so it's
23 the toughest environment you could think of for
24 having this coordination. And this was probably

1 our first concern when we launched four years ago.
2 It has turned out to be one of our smallest
3 concerns.

4 The primary care physicians, oncologists,
5 and cardiologists are very receptive to the
6 palliative care physicians reaching out and are
7 very grateful to have this additional service in
8 the home.

9 MR. STEINWALD: What about the non-
10 physician members of the care coordination team?

11 DR. NGUYEN: Yeah, yeah. You know, I
12 think there is a lot of care coordination --
13 training nurses and social workers and even non-
14 clinicians to do care coordination is now, you
15 know, very much a topic for the entire country.
16 And so I think that we can leverage that bigger
17 wave in terms of training, you know, training at
18 the site of delivery as well as influencing how
19 nurses and social workers train in the future.
20 But, you know, for many of these programs, it's
21 drawing from these clinicians, these non-physician
22 clinicians, who have already done some of this work
23 and still, for example, are drawing from nurses who
24 have done home health or who have done hospice, and

1 even -- you know, so care coordination is not new
2 to medicine. It's care coordination over time,
3 keeping patients at the center. It's expanding on
4 what these clinicians currently do in the current
5 environment, and creating a different context is as
6 much of the change as the clinical skill training
7 itself.

8 From our own experience, if you put these
9 clinicians in the right structure and give them the
10 right delivery structure, and with some
11 orientation, they're able to do well. For example,
12 the AIM program, which has the scale across the
13 footprint within the first year, you know, was able
14 to scale by putting in place the structure and, you
15 know, delivering that kind of -- and putting in
16 place an in-house training program, and it has
17 trained hundreds of nurses and social workers by
18 now.

19 So I think the workforce question is one
20 of -- you know, the workforce need is one that is
21 part of the bigger workforce need, so I think we
22 can leverage the broader changes to help us with
23 long-term workforce development. We structure the
24 team such that it consists of a -- on the team,

1 there has to be at least a palliative care- or
2 hospice-trained medical director, and so there is
3 going to be that consistency in the area of
4 specialty care. And so there is that component
5 that is consistent that will be the guidance. And,
6 obviously, if the team has more of that experience,
7 they're stronger. But we recognize that one will
8 have to draw from multiple sources in terms of
9 nurses and social workers.

10 MS. PAGE: So --

11 MR. STEINWALD: And the specific training
12 for caring for this kind of population, though, is
13 part of the required credentials of the nurses and
14 social workers you're referring to?

15 DR. NGUYEN: Yes, yes. So we described it
16 in the narrative that there will be an operational
17 plan, and so we assume that the model goes forward,
18 organizations will have to apply, and one of the
19 requirements for consideration will be to put in
20 place an operational plan that demonstrates to CMS
21 how an entity would organize itself, including
22 recruitment, training, the ability to collect data,
23 all of the core elements to make this a success,
24 including training.

1 MS. PAGE: And I want to go back to Kris'
2 -- I want to make sure I understand. Kris was
3 talking about a team being headed by a palliative
4 care physician. Is that part of the ACM model that
5 each of the care coordination teams would be headed
6 by a palliative care physician?

7 DR. NGUYEN: Yes, and we clarify here that
8 it's -- we know that palliative care physicians are
9 small in numbers, and so we said that it would be
10 either palliative care or hospice-trained.

11 MS. PAGE: And board certified?

12 DR. NGUYEN: Yes.

13 DR. CASALE: Okay, because in your answers
14 to questions, you also had "or who have practiced
15 more than half-time in hospice and palliative care
16 for at least three years."

17 DR. NGUYEN: Yeah.

18 DR. CASALE: Which would suggest providers
19 who are not board certified or necessarily
20 physicians?

21 DR. NGUYEN: You're right. You're right
22 about that, and I think we're -- you know, a
23 thought here is that we have to recognize the
24 shortage. I think board certified is definitely a

1 consistent approach, and we would be open to
2 discussing this further.

