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AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

August 15, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, DC 20201
PTAC@hhs.gov

Proposal for a Physician-Focused Payment Model –
Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

The American Academy of Hospice and Palliative Medicine (AAHPM) is pleased to submit the attached proposal for a physician-focused payment model titled *Patient and Caregiver Support for Serious Illness (PACSSI).*

If you have any questions, please contact Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, who can be reached at:

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Thank you for your consideration.

Sincerely,

Steve R Smith

Steve R. Smith, MS CAE
Executive Director and CEO

aahpm
AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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Physician-Focused Payment Model Technical Advisory Committee
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Letter of Support – Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

On behalf of the American Academy of Hospice and Palliative Medicine (AAHPM), I am writing to express our full support of the attached proposal for a physician-focused payment model titled *Patient and Caregiver Support for Serious Illness (PACSSI).*

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our more than 5,000 members also include nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families and caregivers. AAHPM's Alternative Payment Model (APM) Task Force, which represents the diversity of palliative care teams serving Medicare beneficiaries across many communities, engaged in an open and collaborative effort to identify and address gaps in care for patients with serious illness and craft a payment strategy that would support palliative care teams of different sizes, organizational structures, and geographies in the delivery of effective, high-value care. PACSSI has emerged from this work as one of two models developed as part of the Academy's proposed *Payment Reforms to Improve Care for Patients with Serious Illness*. We believe the PACSSI model holds great promise for both improving quality of care for Medicare beneficiaries with serious illness and reducing costs for the Medicare program.

We look forward to engaging with the Committee as it reviews the PACSSI model. If you have any questions, please contact Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at 847.375.4841 or jkocinski@aahpm.org.

Sincerely,

Janet Bull MD

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Payment Reforms to Improve Care for Patients with Serious Illness

Patient and Caregiver Support for Serious Illness

August 2017

AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Table of Contents

Abstract

Patients who have serious, potentially life-limiting illnesses or multiple chronic conditions coupled with functional limitations are not well-served by the current fragmented, intervention-oriented health care system. Numerous research studies and pilot projects demonstrate that high-quality, interdisciplinary palliative care services can provide significant benefits for patients, caregivers and payers. Despite these proven benefits, many patients and caregivers do not receive palliative care because current payment systems do not provide adequate resources to enable palliative care teams to deliver those services to the right patient in the right place at the right time.

New accountable payment mechanisms, based on patient need and disease severity, are required to provide palliative care services to patients in all stages of serious illness who are not yet eligible or willing to enroll in hospice care. These services would improve quality of care and quality of life for patients suffering with many different types of serious illness – such as cancer, chronic obstructive pulmonary disease (COPD), heart failure, and dementia – who currently receive health care services in a wide range of settings, including small independent practices, larger physician groups, hospitals, post-acute care facilities, and integrated health systems.

Specifically, the American Academy of Hospice and Palliative Medicine proposes the *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model, which is one initiative under its *Payment Reforms to Improve Care for Patients with Serious Illness*. This model would provide tiered monthly PACSSI care management payments to support interdisciplinary palliative care teams (PCTs) as they deliver community-based palliative care to patients who meet eligibility criteria that include a diagnosis of a serious illness or multiple chronic conditions, functional limitations, and health care utilization. PACSSI care management payments would replace payment for evaluation and management (E/M) services.

PCTs would be held accountable for performance on cost and quality metrics under two tracks:

- PACSSI Track 1: Payment Incentives
- PACSSI Track 2: Shared Savings and Shared Risk

Under Track 1, PCTs would be subject to positive and negative payment incentives of up to 4 percent of total PACSSI care management fees received for a year, based on their performance on quality and spending. Under Track 2, PCTs would take on shared savings and shared risk based on total cost of care, with sharing and risk amounts subject to quality adjustments.

We expect participation from a diverse group of palliative care teams serving urban, suburban and rural populations, and structured within small community-based practices, larger provider organizations, academic health centers, integrated health systems, and hospices. AAHPM believes such diversity is a priority for understanding the impact of the model across settings as a first step towards more widescale implementation.

Background and Model Overview

Patients who have serious illness or multiple chronic conditions frequently experience functional decline over time due to disease progression. All too often, the care these patients receive is fragmented and uncoordinated and can include burdensome and costly interventions that are inconsistent with their values and preferences. They are frequently admitted to the hospital because of the lack of home- and community-based services. Many of these patients and their family caregivers could benefit from palliative care and support services that can better align treatments with their individual preferences and allow more care to be delivered where they live. High-quality palliative care services can provide significant benefits for patients, caregivers, and payers, including:

- Reducing pain and suffering patients experience due to their illnesses;[1,2,3,4,5,6,7]
- Reducing stresses and physical burdens on caregivers that can create or worsen their health problems; [8,9]
- Increasing caregiver satisfaction;[10]
- Reducing the number of times patients visit emergency departments due to burdensome symptoms or exacerbations of their health conditions;[11,12,13,14,15]
- Reducing unnecessary office visits to specialists for routine follow-up care;[16]

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[11] Brumley RD, Enguidanos S, Cherin DA. *Effectiveness of a home-based palliative care program for end-of-life.* J Palliat Med, 2003. 6(5):715-24.

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[16] Smith S, Brick A, O'Hara S, et al. *Evidence on the cost and cost-effectiveness of palliative care: A literature review.* Palliat Med, 2014. 28(2):130-150.

- Reducing unnecessary and duplicative laboratory testing and imaging services;[17]
- Reducing the use of emergency transportation for ED visits and hospital admissions;[18]
- Reducing the use of low-value treatment services and medical technologies that do not extend the patient's life and may worsen the patient's quality of life;[19,20]
- Reducing the number of hospital admissions for exacerbations or complications of the patient's health conditions;[21,22,23,24,25]
- Reducing the use of intensive care beds during hospital stays;[26,27]
- Avoiding the costs of maintaining medical devices that do not support or improve the patient's quality of life;[28] and
- Reducing the use of expensive post-acute care services, such as skilled nursing facilities, to address post-acute care needs that can be addressed at lower cost.[29]

At the same time, too many patients and caregivers do not receive palliative care and support services, in large part because of barriers that exist under current payment systems. The American Academy of Hospice and Palliative Medicine (AAHPM) has developed the *Patient and Caregiver Support for Serious Illness (PACSSI)* alternative payment model (APM) to address these barriers by allowing for the delivery of community-based palliative care medical home services to high-need patients who are not eligible for or ready to elect hospice care. The PACCSI APM was developed by an AAHPM-convened panel of national palliative care leaders, who sought iterative input from numerous relevant stakeholders to meet the panel's goal of maximizing Medicare beneficiaries' access to high-value palliative care services (see Appendix 1). Internal analysis of available data suggests that up to 5 percent (2.75 million) of Medicare beneficiaries could benefit from palliative care services each year.

Under the PACSSI model, palliative care teams (PCTs) serving as APM Entities could participate in one of two tracks that would have increasing levels of accountability and risk. Under both tracks, PCTs would receive tiered monthly payments for enrolled patients based on their health and functional status. These payments would replace payment for evaluation and

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management (E/M) services in order to provide financial support and flexibility for PCTs to manage patients' care. PCTs would work in collaboration with the full spectrum of primary and specialty care clinicians to develop and execute a care plan consistent with patients' needs and preferences. Under Track 1, PCTs would be subject to positive and negative payment incentives of up to 4 percent of total PACSSI care management fees received for a year, based on their performance on quality and spending. Under Track 2, PCTs would be subject to shared savings and shared losses based on total cost of care.

This model would allow the Medicare program (and other payers as interested) to test a new approach to providing palliative care services that addresses patients' needs and preferences early, in order to provide better care and control unnecessary and unwanted health care spending. Moreover, this model furthers ongoing efforts by AAHPM under its work on *Payment Reforms to Improve Care for Patients with Serious Illness* to improve the availability and quality of palliative care for patients with serious or life-threatening conditions and support PCTs across all sizes, settings, and geographies, as described in Appendix 2.

Scope of Proposed PFPM

The PACSSI model is proposed as a five-year demonstration designed to test value-based payment for the delivery of high-quality, community-based, interdisciplinary palliative care services to patients with serious illness who are either not eligible for or who have chosen not to receive hospice services. The PACSSI model will drive the triple aim – improving the patient experience of care, enhancing population health through caregiver and patient quality of life, and reducing the per capita costs of care – by addressing the key barriers that currently exist under the Medicare program to provide high-quality palliative care services.

To begin, payment for palliative care and support services delivered by non-billing clinicians (e.g. nursing, social work, pharmacists, or spiritual care professionals) is generally only available to patients through the hospice benefit, which requires a patient to forgo many treatment services and to have two physicians determine that their life expectancy is six months or less. Many patients who do not qualify for or are unwilling to enroll in hospice care could benefit from palliative care services. As a result, new payment mechanisms are needed to enable access to high-quality palliative care for patients until they are eligible and willing to enroll in hospice care.

Additionally, fee-for-service payments that are currently available to physicians for chronic care management, complex chronic care management, and non-face-to-face services are insufficient to support high-quality palliative care services for patients with advanced illness, multiple chronic conditions, and/or functional limitations. Appendix 3 identifies existing FFS payments and certain payment models that are related to PACSSI, but clearly details how/why these structures are limited and how the PACSSI model fills in the gaps in care that other payments and models fail to sufficiently address.