3 DR. CASALE: Okay. Great. Thanks.

4 MR. SMITH: And, Khue, I think the
5 thought, too, is that certain things might make
6 sense in a more urban area and different things
7 might make sense in, say, a more rural area
8 potentially.

9 MR. STEINWALD: In the experience of the
10 programs that you're already involved with, has
11 there been a lot of rural participation?

12 MR. SMITH: This is Brad. In our case
13 there has, so we are in most of the counties in
14 West Virginia, probably 80 percent of the counties
15 in Alabama, 80 or 90 percent of the counties in
16 Tennessee, probably 75 percent of the counties in
17 Ohio. So, you know, that's not to say that we're
18 in 100 percent of these areas, but we are serving
19 patients in rural areas.

20 What we actually find is the need for
21 these services -- you know, the delivery model is
22 obviously more challenging. But the desire on the
23 part of PCPs and specialists to have these services
24 is exceptionally high, and their engagement around

1 them is very high. So, obviously, density is a
2 factor, and the program would have to have a
3 strategy for how to drive, you know, a meaningful
4 amount of volume and have really tight
5 partnerships, but we've actually found it works
6 quite well in rural areas.

7 MR. STEINWALD: And what entities are you
8 typically partnering up with in rural areas? Just
9 individual physicians or something bigger than
10 that?

11 MR. SMITH: It's typically individual
12 physicians. So, you know, we are unique in that we
13 contract with Medicare Advantage plans, so we know
14 who their members are attributed to. So we then
15 reach out to those PCPs who have a large number of
16 attributed members, and oncologists as well,
17 typically -- although typically there aren't that
18 many in rural areas.

19 MR. STEINWALD: Okay. Okay. So let's go
20 into it a little bit more, make sure we completely
21 understand what happens to patients who are alive
22 after 12 months.

23 By the way, just as a footnote here, a lot
24 of our questions for you are based on what we see

1 in the proposal, and they're payment model-oriented
2 questions. In fact, what PTAC stands for is
3 Physician-Focused Payment Model Technical Advisory
4 Committee. So we're very much focused on the
5 payment and how the payment coordinates with the
6 care model, and, in fact, how sometimes the
7 incentives of the payment model might conflict in
8 some cases with the incentives of the care model.

9 So when we ask questions that sort of
10 focus, okay, what happens to the patient who lives
11 more than 12 months, we're trying to figure out if
12 there are disincentives to providing comprehensive
13 care for those patients because there's no longer a
14 per member per month payment. And we don't want to
15 seem to be heartless or suggest that you are, but
16 we definitely want to focus on that subgroup
17 because we want to make sure that they are
18 accommodated in a way that everyone would be
19 comfortable with.

20 DR. NGUYEN: Yeah, yeah. And, you know,
21 we've thought about it, Bruce, whether should the
22 PMPM extend beyond -- you know, if we go back to
23 that patient 15 months in the program, should the
24 PMPM be up to 15 months? That may be where this

1 payment model could go to in Generation 2. The
2 thought here is that -- you know, so we want to
3 build from a hospice experience, and, you know, the
4 hospice program has to absolutely discharge
5 patients once they pass that six-month prognosis,
6 and we know patients then decline, and then they
7 have to go back into hospice. And so we want to
8 learn from that and create an environment where we
9 recognize that need and also recognize that
10 providers want to continue to care for these
11 patients. We also don't want -- we also want to
12 have success with the payment model and build on
13 that success.

14 And so those were the considerations, and
15 we anticipate that for any of these programs, 80
16 percent of them, if they apply the clinical
17 criteria, will have a one-year prognosis,
18 especially if you care for these patients, you
19 know, you may have the prognosis wrong, and the
20 team is going to be able to detect that within that
21 first month. And sometimes, you know, good
22 prognostication means that there will be some
23 patients where we get it wrong, and those patients
24 should be discharged or go back to usual care. But

1 then there are patients that are followed and they
2 do better because they're being followed, and if we
3 leave them, if we return them back, they may
4 decline again. And there's work to be done there.
5 Our thought is that by supporting providers who
6 want to continue to care for these patients, by
7 recognizing the patient's need, and through a
8 structured program such as this by CMS, we will
9 have the ability to go back and look at this small
10 subgroup population. And maybe part two will be
11 about expanding payment, you know, in some form or
12 another. But we thought that that would have to be
13 something that needs to be explored and analyzed
14 closely before we make those payment
15 recommendations. We just don't have a lot of
16 information about this cohort of patients yet.

17 MR. STEINWALD: Okay. Paul or Ann, any
18 more to ask or say about the more-than-12-month
19 population?

20 It sounds like you're saying that you
21 believe that the provider entities would have an
22 incentive to continue to provide comprehensive care
23 and the care coordination that they would get under
24 the model -- under the first 12 months; and yet

1 there wasn't a guarantee of that, was there, in the
2 way you proposed the model? Or am I missing it?

3 DR. NGUYEN: Yeah, yeah, and you may ask,
4 well, why don't you just guarantee it?

5 MR. SMITH: And, Khue, yeah, and I think
6 this is something that we'd love to talk to the --
7 you know, if we have the chance, to work with the
8 CMMI folks on, because as you guys know from all
9 the work you're doing, there are trade-offs around
10 how tight or narrow you make eligibility criteria,
11 how high and for how long you make the direct cash
12 payment, and then how you structure the shared
13 savings. Where we generally went is trying to pull
14 the clinical criteria pretty tight to cap the PMPM
15 after a pretty defined period of time, and then to
16 use the shared savings structure to try to bridge
17 that gap. Maybe making it a requirement would be a
18 really good idea. It would help on the
19 eligibility.

20 You know, there are obviously ways, you
21 know, depending on your feedback, CMMI feedback, if
22 we had the chance, to tweak some of those things a
23 little bit. You could make the eligibility a
24 little bit broader or a little bit narrower, the

1 PMPM a little bit longer, a little bit shorter.
2 You know, so I think those are things that, you
3 know, if we had the chance to make sense, could
4 definitely talk about some of the trade-offs being
5 made. But I think our general thought was let's go
6 narrow to start, let's try to cap the exposure that
7 the federal government has, and then if it turns
8 out that the program is really successful, you
9 could think about how to tweak back out of that
10 little bit to serve a broader population, if you
11 can figure out how to target it appropriately.

12 MR. STEINWALD: Okay. That's fair. Let's
13 talk a little bit -- if, Paul and Ann, you're
14 comfortable about the hospice benefit. Because
15 you'll see in our topic an implied question about
16 potential conflict of interest, and, again, we're
17 looking at two different payment models now: the
18 one you're proposing in your proposal, and then the
19 hospice benefit that currently exists. And we
20 wanted you to tell us a little bit more about why
21 you don't think that there is a conflict of
22 interest, for example, wanting to refer the patient
23 to hospice when it becomes clear that it's
24 financially advantageous to do so, as opposed to

1 staying in the model, and that, you know, then the
2 implied difficulty there is that if it's not good
3 for patients if they're being referred to a medium
4 of care that's based on financial interests as
5 opposed to clinical.

6 So, please, talk to us a little bit about
7 that, if you will.

8 DR. NGUYEN: Yeah, yeah. You know, the
9 hospice -- the interaction between this model with
10 hospice is an important one, and in some way it is
11 intended to interact with the hospice benefit. You
12 know, we share here that the ACM has accountability
13 through hospice, and so that will motivate the ACM
14 to utilize hospice appropriately. And in our
15 experience, what that has translated to is more
16 hospice days and reducing the extremities that we
17 see in hospice today. You know, today in hospice
18 what has happened is that many patients enter
19 hospice way too late. You know, more than half
20 hospice length of stay -- the median hospice length
21 of stay is, you know, between two to three weeks
22 from program to program, so that's half of
23 patients.