Further, the PACSSI model includes new APM Entities and clinicians whose opportunities to participate in models to date have been limited. Specifically, this model allows PCTs to particpate as APM Entities to work together to provide high-quality care management and palliative care services to eligible beneficiaries. Such APM Entities could include PCTs working as independent provider organizations or PCTs associated with hospices, home health organizations, hospitals, businesses focused on palliative care delivery, or integrated health systems through direct employment or contracting.

In addition to physicians and other Medicare eligible clincians, PCTs could include non-billing clinicians (e.g. nurses, social work or spiritual care professionals) who otherwise are not reimbursed under the Medicare program, and they would work in conjunction with patients' other care providers and provide psychosocial and spiritual support. Further, this model is designed to be accessible to those PCTs that are small or located in rural or underserved areas and might not be able to participate in models that require a higher level of risk. Participating PCTs would be required to demonstrate:

- The capability to perform assessments and deliver services through an interdisciplinary team structured in accordance with the essential elements of the National Consensus Project for Quality Palliative Care guidelines (http://www.nationalcoalitionhpc.org/about-and-history/); and
- The capability to respond appropriately on a 24/7 basis to patient and caregiver requests for advice and assistance in managing issues associated with the patient's health conditions and functional limitations. Appropriate response includes the ability to provide face-to-face services in all care settings when needed (either in person or through videoconference services) as well as telephonic responses.

This model addresses a significant need in the palliative care community and reflects the interest and input of a broad range of stakeholders. (See Appendix 1 for a description of the model development process.) Several of these stakeholders represent sites that would be ready to pilot this model as early as 2018. Additionally, this model is transferrable to other payers, including private payers and publicly funded programs like Medicaid and TRICARE/VA, for patients who meet the eligibility criteria.

We expect that this model will generate significant net savings for the Medicare program, in excess of any costs incurred for the PACSSI care management fees, based on several studies to date that have demonstrated reductions in cost paired with improvements in quality.[30,31,32]

Patient Eligibility and Assignment

A PCT could receive a PACSSI payment for an adult who meets all of the following three criteria:

- **Serious illness**: Has one or more designated diseases, disorders, or health conditions that have progressed to a stage where patients frequently experience avoidable complications that are typically treated using expensive acute care services OR has three or more chronic conditions; AND

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[30] Lustbader D, Mudra M, Romano C, et al. *The impact of a home-based palliative care program in an accountable care organization*. J Palliat Med, 2017. 20(1):23-28.

[31] Cassel JB, Kerr KM, Mcclish DK, et al. *Effect of a home-based palliative care program on healthcare use and costs.* J Am Geriatr Soc, 2016. 64(11):2288-2295.

[32] Brumley R, Enguidanos S, Seitz R, et al. *Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care.* J Am Geriatr Soc, 2007. 55(7):993-1000.

- **Functional limitation**: Has significant functional limitations as indicated by the patient's performance on the Palliative Performance Scale (PPS) or the Eastern Cooperative Oncology Group (ECOG) Scale of Performance Status, and/or the need for assistance with activities of daily living (ADLs), OR – for the moderate complexity tier only – a claim for the following durable medical equipment: oxygen, a wheelchair, or a hospital bed; AND
- **Health care utilization**: Has used unscheduled health care services in the past year including inpatient hospitalization(s), emergency department visits, or observation stays. Patterns of utilization are specific to patient tier (see Table 1 below), and utilization requirements may be waived under certain circumstances specified below.

Enrolled patients would be assessed every six months for ongoing PACSSI eligibility and tier determinations to ensure that PCTs are not providing services for longer than necessary or receiving payments for a higher level of services than necessary. See Appendix 4 for additional data supporting the selection of these eligibility criteria.

Table 1: Eligibility and Tiering Criteria

Tier	Diagnosis of Serious Illness (one of the below)	Function (one of the below)	Health Care Utilization
Tier 1: Moderate Complexity	One of the specified diseases, disorders, or health conditions in Table 2 below Three or more serious chronic conditions*	**Non-Cancer**: PPS of ≤60% or ≥ 1 ADLs or DME order (oxygen, wheelchair, hospital bed) **Cancer**: PPS of ≤70% or ECOG ≥2 or ≥ 1 ADL or DME order (oxygen, wheelchair, hospital bed)	One significant health care utilization in the past 12 months, which may include: - ED visit - Observation stay - Inpatient hospitalization *Note: This criterion may be waived under certain circumstances specified below.*
Tier 2: High Complexity	Same as above, excluding dementia as the primary illness	**Non-Cancer**: PPS of ≤50% or ≥ 2 ADLs **Cancer**: PPS of ≤60% or ECOG ≥3 or ≥ 2 ADLs	Inpatient hospitalization in the past 12 months AND one of the following - ED visit - Observation stay - Second Hospitalization *Note: This criterion may be waived under certain circumstances specified below.*

* Serious chronic conditions as described in the Dartmouth Atlas: http://www.dartmouthatlas.org/downloads/methods/chronic_disease_codes_2008.pdf

Patients would be categorized into one of two tiers, based on the criteria specified in Table 1. This tiering reflects the fact that patients who could benefit from PACSSI services vary in the frequency and nature of problems they experience, as well as in the amount of support they and their caregivers need to avoid those problems or to address them effectively when they occur. As a result, a payment amount that would be adequate to address the needs of one set of patients would be inadequate for patients with greater needs, and rates of problems and service utilization might be higher for one group of patients because of differences in the patients' characteristics, rather than the effectiveness of the services delivered by the PCT.

For patients already enrolled in PACSSI, the health care utilization criterion may be waived under the following circumstances:

- Upon six-month reassessment and recertification, patients would be able to remain enrolled in PACSSI if they meet the criteria for serious illness and functional limitation but do not meet the health care utilization criterion; disenrollment for a patient's failure to meet the health care utilization criterion would penalize those PCTs who are effective at reducing unnecessary utilization for their enrolled patients.
- A patient who qualifies for the moderate complexity group and demonstrates functional decline consistent with Tier 2 eligibility could move to the high complexity tier without meeting the health care utilization requirement.
- Likewise, patients who are enrolled in the high complexity tier may improve in functional score, but still qualify for Tier 1 based on serious illness and functional status. These patients could move from high to moderate complexity tier without meeting the health care utilization requirement.

Table 2: Available Diagnoses for Meeting the Serious Illness Criteria

Option	Available Diagnoses
Option 1	A diagnosis of one of the following would meet the serious illness criterion: - Metastatic Cancer - Pancreatic, Gastrointestinal, Lung, Brain, or Hematologic cancers - Heart Failure with Class III or IV level function under the New York Heart Association (NYHA) Functional Classification - Heart Failure with a Left Ventricular Assist Device (LVAD) - Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis) - Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool (FAST) or ≥ 2 ADLs * - Progressive Neurologic Disorder (e.g. Cerebrovascular Accident (CVA), Parkinson's Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy) - Hepatic Failure (Cirrhosis) - End Stage (V) Renal Disease (excluding patients on dialysis) - Protein-Calorie Malnutrition - Cachexia - Hip Fracture (with functional decline)
Option 2	Diagnoses of three or more serious chronic conditions would also allow a patient to meet the serious illness criterion.

* Dementia as the primary illness would be confined to the moderate complexity group, as the rate of decline is often slow, and functional limitations occur significantly earlier in the course of an illness.

AAHPM recognizes that assessment of patient function may rely on PCTs' clinical judgment, and that there may be an incentive for PCTs to document greater functional decline among patients than they would otherwise in order to either enroll a high-functioning patient into PACSSI or receive a Tier 2 payment for a patient with Tier 1 functional status. This risk is mitigated, in large part, by the requirement that patients meet all three components of the eligibility criteria to enroll in PACSSI, with the diagnosis and health care utilization criteria together already limiting enrollment to those patients who are high need. However, this reliance on clinical judgement is consistent with practices applied throughout Medicare payment systems. For example, clinical judgement (with documentation in patients' medical records) is the basis for determining E/M coding levels, prescription of durable medical equipment, and eligibility for hospice services. Under this model, where PCTs will be more closely held accountable for minimum service levels, quality reporting and performance, and other participation requirements, risk of improper assessment and coding is lower than what exists under the fee-for-service system more broadly. Further, the division of patients into two tiers provides for payment based on patients' needs, rather than imposing a one-size-fits-all approach to care delivery.

In order for the PCT to receive the PACSSI payment for an eligible patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would need to:

- Designate the PCT as the patient's primary provider of care management services and palliative care services, in coordination with primary care and/or primary treating providers;
- Agree to work with the PCT to develop a care plan, in coordination with primary care and/or primary treating providers; and
- Agree to adhere to the care plan to the best of the patient's and caregiver's ability as long as the PCT meets its commitments to deliver quality care and support to the patient and caregiver.

Since the PACSSI payment is intended to support complex chronic care management for patients who meet eligibility criteria, beneficiary participation in the PACSSI model would preclude payment for chronic care management (CCM) and complex chronic care management (CCCM) services for patients' non-PACSSI providers. This restriction is similar to the existing requirement under the Medicare Physician Fee Schedule that only one practitioner may be paid for these services for a given patient for a month. Patients would be informed of this limitation, similar to beneficiary consent requirements for chronic care management services, prior to enrollment under the model.