24 And then there's the other worry, which

1 is, you know, are we overutilizing hospice, and
2 there's a small percentage of patients that do need
3 this support, do need some form of support longer
4 than six months. And what this program does is it
5 creates that space, that landing space for patients
6 to go into where they can receive care. And that's
7 where we can tackle both reducing those unnecessary
8 long lengths of stay. The frail, elderly patients
9 with dementia, for example, can get this form of
10 support until they truly need a higher form of
11 service, and that's where hospice comes in. The
12 same is true for the short length of stay.

13 DR. SMITH: Khue, this is Kris.

14 DR. NGUYEN: Yeah.

15 DR. SMITH: I think one of the important
16 things to recognize, too, about the way we've
17 structured the payment model is, you know, with
18 this additional \$400 or so PMPM that the ACM would
19 receive, that is obviously not a high enough
20 reimbursement to mimic the suite of services that
21 are available through hospice. So there will come
22 a natural point in time where since you are trying
23 to act in the best interests of the patient -- and
24 I think we have to give these clinical teams that

1 benefit of the doubt -- and since they are
2 ultimately responsible for total cost of care,
3 there is an incentive to get patients to the right
4 intensity care model, and hospice will certainly be
5 a higher-intensity care model than what we're
6 proposing here. So there will be an incentive to
7 get these patients to hospice at the right time.

8 I think the other thing we need to think
9 about, too -- and this is where Khue was going with
10 her comments, which is, you know, up until this
11 point our sole marker of success -- or maybe not
12 sole, but one of the most important markers of
13 success in care at the end of life is hospice
14 length of stay. What I think is really an
15 opportunity here is that all of those days prior to
16 hospice enrollment, these at-risk, suffering
17 patients and families could be in this new care
18 model that bridges the gap between hospice and sort
19 of traditional ambulatory care. So I think we can
20 think of a new quality measure of being on a
21 higher-intensity care model in the last 12 months,
22 not simply just hospice.

23 So I think that there's not a -- I don't
24 see that there's a conflict between hospice and

1 this model. I see that they would be very much
2 intertwined.

3 MR. STEINWALD: Okay. And you're saying
4 that in part because that's a -- there was a
5 patient who could -- who might be referred to
6 hospice too soon, whatever that means exactly --
7 well, maybe with more than six months left in life,
8 and not otherwise suitable.

9 Financially, since you're responsible for
10 the total cost of care, the longer that patient is
11 in hospice, the longer the payment will be based on
12 the hospice payment schedule.

13 DR. SMITH: Right.

14 MR. STEINWALD: And that will affect their
15 ability to have shared savings and good outcomes
16 otherwise.

17 DR. SMITH: Right. Yes, definitely on
18 that end there is also -- the way in which we've
19 tried to construct this is there's an incentive to
20 get patients into hospice, but there's also not --
21 there is also an incentive not to have them on
22 hospice for five months. You know, we think that
23 that is sort of an appropriate way of thinking
24 about this in terms of trying to be good stewards

1 for how we help Medicare find a way to provide
2 higher-quality care at a lower total cost.

3 DR. NGUYEN: Yeah, yeah, I mean, Bruce,
4 the ACM interacts with hospice, but it interacts to
5 complement the real-life experiences that it
6 complements hospice and it doesn't create, you
7 know, these potential -- it doesn't create
8 potential conflicts.

9 MR. STEINWALD: Okay. I understand your
10 argument there. And I agree, it's sensible. As I
11 said before, you know, we kind of look at these
12 models -- and I'm generalizing now -- as if they
13 were going to be implemented by entities that
14 didn't create them or have a mission to make them
15 succeed, if you understand what I'm saying.

16 DR. NGUYEN: Sure.

17 MR. STEINWALD: So we sort of try to think
18 about, well, how would this actually work in a
19 population of patients and providers where they
20 weren't the developers of the model but they were
21 interested in participating? And we believe that's
22 sometimes the way that CMS looks at it, too.