In order to receive PACSSI payments, a PCT would be required to accept any patient living in the service area who met the eligibility criteria, unless the team had reached a pre-defined capacity limit. If the PCT were unable to serve a patient due to the capacity limit, it would be required to establish a waiting list. If changes in the existing patients under the PCT's care enabled the PCT to accept additional patients, it would be required to accept patients from the waiting list before accepting new patients.

The following types of patients would be *ineligible* to receive services supported by PACSSI payments:

- Patients with serious mental illness without another serious, life-threatening condition.
- Patients who have elected to receive hospice care.
- Patients who do not consent to receive PACSSI services.

Patients would also be advised of their right to disenroll from participation in PACSSI at any time. Patients may also be disenrolled if their health status improves. For patients who disenroll (including as a result of a hospice election), the PCT would be eligible to receive payment for the month of disenrollment, and disenrollment (for the purposes of evaluation and payment) would be effective the first day of the month following hospice enrollment or a disenrollment request. Such timing of disenrollment from PACSSI, however, would not have any bearing on initiation and payment of hospice services; that is, coverage and payment of hospice services would begin on the date of hospice election regardless of whether a PCT receives a PACSSI payment for the calendar month.

Quality and Cost

The PACSSI model is anticipated to both improve health care quality and decrease costs through a combination of quality and financial incentives and a framework for providing high-quality palliative care services. As noted above, high-quality palliative care services have been shown to provide significant benefits for patients, caregivers, and payers, including reduction of emergency department visits, hospital admissions, emergency transportation, intensive care bed days, and unnecessary, duplicative, or low-value treatments and services. These improvements reduce patient pain and suffering and improve caregivers' experience. Further, they avoid the use of unnecessary, preventable, and potentially harmful health care services, thereby contributing to health care savings.

To promote the delivery of high-quality palliative care services, PCTs would be required to provide the following services to enrolled patients, as appropriate:

- Educate the patient and caregiver about the patient's health conditions and the normal progression of those conditions, the types of complications that can arise, and ways to manage disease progression, minimize symptoms, and avoid complications;
- Identify areas of distress through a comprehensive physical, psychosocial, emotional, cultural, functional, and spiritual assessment;
- Identify threats to the safety of the patient or caregiver from the physical environment, medication interactions, and other sources;
- Assist the patient in establishing clear goals for care and treatment and to define their preferences for interventions and the site of care delivery if complications arise;
- Develop a coordinated care plan with input from all of the patient's physicians and providers that is consistent with the patient's care goals.
- Arrange for services from other providers in order to implement the care plan;
- Communicate with the patient's other physicians and providers on an ongoing basis to ensure care is being delivered consistent with the care plan and to update the care plan as conditions warrant;
- Respond on a 24/7 basis to requests for information and assistance from the patient or caregiver or from other providers who are caring for the patient;
- Make visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns; and
- Provide other services that the PCT believes would assist the patient in more effectively managing their illnesses.

To maintain minimum standards for participation, PCTs would be required to meet the following requirements:

- Have a written care plan developed for each patient and approved by the patient by the end of the first month of services;
- Maintain documentation that the patient had been assessed and determined to have the characteristics required for eligibility for payment and for the assigned payment category;
- Have at least one face-to-face visit with the patient every month. Face-to-face visits may be conducted by non-physician members of the PCTs and/or may be provided virtually; and
- Maintain documentation that it had responded to all telephone calls from patients.

Additionally, PCTs would be required to participate in a PACSSI Learning Collaborative that would allow for the dissemination of lessons learned across model participants. Participation requirements include in-person attendance at a national conference of the Learning Collaborative each year, as well as regional virtual Learning Collaborative sessions conducted on a quarterly basis.

PCTs' payment would be tied to risk-adjusted performance on several quality measures, as described below.[33] Additionally, if PCTs fail to meet minimum participation standards, they would be terminated from the model, starting at the end of Year 1 or in any subsequent year.

Accountability for Quality

Under PACSSI, PCTs would share accountability for delivering high-quality care for patients and their families, caregivers and significant others. Specifically, this model would assess PCTs across three categories of quality metrics:

- Category 1: Patient-reported outcomes regarding the experience of palliative care;
- Category 2: Completion of care processes that are proven by evidence to drive quality; and
- Category 3: Utilization of health care services that are generally desirable or undesirable for patients at the end of life.

Additional details on proposed quality measures under each category are provided below.

Because several of the proposed measures are new measures that require additional testing and do not have sufficient evidence to establish benchmarks, PACSSI phases in accountability for performance on this subset of measures over time. For Years 1 and 2, PCTs will be required to report applicable measures, but payment will not be tied to performance on these measures. This will provide time to test these measures in Year 1, collect and analyze Year 1 data in Year 2, and determine appropriate performance benchmarks before the start of Year 3. For Year 3, when all measures have established benchmarks and therefore can be fully phased in, PCTs' accountability for quality performance would be based on a composite score that equally weights performance across each of the three categories. See Table 3 below for those measures/items included for performance assessment in each year of the model.

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[33] To the extent that practice sizes and caseload are insufficient to achieve reliable quality performance results for a given practice for one or more measures, application of quality performance may be adjusted to ensure meaningful assessment and appropriate payment. Options may include, but are not limited to: formation of voluntary virtual groups among PCTs, assignment of PCTs to designated virtual groups, or assignment of average performance ratings to the PCT.

Additionally, because PCTs will be responsible for controlling health care spending, PCTs will *de facto* also be accountable for reducing unwanted outcomes such as unplanned hospital readmissions and emergency department visits.

Category 1: Patient Reported Outcomes for Experience of Palliative Care

The first component of the composite quality score is based on patient- or proxy-reported perceptions of the care received from the PCT. A care plan that reflects patients' specific needs and goals is a cornerstone of quality care for patients with serious illness. Patients may reasonably differ in their preferences for care. Therefore, the PCT should educate patients and their families about the likely prognosis and help them formulate goals of care based on their values and personal preferences. In conducting this education, key elements of communication include:

- Whether the information was presented in a way the person could understand;
- Whether the health care professionals communicated in a sensitive manner;
- Whether the seriously ill person and family were allowed to ask questions; and
- Whether they were able to make a decision without feeling pressured by the health care team to make a decision that they did not want.

Other aspects of the PCTs' care delivery also affect patients' experience of care, including PCTs' responsiveness and success at managing patients' care needs. Such information can only be captured by an experience of care survey.

Existing Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys fail to address the experience of seriously ill patients in certain common situations relevant to palliative care, including those who die during a hospital stay without hospice or who receive home-based services outside of a home health care benefit. Until the experience of seriously ill patients is incorporated into CAHPS surveys in all health care settings and clinical scenarios, it will be necessary to use surveys of the experience of palliative care specifically developed for these proposed alternative payment models.

Key times to assess the patient and family experience of care are at the initiation of palliative care services and following the patient's death. The admission survey would be administered about one month after enrollment in PACSSI for patients who received care from the PCT for at least 7 days. This brief survey would focus on:

- Patient's perceptions regarding the quality of communication (including the key elements outlined above);
- Timeliness of response to urgent needs;
- Adequacy of treatment for pain and symptoms; and
- Likelihood to recommend the PCT to friends or family.

If the patient were not capable of answering the survey questions, the primary caregiver (usually a close family member) would act as a proxy for certain domains and report based on their own experience (e.g., whether they received the needed education and training in providing assistance to the seriously ill person). For patients who die while enrolled in PACSSI, a separate survey would be administered to the primary caregiver (who is usually a family member) about two months following the death. This post-death survey would closely mirror the CAHPS Hospice survey. In addition, for patients who die under hospice care within 7 days of disenrollment, CAHPS Hospice Survey results would be attributed to the PCT as well as the hospice provider.

Category 2: Completion of Care Processes

This second quality category reflects completion of processes known to drive quality palliative care. Specifically, PCTs will be assessed for performance of the following six activities within 15 days of the start of palliative care services, across all settings, conditions, and circumstances for consultation, unless the activity is inapplicable or inappropriate and the exceptions are documented.

- Completion of a comprehensive assessment (physical, psychological, social, spiritual, and functional);
- Screening for pain, dyspnea, nausea, and constipation;
- Documentation of a discussion regarding emotional needs, or screening for anxiety or depression;
- Documentation of a discussion of spiritual concerns or screening with the “Do you have any unmet spiritual needs?” question;
- Documentation of a discussion about advance care planning, including preferences for surrogate decision-maker(s) and life-sustaining treatments; and
- Completion of a structured assessment of caregiver needs and distress.

The first five of these measures were selected or adapted from the *Measuring What Matters*[34] list based on their clinical importance, evidence of feasibility, demonstration of important gaps in care, and variance across diverse settings.[35] The sixth process measure, completion of a structured assessment of caregiver needs and distress, was included because caregiver support is a key deliverable of the palliative care services covered under the PACSSI model. Data for these process measures will come from assessments documented in patients’ medical records.

When accountability for performance on these measures is fully phased in, PCTs will be assessed on the extent to which they complete all six of the above activities for patients within 15 days of the start of palliative care services; those patients for whom all six activities are not completed will not be counted in the numerator of this quality measure. Because robust data on performance for two of the activities are not currently available, the first two years of the model will only hold PCTs accountable for their performance in completing four of the above activities, as detailed in Table 3 below.

Table 3: Treatment of Quality Measures by Model Year

Quality Measures/Items	Treatment in Years 1 and 2	Treatment in Year 3 and onward
Category 1: Patient-reported outcomes for experience of palliative care		
Measure: Item from admission survey – Likelihood to recommend the PCT to friends or family	Pay-for-performance	Discontinued as standalone measure

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[34] Dy SM, Kiley KB, Ast K, et al. *Measuring what matters: top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association.* J Pain Symptom Manage, 2015. 49(4):773-81.

[35] Kamal AH, Bull J, Ritchie CS, et al. *Adherence to Measuring What Matters measures using point-of-care data collection across diverse clinical settings.* J Pain Symptom Manage, 2016. 51(3):497-503.

Quality Measures/Items	**Treatment in Years 1 and 2**	**Treatment in Year 3 and onward**
Category 1: Patient-reported outcomes for experience of palliative care (cont'd.)		
Measure: Admission survey	Pay-for-reporting	Pay-for-performance
Item set: *Patient's perceptions regarding the quality of communication*	*Pay-for-reporting*	*Pay-for-performance*
Item set: *Timeliness of response to urgent needs*	*Pay-for-reporting*	*Pay-for-performance*
Item set: *Adequacy of treatment for pain and symptoms*	*Pay-for-reporting*	*Pay-for-performance*
Item: *Likelihood to recommend the PCT to friends or family*	*Pay-for-reporting at the measure level. See above for standalone item.*	*Pay-for-performance*
Measure: Post-death survey for PACSSI enrollees who die while enrolled in the model	Pay-for-reporting	Pay-for-performance
Measure: Hospice CAHPS survey for PACSSI enrollees who transfer to hospice and die within 7 days of disenrollment from PACSSI	Pay-for-reporting	Pay-for-performance
Category 2: Completion of care processes		
Measure: Completion of all four applicable palliative care activities within 15 days of PACSSI enrollment	Pay-for-performance	Discontinued
Item: *Completion of a comprehensive assessment (physical, psychological, social, spiritual, and functional)*	*Pay-for-performance*	*Discontinued*
Item: *Screening for pain, dyspnea, nausea, and constipation*	*Pay-for-performance*	*Discontinued*
Item: *Documentation of a discussion regarding emotional needs, or screening for anxiety or depression*	*Pay-for-performance*	*Discontinued*
Item: *Documentation of a discussion about advance care planning, including preferences for surrogate decision-maker(s) and life-sustaining treatments*	*Pay-for-performance*	*Discontinued*
Measure: Completion of all six applicable palliative care activities within 15 days of PACSSI enrollment	Not applicable	Pay-for-performance
Item: *Completion of a comprehensive assessment (physical, psychological, social, spiritual, and functional)*	*Not applicable*	*Pay-for-performance*
Item: *Screening for pain, dyspnea, nausea, and constipation*	*Not applicable*	*Pay-for-performance*
Item: *Documentation of a discussion regarding emotional needs, or screening for anxiety or depression*	*Not applicable*	*Pay-for-performance*

Quality Measures/Items	Treatment in Years 1 and 2	Treatment in Year 3 and onward
Category 2: Completion of care processes (cont'd.)		
Item: *Documentation of a discussion about advance care planning, including preferences for surrogate decision-maker(s) and life-sustaining treatments*	*Not applicable*	*Pay-for-performance*
Item: *Documentation of a discussion of spiritual concerns or screening with the "Do you have any unmet spiritual needs?" question*	*Not applicable at the measure level. Individual item will be pay-for-reporting.*	*Pay-for-performance*
Item: *Completion of a structured assessment of caregiver needs and distress*	*Not applicable at the measure level. Individual item will be pay-for-reporting.*	*Pay-for-performance*
Category 3: Utilization of health care services near the end of life		
Measure: Percentage of patients who died who received hospice care	Claims-based reporting	Pay-for-performance
Measure: Percentage of patients who died and were enrolled in hospice more than 7 days before death	Claims-based reporting	Pay-for-performance
Measure: Percentage of patients who died and did not have any days in an ICU during the 30 days before death.	Claims-based reporting	Pay-for-performance

Category 3: Utilization of Health Care Services Near the End of Life

The third component of the composite quality score is based on utilization of services near the end of life, including provision of desirable services and avoidance of undesirable services:

- Percentage of patients who died who received hospice care;
- Percentage of patients who died and were enrolled in hospice more than 7 days before death; and
- Percentage of patients who died and did not have any days in an ICU during the 30 days before death.

These measures were adapted from National Quality Forum (NQF)-endorsed measures that were developed for patients with invasive cancer. Data for these measures will come from claims for health care services provided during the last 30 days for patients who died.

Phase-in of Accountability for Quality

As noted above, accountability for quality performance on all of the above measures will be phased in by Year 3. When fully phased in, PCTs' accountability for quality performance would be based on a composite score that equally weights performance across each of the three quality categories. For the first two years of the PACSSI model, however, PCTs would only be held accountable for performance on a subset of the measures, as detailed in the table above. Accountability for all measures will be based on performance relative to benchmarks. Benchmarks for measures to be included for performance assessment in Year 3 will be established prior to the start of Year 3.

Payment Methodology

Participation under the PACSSI model could take place under one of two payment tracks:

- PACSSI Track 1: Payment Incentives
- PACSSI Track 2: Shared Savings and Shared Risk

Under both tracks, PCTs would receive monthly PACSSI care management payments based on the patient's eligibility (see the two eligibility tiers discussed above). PACSSI care management payment amounts would be set as follows:

- In Year 1, Tier 1 base payment amounts would be set at $400 per beneficiary per month, and Tier 2 base payment amounts would be set at $650 per beneficiary per month. [36]
- Base payment amounts would be adjusted upward or downward based on the existing Geographic Practice Cost Indices used to adjust the Work RVU component of PFS payments.
- Monthly PACSSI payments would also be adjusted for patients' primary site of care (domiciliary versus facility-based). Specifically, payments for facility-based patients would be reduced by 20 percent to reflect the lower costs incurred for caring for such patients due to supportive care services provided by the facility.
- Base payment amounts would also be increased each year based on the annual increase in the Medicare Physician Fee Schedule conversion factor.

These monthly PACSSI payments would replace payment for Evaluation and Management (E/M) services, including office visits, home visits, hospital visits, as well as Chronic Care Management, Complex Chronic Care Management, Transitional Care Management, and Advance Care Planning services. Replacing payment for these services with monthly PACSSI care management payments would reduce the marginal incentive to provide unnecessary visits; at the same time, protections related to quality would ensure that patients are receiving the care they need. Monthly PACSSI payments would be exempt from cost-sharing requirements to eliminate potential barriers to care for patients.

The two tracks would diverge, however, with respect to how PCTs are held accountable for spending and quality.

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[36] Payment amounts were based on evaluation of cost delivery for palliative care services under a separate but related project currently in operation under a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award, the Four Seasons Compassion for Life project, as well as input from several AAHPM APM Task Force members who provided feedback on cost of service delivery at their institutions. The Four Seasons Compassion for Life project began in September 2014 and tests a new model for community-based palliative care (in conjunction with Duke University) that spans inpatient and outpatient settings.

Under Track 1, PCTs would be subject to annual positive and negative performance incentives of up to 4 percent of the year's PACSSI payments based on performance on quality and spending, as shown in Table 4 below. Based on final performance determinations for quality and spending in a given year, PCTs would either receive a lump sum payment amount based on total PACSSI payments received for that year, break even, or be required to return funds in a lump sum to the Medicare program for poor performance under the model.

Table 4: PACSSI Track 1 Performance-Based Incentive Payments for a Model Year (as a Percentage of the Year's Total PACSSI Payments)

Performance on Quality	Performance on Spending	
	Meets/Exceeds Benchmark	**Misses Benchmark**
Meets/Exceeds Benchmark	+4%	0%
Misses Benchmark	-2%	-4%

As shown in Table 4, PCTs that fail to meet quality benchmarks would be required to pay a penalty, regardless of whether they meet spending benchmarks. PCTs that meet quality benchmarks may either receive a 4 percent bonus payment if they meet the spending benchmark, or will neither receive a bonus nor owe funds if they do not meet the spending benchmark. To meet the spending benchmark, total cost of care for enrolled patients (including PACSSI care management payments) must be below risk-adjusted predicted spending levels, where such predicted spending levels include a point estimate plus or minus 4 percent. This +/-4.0 percent is intended to serve as a minimum loss rate to account for potential variation in spending due to small sample sizes and chance.

Table 5: Illustrative Shared Savings/Losses Incurred by PCT Based on Quality and Spending Performance under PACSSI Track 2

Performance on Quality	Spending Relative to Benchmark			
	Shared Savings		**Shared Losses**	
	< 95%	**Between 95% and 100%**	**Between 100% and 105%**	**> 105%**
Poor	0% of savings*	0% of savings*	60% of losses	50% of losses
Good	60% of savings	70% of savings	50% of losses	40% of losses
Excellent	70% of savings	80% of savings	40% of losses	30% of losses

* Track 2 PCTs with "poor" quality performance would not receive shared savings and would be subject to additional penalties up to and including denial of any future PACSSI payments.