23 Any other questions, Paul and Ann, about
24 the relationship with hospice?

1 MS. PAGE: Sort of indirectly, because you
2 talked about, you know, having a model for this
3 transition from treatment care to palliative care,
4 and we wanted to get your thoughts on how different
5 this is from the Medicare Care Choices Model, which
6 we understand is aiming to do that same thing.

7 DR. NGUYEN: Yeah, I think this is broader
8 than the Medicare Care Choices Model. I think the
9 Medicare Care Choices Model moves in the right
10 direction. There are limitations there in terms of
11 the population. It's almost too late. You know,
12 for Medicare Care Choices, you have to be hospice
13 eligible. And the entity there is hospice;
14 whereas, for the ACM entity, it could -- physicians
15 have to be a part of it. It could be physicians
16 and hospice coming together. And so I think we --
17 you know, the idea of walking with patients and
18 physicians is really, you know, expand what hospice
19 is doing into a broader -- into the mainstream
20 delivery, and that means doing more integration.
21 And so I think one can -- you know, the ACM is
22 really an expansion of what the Medicare Care
23 Choices Model is, and it draws on, you know -- but,
24 you know, the population is key. By targeting

1 patients with a one-year prognosis, you have a
2 greater chance to really impact and really do that
3 care coordination with physicians and patients.

4 MS. PAGE: Thank you.

5 MS. MITCHELL: Bruce, this is Elizabeth.
6 I've been on for a while listening. Thank you.
7 But this was a real question that I had. Have you
8 thought about if and how your model could interact
9 with that or in the same markets has there been any
10 exploration of how those two programs could work
11 together?

12 DR. NGUYEN: Yeah, yeah. I mean, we
13 currently operate -- we currently help
14 organizations implement the ACM, Elizabeth. In
15 some of these markets, the Medicare Care Choices
16 demo is also running concurrently. The thought
17 here is that the ACM would incorporate in the
18 Medicare Care Choices, likely that the Medicare
19 Care Choices will be a sub-component. It continues
20 to turn it over, or it can run as a -- you know,
21 programs can have the option -- if you're an
22 organization that's running the ACM as well as the
23 Medicare Care Choices, one can choose to transition
24 a patient from one payment -- well, actually, in

1 this case you can't transition from one payment to
2 the other. What we recommend here is that the MCCM
3 becomes a component of the ACM, a subset.

4 MS. MITCHELL: Okay. Thank you.

5 MR. STEINWALD: What about operating side
6 by side with some of the other models that are,
7 let's say, ACO-based shared saving programs for a
8 bigger population?

9 DR. NGUYEN: Yes, yes. So we propose
10 different integration pathways. An ACO can choose
11 to run the -- an ACO can choose to apply the ACM as
12 a layer of payment within the ACO for its advanced
13 illness population. So that's one way.

14 The other is that an organization can
15 choose to run an ACO and an ACM in parallel and
16 capture two separate cohorts of patients. So one
17 can run in parallel or one can run by integrating
18 the two payments.

19 MR. STEINWALD: Doesn't that make it a
20 little tricky to determine what the financial
21 outcomes are of the two separate models?

22 DR. NGUYEN: Right, so these will have to
23 be design decisions that the entity will have to
24 make up front, Bruce, as they do today. You know,

1 Kris, for example, he runs several alternative
2 payment models. He runs ACOs, he runs Independence
3 At Home. You know, if it was up to Kris, he would
4 like to be able to pull them all together, but
5 right now Medicare runs them separately, and you
6 apply different populations to that.

7 MR. STEINWALD: I see. Okay.

8 DR. CASALE: But presumably -- this is
9 Paul. Just so I understand, the costs related to
10 the ACM would then be applied to the ACO, right?

11 DR. NGUYEN: Right. So when it looks as a
12 layer of payment within a payment, the ACM would be
13 a payment within the broader ACO payment.