Track 2 would be a voluntary track available to those PCTs that may be more willing and able to take on risk starting in Year 3, when accountability for all quality measures is fully phased in. Under this track, instead of payment incentives based on PACSSI care management fees, accountability for quality and spending would be directly linked to total cost of care for enrolled patients. That is, practices would take on shared risk and savings based on total cost of care. Risk would be based on spending above the risk-adjusted benchmark, but would be limited to the lesser of 3 percent of the total cost of care benchmark or 8 percent of each PCT's total Medicare A and B revenues. Shared savings would be based on spending below the benchmark and would be capped at 20 percent of the total cost of care benchmark. Mechanisms such as outlier provisions and risk corridors would provide protections for PCTs against catastrophic losses. The monthly PACSSI care management payments would be included in total spending, and PCTs' eligibility for and extent of savings or risk would be dependent on quality performance. Table 5 above illustrates a potential risk sharing arrangement.

Under both tracks, PCTs would be required to submit a claim for each patient who meets the eligibility criteria each month. In addition to the PACSSI payment, PCTs could bill and be paid for any other non-E/M professional services or other services that are medically necessary and otherwise eligible for payment and are not included in the services covered by the PACSSI care management payment. For example, PCTs could continue to bill for durable medical equipment, Part B drugs, ambulance services, or clinical laboratory services that they are eligible to provide. Physicians and other providers who are not part of the PCT could continue to bill for and be paid for their E/M services and for any procedures or treatments they deliver for the patient's health conditions, except that such non-PACSSI providers could not bill for Chronic Care Management (CCM) or Complex Chronic Care Management (CCCM) codes, as discussed above.

The payment reforms detailed above reflect a significant departure from payment currently available under the Medicare fee-for-service program. Specifically, they:

- Provide for an up-front care management payment that provides flexibility for PCTs to offer services – including services of providers not regularly covered under the Medicare program – in a manner that is consistent with patients' needs and preferences;
- Mitigate incentives to provide unnecessary palliative care services through the replacement of fee-for-service E/M visits with monthly payments;
- Allow PCTs to report and be assessed on measures that are clinically meaningful;
- Allow PCTs to provide services in a variety of settings that are restricted under current program rules, including through the use of telehealth without meeting telehealth requirements;
- Hold PCTs accountable for controlling spending, including through shared savings/risk under Track 2; and
- Allow for the delivery of a robust set of community-based palliative care services to patients who are not eligible for or who have not elected hospice.

To accommodate these variances from Medicare payments allowed under current law, several statutory and regulatory waivers would be required. In addition to waivers to adjust basic payment requirements under the Medicare Physician Fee Schedule and to allow for shared savings/risk, waivers would be required to waive deductible and copayment requirements for PACSSI care management fees, allow for the delivery of palliative care services in community-based settings, allow the use of telehealth services outside of current requirements regarding originating sites, and allow for payment to PCTs under Part B even when PCT providers may not typically be paid. Additional waivers may also be considered, for example regarding fraud and abuse or three-day inpatient hospitalizations prior to the use of skilled nursing facility services.

If successful, these payment and associated health care delivery reforms will provide the basis for enhanced payment to palliative care teams to provide sufficiently resourced need-based palliative care services to patients.

Value over Volume

The combination of payment and delivery reforms included in the PACSSI model provides strong incentives and accountability for PCTs to deliver high-quality care, based on the following model characteristics:

- The linkage of payment to performance on both cost and quality holds PCTs accountable for providing high-quality care and striving to prevent unnecessary, preventable, and/or potentially harmful utilization, such as emergency department visits or hospital readmissions.
- The availability of up-front, predictable monthly PACSSI payments provides PCTs with sufficient resources and flexibility to provide services consistent with patients' needs, including through the availability of professionals essential to the delivery of quality palliative care who have not traditionally been eligible for Part B reimbursement under the Physician Fee Schedule, such as social workers and spiritual care providers.
- The replacement of fee-for-service E/M payments reduces PCTs' marginal incentives to provide unnecessarily palliative care services.
- The care model requirements emphasize comprehensive assessment, effective care management and care coordination, and delivery of care consistent with patients' needs and preferences, as well as documentation of clinical findings and recommendations.
- The regular collection of data via patient surveys will provide immediate feedback to PCTs to more effectively tailor services to improve patient and caregiver experience.

Additionally, PCTs will be required to participate in a PACSSI Learning Collaborative operated by the Centers for Medicare & Medicaid Services (CMS) to allow for the dissemination of lessons learned across model participants.

Flexibility

The PACSSI model provides flexibility for practitioners to deliver high-quality health care on multiple levels. At a high level, the availability of options provided under this model, including the two tracks with differential requirements for accountability, provides flexibility to allow providers and practices of all sizes, settings, and geographies to participate in a manner that is appropriate for them. Furthermore, providing incremental monthly payments, which are not tied to specific services, will allow for robust delivery of needs- and preference-based palliative care services to patients who require such services before they are eligible for or elect to receive hospice services.

While practices will have to meet criteria demonstrating their ability to provide community-based palliative care services consistent with the requirements of the care model, they will also receive assistance through the Learning Collaborative, which could include, for example, data collection templates, checklists, resource sharing, and more.

Ability to be Evaluated

The PACSSI model seeks to:

1. Improve the availability of high-quality, interdisciplinary palliative care for patients with serious illness who are not eligible or who have not elected hospice care, and their caregivers, and allow broad participation in a new payment model for interdisciplinary PCTs serving patients and caregivers in all settings and all geographies;
2. Improve the quality of care such patients receive, as well as patients' and caregivers' quality of life;
3. Achieve savings for the Medicare program for those patients with serious illness who are eligible to participate in the model.

A comprehensive evaluation can assess if the model achieves these goals. This evaluation will be based on the quality and cost accountability structure built into the PACSSI model. Additionally, for those patients who are enrolled in PACSSI and who die during a performance year, performance can be assessed on outcomes such as hospice length of stay, days in the intensive care unit, emergency department visits, and hospital admissions in the last year of life.

In addition to assessment of cost and quality metrics, the evaluation should include key informant interviews and PCT surveys to determine how PCTs' approach to care delivery changes as a result of the model, and to identify implementation challenges, enabling factors, and lessons learned.

While this model was built on progress achieved through other efforts, PACSSI is unique in its payment arrangements and accountability structure. As a result, there are not existing evaluation efforts underway. We expect, however, to incorporate evaluation strategies from related initiatives, including the Medicare Care Choices Model and other palliative care interventions tested under CMS Health Care Innovation Awards.

Integration and Care Coordination

The PACSSI care model relies on PCTs, which themselves require interdisciplinary expertise, to coordinate with the full medical community supporting patients and their care needs. Core requirements include developing a coordinated care plan with input from all of the patient's physicians and providers, arranging for services from other providers, and communicating with other physicians and providers on an ongoing basis to ensure care is being delivered consistent with patients' care plans. Additionally, the quality and spending accountability structure specified under this model are intended to encourage optimal care coordination and integration for patients with serious illness and their caregivers.

PCTs would be able to organize themselves and determine the appropriate level of representation across multiple disciplines, including physicians, nurses (including advanced practice nurses), social workers, spiritual care providers, physician assistants, pharmacists, counselors and others, as necessary and appropriate to address the needs of the local patient community.

Patient Choice

The PACSSI model is dedicated to increasing the availability of community-based palliative care services, particularly for those individuals who generally are not qualified recipients of these services under current Medicare program rules, while supporting the unique needs and preferences of individual patients. As the starting point for patient engagement, patients would be required to consent to participation in the model. PCTs would then conduct assessments that would cover patients' physical, psychosocial, emotional, cultural, functional, and spiritual needs. PCTs would then assist patients to establish clear goals and develop a coordinated care plan that specifically includes their preferences for interventions consistent with their care goals. Additionally, PCTs would provide care to patients in a variety of settings that reflect their choice, including home-based care.

Further, PACSSI payments would not be subject to cost-sharing requirements, enabling patients to receive appropriate palliative care and care management services without concerns about potential payment liabilities.

Patient Safety

The PACSSI model is designed to improve patient safety and quality of life by addressing patients' health care needs based on their preferences. Effective palliative care services have been shown to control exacerbations or complications of patients' conditions that can lead to emergency department visits or hospital admissions. These services can also reduce the use of low-value treatments and medical technologies that may worsen patients' quality of life.

This model increases the availability of effective palliative care services to patients who do not qualify for or elect to receive hospice care. At the same time, it also addresses potential risks to patient safety that may potentially arise under the model itself. Key risks to patient safety and the embedded protections under the model are as follows:

- Research shows the benefits of hospice election once individuals are ready and able to elect hospice. Under this model, where PCTs receive payments to manage care for those patients who have not elected hospice, there could be a risk that PCTs delay patients' transition to hospice. In order to protect against this risk, the model includes two quality measures that will be monitored for the first two years, and tied to payment starting in Year 3, relating to hospice election. By year 3, PCTs will be held accountable for having a satisfactory rate of hospice election. Overall, it is expected that hospice election rates will be higher under the model than in comparison groups due to effective delivery of palliative care services.
- Since both tracks of the PACSSI model require accountability for total cost of care, the potential for PCTs to encourage stinting of care in order to meet spending targets exists. The PACSSI model addresses this risk by monitoring quality performance and linking payment to such performance. For example, patients (or their proxies) will be asked to complete a survey approximately one month from the start of care. For patients who die while enrolled in PACSSI or who die in hospice immediately after PACSSI disenrollment, family/caregiver surveys will also be conducted. Performance on specified survey measures will be tied to payment starting with Year 1 and, by Year 3, performance across all surveys

will be tied to payment under the quality composite measure. As a result, PCTs will have strong incentives to ensure that patients are receiving appropriate care consistent with their needs that will lead to high performance on patient survey questions.

- To the extent that there is a risk of PCTs not providing care as intended under the model, the minimum participation standards noted in the Quality and Cost section above will allow for monitoring of these risks. Further, the model includes accountability for the performance of processes of care that are proven by evidence to drive quality. Four out of six processes of care are tied to payment starting with Year 1, and the remaining two will be incorporated into the pay-for-performance structure starting with Year 3.
- Lastly, participation in the PACSSI Learning Collaboratives will allow participating PCTs to report back on implementation success and challenges, in order to facilitate shared learning, strategizing, and adoption of rapid-cycle adjustments across the PCT community.

Health Information Technology

Health Information Technology (HIT) will be used under the PACSSI model to facilitate service delivery, monitoring, data capture, and data exchange. HIT will be used to support the delivery of remote telemonitoring services, as needed and appropriate, for PCTs to provide care on a 24/7 basis. Care teams will also be required to engage in electronic reporting of quality data through one of the submission methods currently accepted for quality reporting under the Merit-Based Incentive Payment System (MIPS).

In using HIT, it is not expected that any aspect of the model would undermine protections related to personal health information that are currently in place.

Supplemental Information

Please see the Appendices that follow for additional information related to the PACSSI model:

- Appendix 1: PACSSI Model Development Process
- Appendix 2: AAHPM Initiatives for Improving Access to Palliative Care
- Appendix 3: Limitations of Currently Available Payments
- Appendix 4: Data Supporting the Selection of Eligibility Criteria
- Appendix 5: Determining PACSSI’s MIPS APM Status
- Appendix 6: Determining PACSSI’s Advanced APM Status
- Appendix 7: Comparison of Model Submissions by AAHPM and the Coalition to Transform Advanced Care
- Appendix 8: Letters of Support

Appendix 1: PACSSI Model Development Process

The American Academy of Hospice and Palliative Medicine (AAHPM) engaged in an transparent and collaborative effort to build a physician-focused payment model that addresses identified gaps in care for patients with serious illness. This process begain in June 2016, when the Academy's Board of Directors authorized a project to convene subject matter experts and contract for consultative support to develop a physician-focused payment model for palliative care that would provide sustainable reimbursement for interdisciplinary palliative care teams and appropriately reflect the value they deliver, as well as to craft a broader strategy to support members in engaging and succeeding in alternative payment models (APMs). The overall goal was to ensure support for high-quality palliative care and hospice services that improve quality of care and quality of life for patients suffering with serious illness.

In October 2016, the AAHPM APM Task was appointed. (See roster that follows.) Members were selected for their recognized leadership in key aspects of APM development, including quality measurement and improvement, delivery innovation, novel collaboration and partnerships, and community engagement. These palliative care thought leaders include representatives of palliative care provider organizations, hospices, health systems, and payers serving urban, suburban and rural communities. The Task Force met in person the following month to establish the building blocks of an APM that would address a significant unmet need for palliative care among Medicare patients who were not eligible or ready for hospice, while also being responsive to the wide array of markets, practice sizes, organizational structures, and geographies AAHPM's members represent.

After several months of research, deliberation, and development, the AAHPM APM Task Force presented the first draft of its proposals to attendees at the February 2017 Annual Assembly of Hospice and Palliative Care. This presentation was immediately followed by a roundtable dialogue and question and answer session between Task Force members and representatives from stakeholder organizations.

Based on feedback from those engagements, AAHPM finalized a discussion draft in March 2017. The next month, the draft was posted for review by the Academy's more than 5,000 members, who were invited to provide detailed feedback through an online survey; over 100 members responded with input on priorities, design parameters, expected participation, and more. AAHPM also shared the discussion draft with nearly 20 external organizations to solicit feedback. These included hospice and palliative care stakeholders such as national associations representing other disciplines or entities involved in providing palliative care (nurses, social workers, physician assistants, chaplains, pharmacists, hospice organizations), other medical specialty societies (geriatrics, home care medicine, post-acute and long-term care, clinical oncology), and others. Leading researchers were also consulted to provide data to help refine AAHPM's payment reform proposals.

Task Force leadership then met with representatives from the Center for Medicare and Medicaid Innovation (CMMI) in May 2017 to discuss options for strengthening the model and considerations for potential implementation, should the PTAC vote to recommend the model for implementation.

Input from all of these sources, as well as ongoing deliberation by the Task Force, have strengthened, refined, and focused the final proposal to best achieve the goals of the model.

AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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Appendix 2: AAHPM Initiatives for Improving Access to Palliative Care

The American Academy of Hospice and Palliative Medicine's (AAHPM's) core mission is to expand access of patients and families to high quality palliative care and advance the discipline of hospice and palliative medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy. The development and submission of the *Patient and Caregiver Support for Serious Illness (PACSSI)* model is one of several AAHPM initiatives focused on delivery system reform designed to support this mission.

Most notably, AAHPM has developed the ***Palliative Care Support to a Medical Home (PCS)*** model. The proliferation of new payment and care delivery models to manage patients' care, such as Accountable Care Organizations, the Comprehensive Primary Care Plus Model, and the Oncology Care Model, have the potential to reform health care in a manner that lowers spending and improves quality outcomes. At the same time, participants in such models often lack expertise in the delivery of palliative care and would benefit from collaboration with trained specialists to assess and address patients' palliative care needs.

AAHPM devised the PCS model to provide a framework for APM participants to engage with palliative care teams (PCTs) to deliver appropriate care to patients under mutually-beneficial arrangements. Our hope is that such a framework would encourage partnership and collaboration to support patients and their caregivers with high-quality palliative care, while also increasing opportunities to reduce spending associated with unnecessary and potentially harmful services. Details of the model are provided below, as they would apply under the Medicare program. Variations applicable to patients enrolled under Medicare Advantage or other private health coverage are also available.

Eligible Patients

A PCT could receive PCS payments for a patient not enrolled in hospice:

- who has been assigned or attributed to a primary care practice, specialty practice, multi-specialty group, accountable care organization, or other Alternative Payment Entity that is participating in an alternative payment model, providing care management services to the patient and taking accountability for the overall cost and quality of services to the patient, and
- for whom the accountable provider has ordered a palliative care assessment or palliative care services by a PCT.

Structure of Payments and Services Covered

Assessment and Planning Services (PCS-AP) Payment

The PCT would receive a PCS-AP payment in return for delivering the following services:

- Educating the patient and caregiver about the patient's health conditions, their progression, the types of complications that can arise, and ways of managing the condition more effectively;
- Identifying areas of distress through a comprehensive physical, psychosocial, emotional, cultural, functional, and spiritual assessment;
- Identifying threats to the safety of the patient or caregiver from the physical environment, medication interactions, and other sources;
- Assisting the patient to establish clear goals for care and treatment and to define their preferences for interventions and the site of care delivery when problems arise;
- Assisting the patient's care manager to develop a coordinated care plan with input from all providers that is consistent with the patient's care goals.

A PCT would receive one PCS-AP payment for all of the services needed to complete the assessment and planning process; the amount of payment would be designed to be sufficient to cover as many visits or other types of contacts as were necessary to complete the process. Payment amounts would be tiered consistent with the PACSSI eligibility tiers. The members of the PCT would not bill for an E/M Service for the assessment if the team was receiving a PCS-AP payment.

The PCT could only bill for a PCS-AP payment if the service was specifically ordered by a physician or Alternative Payment Entity that is participating in an alternative payment model in which the physician or entity is responsible for managing the quality and cost of care for the patient. The team could provide PCS-AP services multiple times to the same patient if they were ordered by the physician who is managing the patient's care.

Monthly Support Services (PCS-MS) Payment

The PCT would receive a PCS-MS payment to deliver the following services on an ongoing basis:

- Responding on a 24/7 basis to requests for information and assistance from the patient or caregiver or from other providers who are caring for the patient;
- Making visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns;
- Providing other services that the PCT believes would assist the patient in more effectively managing their health condition.

A PCT would receive one PCS-MS payment each month to provide all of the palliative care services identified in the patient's care plan. Payment amounts would again be tiered consistent with the PACSSI eligibility tiers. The members of the PCT would not bill Medicare for E/M Services during a month in which the team was receiving a PCS-MS payment (i.e., no E/M payments for face-to-face visits to the patients, no Chronic Care Management or Complex Chronic Care Management services, etc.).

The PCT could only bill for a PCS-MS payment if the service was specifically ordered by a physician or Alternative Payment Entity that is participating in an alternative payment model in which the physician or entity is responsible for managing the quality and cost of care for the patient.

Accountability for Quality

The PCT would share accountability for delivering high-quality care to patients and for achieving a good care experience for the patient and their caregivers, family, and significant others. PCTs' performance on quality and patient experience would be assessed using a quality framework similar to that used under PACSSI, with quality performance assessed under the following three categories:

- Category 1: Patient-reported outcomes regarding the experience of palliative care;
- Category 2: Completion of care processes that drive quality; and
- Category 3: Utilization of health care services that are generally desirable or undesirable for patients at the end of life.