14 DR. CASALE: And the shared savings, there
15 would be a decision as to who gets that? Or do you
16 think the ACM gets a shared savings for this
17 population and it's subtracted from the ACO? Would
18 that --

19 DR. NGUYEN: Right, right. So the thought
20 here is that the shared savings would be analyzed
21 at the ACO level, the umbrella level. And so an
22 ACO can choose to run the ACM as a subpayment, in
23 which case what the ACO will get is the PMPM
24 payment, and it will also have the ability to

1 analyze the advanced illness population as a subset
2 of its overall ACO population. So it will have
3 access to PMPM, and it will have access to data and
4 analysis. The shared savings will still be
5 analyzed at the ACO level and go up to the ACO
6 level.

7 DR. CASALE: And then what about the risk
8 part?

9 DR. NGUYEN: The risk part, yes, so --
10 right, right. So if you attract one and you don't
11 have risk in the overall, then you would have risk
12 at the ACM level. The savings would be rolled up,
13 but the risk is new, and so the risk would retain.

14 DR. CASALE: The risk with the ACM
15 providers or with the --

16 DR. NGUYEN: Yes. The risk would be
17 associated with the ACM. So if you attract one ACO
18 where you only have shared savings and you're not
19 at risk --

20 DR. CASALE: Yeah.

21 DR. NGUYEN: -- you would be at risk for
22 the ACM because the ACM is two-sided risk.

23 MR. SMITH: And I think, Khue, I don't
24 want to speak for them, but when we had, you know,

1 six or eight months ago, before PTAC had been set
2 up, some meetings with CMMI, you know, I think one
3 of the things that they had thought was exciting
4 about the model was it potentially provided funding
5 to some of the MSSP ACOs who had up- and downside
6 risk to help them be more likely to be successful
7 in their ACOs. Again, I don't want to speak for
8 them, but the takeaway that I took from the
9 conversation was that they perceived that this
10 would actually increase the chance of the ACO
11 program's success by helping them have additional
12 support for their sickest patients.

13 DR. NGUYEN: Right. You can think of this
14 for the ACO as a Track 1+, and the Track 1+, which
15 is up and coming, a part of the ACO population will
16 be at two-sided risk, and that is what essentially
17 the ACM would be for an ACO. You know, for the
18 advanced illness, it would have two-sided risk.

19 MS. MITCHELL: This is Elizabeth. This
20 may be a question for Ann or CMS. I don't know.
21 But can you embed these models given the need for
22 evaluability and their avoidance of paying twice?
23 Do you know?

24 MS. PAGE: I think we can talk with CMS

1 about that.

2 MS. MITCHELL: Okay. Thanks.

3 DR. NGUYEN: Yes, this is an element that
4 they're excited about. We hope that we can work
5 through it, yes.

6 MR. STEINWALD: Paul and Elizabeth, any
7 other questions for the C-TAC group?

8 MS. MITCHELL: I may --

9 MR. STEINWALD: By the way, thank you for
10 -- go ahead.

11 MS. MITCHELL: Yes, thank you. I may have
12 missed this. I was really eager to understand how
13 the patients experience this model, and I heard
14 quite a lot of that. But was there any discussion
15 -- and if there was, I can follow up later -- on if
16 a patient is ultimately discharged from the model,
17 they've lived longer than 12 months, is there any
18 communication to the patient of that?

19 DR. NGUYEN: Yes, we touched on this
20 Elizabeth, that we anticipate that the ACM will
21 want to hold onto patients that live more than 12
22 months, especially if they anticipate the patient
23 will decline again. They want to do that because
24 that's what providers want to do with patients from

1 patient care. They also want to do that because
2 they ultimately will have this once the patient is
3 in the last year of life. So both care and payment
4 drives that.