Accountability for Spending

Under this model, the PCT would be expected to help reduce spending at least enough to offset the cost of their services to the accountable entity (e.g. ACO, medical home) under their specific payment model (e.g. bundled payments, shared savings, global payments, etc.). Accountable providers are incentivized to collaborate closely with PCTs to ensure performance on spending, and PCTs are incentivized to add value to the accountable provider's care management processes.

Setting and Adjusting the Payment Amounts

The PCS-AP and PCS-MS services and payments are currently being deliberated with the American Medical Association's Current Procedural Terminology (CPT) Committee, as part of CPT's work to describe professional services provided within alternative payment models. To facilitate quality accountability, payment amounts could be reduced for PCTs with a poor performance rating and could be increased for PCTs with an excellent performance rating. We suggest payment adjustments of negative and positive 8 percent, respectively. Further, physicians, care managers, and ACOs could decide to no longer refer patients to teams with poor performance ratings, or could provide further bonuses for exceptional quality.

Conclusion

AAHPM is optimistic that this effort will create a mechanism and infrastructure to enable PCTs to better deliver high-quality palliative care to a broader target population, while limiting accountability for those PCTs that may not have the resources, infrastructure, or financial position to take on higher levels of risk. Note that the PCS model is not a substitute for the PACSSI model, which requires payment changes and waivers of statutory and regulatory requirements under the Medicare program in order to allow PCTs to take on the highest level of accountability. The PACSSI model also provides an opportunity for palliative care clinicians to participate in an advanced alternative payment model (see Appendix 6).

Appendix 3: Limitations of Currently Available Payments

Type of Payment	Patient Eligibility	Services Covered by Payment	Accountability for Cost and Quality of Care	Limitations
(Current) Evaluation & Management Services (E/M)	No limits on eligibility	Face-to-face visit with the physician or billing-eligible clinician	Payment amounts will be adjusted based on performance under MIPS.	Services may not be billed by core palliative care providers including social workers and spiritual care providers. Payment amounts are insufficient to cover comprehensive palliative care. Payments are provided on a fee-for-service basis that limits incentives for comprehensive care management and encourages delivery of volume-based care.
(Current) Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM)	A patient with two or more chronic conditions that place them at significant risk of death, acute exacerbation, or functional decline, if the patient agrees to receive care management services from the provider	Creation of a care plan for the patient; 24/7 access for the patient to care management services and coordination with PCP	Payment amounts will be adjusted based on performance under MIPS.	Services may not be billed by core palliative care providers including social workers and spiritual care providers. Payments include administratively burdensome requirements that take away from patient care. All patients with serious illness may not meet patient eligibility criteria.

Type of Payment	Patient Eligibility	Services Covered by Payment	Accountability for Cost and Quality of Care	Limitations
(Current) Advance Care Planning (ACP)	No limits on eligibility	Discussion with the patient regarding advance care planning and goals of care	Payment amounts will be adjusted based on performance under MIPS.	Services may not be billed by core palliative care providers including social workers and spiritual care providers.
(Current) Medicare Care Choices Demonstration (MCCM)	A patient with cancer, COPD, heart failure, or HIV/AIDS who has been determined by a physician to have 6 months or less to live	Palliative care services for the patient (all treatment services can continue to be delivered and paid for separately)	The provider must report quality measures, but no adjustments in payments are made based on quality or spending.	All patients with serious illness may not meet patient eligibility criteria. There is no accountability for performance on quality or spending.
(Current) Hospice Care	A patient who has been determined to have 6 months or less to live and who agrees to forgo treatment services for the terminal condition.	Palliative care and all services related to the patient's terminal condition (treatment services for unrelated conditions can continue to be delivered and paid for separately)	The hospice provider is responsible for payment of all services related to the terminal condition. The provider must report on the quality of hospice care. Treatment services unrelated to the terminal condition are managed by the treating physician.	All patients with serious illness may not meet patient eligibility criteria for hospice care.

Appendix 4: Data Supporting the Selection of Eligibility Criteria

Eligibility criteria under the *Patient and Caregiver Support for Serious Illness (PACSSI)* model focus on the following three dimensions:

- **Serious illness.** Diagnoses of serious illness are intended to limit the patient population to those who would most benefit from community-based palliative care.
- **Functional limitations.** Due to the relationship between functional limitations and prognostication, the AAHPM Task Force agreed that collecting and reporting on functional status is considered of significant importance in palliative care.[37]
- **Health care utilization**. Health care utilization data are intended to identify those patients who are most at risk of poor quality and cost outcomes absent strong care management.

To finalize patient eligibility criteria to include in the PACSSI model, AAHPM assessed data available through several data sets, as detailed below.

A. Four Seasons Center Medicare and Medicaid Innovation (CMMI) Project

The Four Seasons Compassion for Life project is funded under a CMMI Round 2 Health Care Innovation Award. This project, which began in September 2014, tests a new model for community-based palliative care (in conjunction with Duke University) which spans inpatient and outpatient settings. The model features interdisciplinary collaboration and the integration of palliative care into the health care system, continuity of care across transitions, and longitudinal, individualized support for patients and families.

Four Seasons Compassion for Life compiled functional scores on patients who enrolled in this CMMI project, as well as patients served under other arrangements, including Medicare Advantage, commercial insurance, and self payment. Eighty-seven percent of patients had a Palliative Performance Scale of ≤ 60% and 94 percent had a PPS score of ≤ 70%. Data supported including functional status in the PACSSI eligibility criteria and limiting to this percentage or below.

	CMMI		Non-CMMI		Total Number of Patients	Total Percentage
PPS Score	**Number of Patients**	**Percentage**	**Number of Patients**	**Percentage**		
0%	2	0%		0%	2	0%
10%	65	3%	79	6%	144	4%
20%	106	5%	66	5%	172	5%
30%	285	14%	142	11%	427	13%
40%	532	27%	277	22%	809	25%
50%	524	26%	287	23%	811	25%
60%	264	13%	195	15%	459	14%
70%	126	6%	130	10%	256	8%
80%	72	4%	60	5%	132	4%
90%	22	1%	21	2%	43	1%
100%	5	0%	3	0%	8	0%
Grand Total	**2003**	**100%**	**1260**	**100%**	**3263**	**100%**

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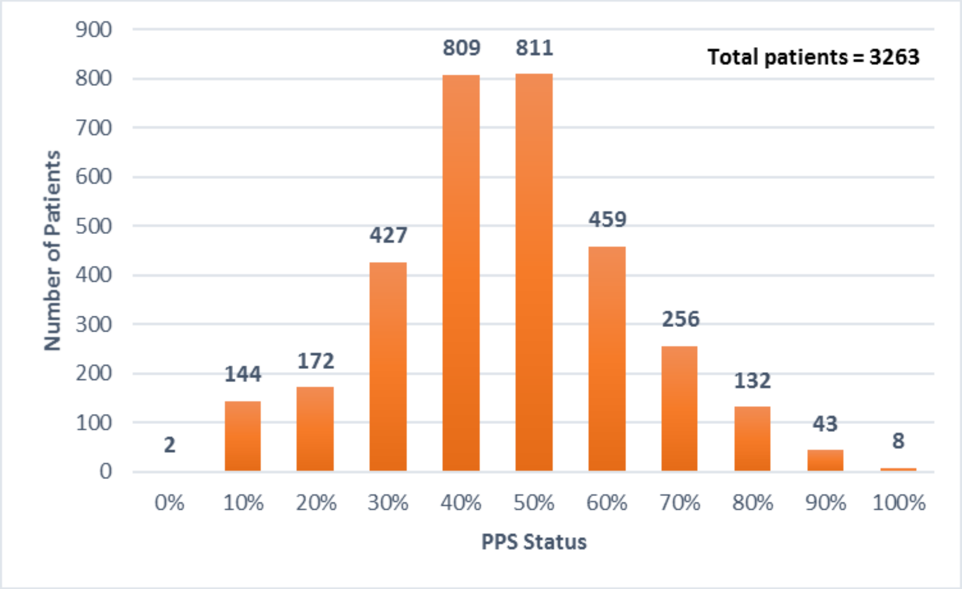
[37] Research shows that patients with cancer may have higher function than patients without cancer who require palliative care. See: Bostwick D, Wolf S, Samsa G, et al. *Comparing the Palliative Care Needs of Those With Cancer to Those With Common Non-Cancer Serious Illness.* J Pain Symptom Manage, 2017. 53(6):1079-1084.e1.



PPS Score	CMMI	Non-CMMI	Total
0-60	89%	83%	87%
70	6%	10%	8%
80-100	5%	7%	6%

B. Aspire Health

Aspire Health provides specialized medical care for patients facing a serious illness, with a focus on home-based palliative care. Aspire works in more than 20 states across the country and partners with national health plans to address patients' palliative care needs, including several million Medicare Advantage members.

In looking at proposed eligibility criteria, Aspire used the claims and death data on their Medicare Advantage members in an attempt to provide some sense of what the population those criteria would identify might look like. Specifically, they applied the serious illness diagnosis, utilization and durable medical equipment (DME) criteria on 2015 claims so that AAHPM could examine what happened to eligible patients in 2016 and 2017.