5 There will be times when the patient --
6 you know, good prognostication means that we don't
7 always get it right 100 percent, and so it may just
8 -- there may be patients where we simply have the
9 prognostication wrong. They indeed have many more
10 years left. They're stable. Once we assess and
11 get to know patients, we find that they do better,
12 and this program is not designed for them, then
13 those patients will be discharged. And we talked
14 about that part of the care model is to engage with
15 patients and family closely, and so this will be a
16 very natural kind of conversation about, you know,
17 what's the next level of care. For these patients,
18 it will be, you know, a natural conversation, you
19 know, "It looks like you have stabilized, and we
20 will discharge you from the program, and you will
21 have the ability to come back to the program again
22 if needed."

23 This is the kind of conversations that are
24 already happening out there. The Sutter Health

1 program, for example, discharges eight percent of
2 patients that no longer have advanced illness on a
3 yearly basis, and it's a pretty natural
4 conversation for both -- it's a conversation to
5 have with patients and a conversation to have with
6 their physicians.

7 MS. MITCHELL: Okay. Thank you.

8 DR. CASALE: Bruce, this is Paul. Can I
9 just ask one other question? I know we're at the
10 end.

11 MR. STEINWALD: Sure.

12 DR. CASALE: This is related to risk
13 adjustment, because if I understood in your model,
14 you tell if HCC was adequate for risk adjustment,
15 and then there's some suggestions around episode-
16 based actuarial modeling, regression analysis,
17 regional adjustments, outlier. But are you
18 suggesting that basically CMS will figure this out,
19 or are you proposing a specific risk adjustment
20 methodology?

21 DR. NGUYEN: Yeah, so we proposed a
22 methodology, Paul, but we don't have access to the
23 data, or this is something that we anticipate CMS
24 could easily do. So we lay out, for example, that,

1 you know, CMS will need to determine a target price
2 for different patient profiles, so we could have an
3 advanced illness patient, an advanced heart failure
4 patient with no co-morbidity versus one with
5 cancer, and their costs will be different. And so
6 we propose a way that CMS would go about doing the
7 regression analysis to come up with the different
8 types of patient profiles and what the pricing will
9 be for each of those, and then matching that to
10 patients that are enrolled.

11 So what we did was we proposed an approach
12 to doing the matching and the evaluation.

13 DR. CASALE: Okay.

14 MR. STEINWALD: Okay. Any other
15 questions, Paul and Elizabeth?

16 [No response.]

17 MR. STEINWALD: And, C-TAC team, do you
18 have any questions for us or anything you'd like to
19 say to enhance our understanding of your model?

20 [No response.]

21 MR. STEINWALD: If not, I see we're past
22 3:30, and I would like to thank you for making such
23 an investment in this telephone conversation. That
24 was very nice of you to do, and it was very

1 helpful, too.

2 MR. KOUTSOUMPAS: Well, thank you. This
3 is Tom Koutsoumpas. We just want to thank you as
4 well. We feel so strongly about the importance of
5 our ACM model. We believe we have built a
6 continuum that will serve patients and families in
7 the most important and vulnerable period of the
8 patient's life. So we're really pleased to have
9 the opportunity to talk to you about it today. We
10 look forward to talking with you more. Certainly
11 if you have any additional questions, we look
12 forward to answering those questions. We have
13 really looked at best practices across the nation
14 and have built this in accordance with what we
15 believe are the best practices.

16 So we have a level of confidence in this
17 initiative, and we're just thrilled to be able to
18 share it with you and look forward to answering any
19 additional questions and going forward in
20 discussion with you.

21 MR. STEINWALD: Well, we'll certainly take
22 advantage of that, if needed, and I do appreciate
23 that offer.

24 If there is no more, I think it's probably

1 time to end the call. Once again, thanks a lot,
2 and we will be certainly getting in touch with you
3 at some point before September.

4 MR. KOUTSOUMPAS: Excellent. Thank you so
5 much.

6 ALL: Thank you.

7 [Whereupon, at 3:32 p.m., the conference
8 call was concluded.]

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