Aspire found:

- Using the diagnosis criteria alone, approximately 29 percent of the total population in 2015 was identified.
- Combining the diagnosis criteria and two or more utilizations in 2015, 8 percent of the total population was identified.
- Combining the diagnosis criteria, two or more utilizations in 2015 and DME for a hospital bed, wheelchair or oxygen in 2015, 2.9 percent of the total population was identified.
- Of the 2.9 percent of the population identified, the 12-month mortality rate was 23 percent, and 18-month mortality rate was 29 percent.

Claims data is not able to fully assess activities of daily living (ADLs) or functional scores according to the Palliative Performance Scale (PPS) or Eastern Cooperative Oncology Group (ECOG) Scale of Performance Status, however the addition of a PPS score of 70% is expected to capture 5 to 6 percent of the Medicare population.

C. NHAT Data Simulation prepared by Amy S. Kelley, MD MSHS

Amy S. Kelley**,** MD MSHS, is Associate Professor in the Brookdale Department of Geriatric and Palliative Medicine at Mount Sinai. She is a geriatrician, palliative care physician and health services researcher who has focused on examining the patient, family, and regional factors associated with high-cost hospital treatments, with the aim of improving quality by better aligning treatment with patients' personal goals and preferences. She has eight years of experience working with Medicare claims data linked to large nationally-representative longitudinal cohort studies, including the National Health and Aging Trends Study (NHATS).

Using NHATS and linked Medicare claims, Dr. Kelley's team identified the Medicare fee-for-service population with a serious illness who also had evidence of functional decline and at least one health care utilization, consistent with the PACSSI eligibility criteria described above.

In the moderate complexity category (Tier 1), annual Medicare costs averaged $26,181, 46 percent were hospitalized, and 23 percent died within the year.

Those who qualified in the high complexity category (Tier 2) experienced annual mean Medicare costs of $35,584, 66 percent were hospitalized, and 29 percent died within the year.

NHATS Sample Characteristics and Outcomes by Proposed PACSSI Payment Category

	Does not meet both dx and function requirements	Meets dx and function, but not utilization	Moderate complexity patients	High complexity patients
Age at interview, mean	75.19	79.63	80.17	79.89
Income, mean	61,493.21	35,217.07	35,219.81	38,060.03
Female	55.44	65.96	60.80	62.22
White Non-Hisp	83.89	81.98	77.30	79.73
Black Non-Hisp	7.04	10.58	8.54	8.19
Hispanic	4.55	6.33	10.92	6.39
Other race/ethnicity	3.42	*	*	*
Married	55.17	40.60	46.23	36.32
Education: HS+	80.38	72.44	64.91	64.91
proxy	4.19	28.26	23.11	23.98
Medicaid	11.71	23.38	26.18	24.32
Medigap	62.54	61.78	58.61	54.60
Self reported health=fair/poor	21.79	60.32	60.44	71.07
Independent in ADLs	91.93	25.27	20.61	13.92
Full ambulation	94.26	50.70	40.88	41.90
Reports help getting around inside or getting out of bed, or not going parts hom	5.29	38.40	45.47	45.95
Reports not getting out of bed by self	0.40	10.90	12.46	10.91
Any SMI	10.26	100.00	100.00	100.00
Health keeps from activities	15.80	60.92	60.83	68.89
R1 PA6 HEALTH KEEP FRM RELI SERV	9.99	40.34	43.69	43.54
R1 PA14 HLTH KP GO OUT FOR ENJOY	7.54	36.73	38.90	48.06
R1 PA18 HEALTH KEEP YOU FRM WORK	4.89	24.01	23.77	23.10
Did not prepare meals or do laundry by self due to health	3.15	33.33	40.17	36.11
Any difficulty in ADLs or IADLs	35.79	75.60	81.20	88.41
No difficulty reported	59.65	7.54	*	*
Difficulty in ADLs/IADLs	26.69	25.41	25.67	19.54
Difficulty & unable to do activities b/c health	10.51	33.73	29.56	43.44
Unable to prepare meals or do laundry	3.15	33.33	40.17	36.11
No assistance	91.94	25.27	20.61	15.55
Care dependent, mostly do by self	3.45	20.57	22.47	20.52
Sometimes do by self	1.35	11.10	14.65	9.04
Rarely do by self	0.65	6.45	7.79	13.20

Never do by self	2.61	36.61	34.48	41.69
1+ high-need indication	33.62	69.57	82.29	94.34
Significant symptom burden--activity limited by pain or breathing problem	31.30	58.94	64.36	71.16
Breathing problem limits activity	8.80	28.36	38.86	35.56
Pain limits activity	27.44	48.45	53.88	61.10
Hospital discharge within 30 days	1.10	0.00	16.07	27.78
Malignant Cancer or Leukemia, Dartmouth	1.68	10.38	19.29	9.85
Chronic Pulmonary Disease, Dartmouth	7.16	33.02	41.05	47.47
CAD, Dartmouth	18.58	33.22	50.19	71.60
CHF, Dartmouth	6.18	23.20	40.41	57.98
PVD, Dartmouth	9.74	29.51	34.54	47.57
Diabetes w/ End Organ Damage, Dartmouth	7.22	21.47	18.88	37.48
Renal Failure, Dartmouth	5.98	14.04	32.28	43.22
Dementia, Dartmouth	2.56	29.45	26.90	31.76
Any chronic disease, Dartmouth	38.22	90.75	98.10	97.71
3+ Chronic diseases, Dartmouth	5.02	31.17	54.02	76.20
Neurodegenerative Disorder,6m	0.39	7.43	*	11.20
CVA, 6m	1.26	13.55	17.32	18.55
Indicator of Dementia 6m, Elixhauser 2+dx & 2+ ADLs req.	0.00	24.05	15.54	22.83
Indicator of Metastatic Cancer 6m	1.70	10.75	19.29	9.85
Indicator of ESRD 6m, Elix and claims DN file	1.13	5.20	15.39	13.64
Indicator of CHF 6m, Primary dx from IP claim	*	0.00	4.51	9.40
Indicator of COPD 6m, COPD any dx and home o2 use or COPD as prim dx	0.29	23.85	21.85	20.98
Elix compl diabetes + peripheral vas, renal or ischem, 6m	3.37	17.58	16.26	35.99
3 or more serious medical illnesses	*	*	*	7.88
2 or more serious medical illnesses	3.41	29.34	49.40	75.18
Any serious medical illness	10.26	100.00	100.00	100.00
Indicator for any hospital admission 6m pre ivw	6.74	0.00	56.27	100.00
Indicator of any observation stay 6m pre interview	3.34	0.00	4.47	20.04
Indicator ED visit not leading to admission	10.26	0.00	46.94	57.64
Estimated PPS score				
100	55.02	0.00	0.00	0.00
90	4.60	7.54	*	*
80	23.01	5.91	*	*

70	8.54	8.84	*	10.25
60	4.21	23.55	29.70	21.86
50	1.35	11.10	14.65	9.04
40	0.65	6.45	7.79	13.20
30	2.61	36.61	34.48	41.69
Outcomes				
Total paid by MC 12m post interview, mean	7,779.12	16,619.92	26,181.11	35,584.26
Total hospital days 12m post interview, mean	1.12	3.04	4.33	8.44
Any hospital admission 12m post interview	15.79	35.95	46.34	65.75
Died 12m post interview	2.07	14.39	23.16	29.02
_				
N	4,272	269	188	165
National Estimate	20,489,019	1,034,143	689,367	640,245

NHATS 2011 Sample w/ 6+ months FFS pre interview, community dwelling (not nursing home) with SP interview; HIV, ALS, hip fracture, and liver disease not shown due to cell size restriction
* -not shown for cell size restriction

Appendix 5: Determining PACSSI's MIPS APM Status

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) transformed Medicare payment for physicians and other clinicians. Specifically, it terminated the Medicare Sustainable Growth Rate (SGR) formula and replaced it with specified payment updates in order to provide a period of payment stability while clinicians adjust to two new programs: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs), which the Centers for Medicare and Medicaid Services (CMS) collectively calls the Quality Payment Program (QPP).

In its final rules implementing MACRA reforms (81 FR 77008 – 77831), CMS established a special type of Alternative Payment Model (APM) called "MIPS APMs." Participation by MIPS eligible clinicians in MIPS APMs would be subject to special scoring under MIPS, in order to reduce participant reporting burden and minimize the potential for conflicting incentives between MIPS and APMs. CMS finalized criteria for designation as a MIPS APM in its final regulations.

AAHPM supports these goals and has designed both tracks under the PACSSI model to meet MIPS APM status. The table below details finalized criteria for MIPS APMs and identifies how PACSSI Tracks 1 and 2 meet such criteria.

MIPS APM Final Criteria 42 CFR 414.1370(b)	**PACSSI Model Parameters**
MIPS APMS are those in which:	
APM Entities participate in the APM under an agreement with CMS or through a law or regulation	PACSSI Track 1 and Track 2 are intended to be Medicare APMs for which palliative care teams (PCTs) participate under an agreement with CMS.
The APM is designed such that APM Entities participating in the APM include at least one MIPS eligible clinician on a Participation List	Under both Track 1 and Track 2 of PACSSI, the APM Entity is specified as the palliative care team. These teams would generally be able to organize themselves and determine the appropriate level of representation across multiple disciplines, including physicians, nurses (including advanced practice nurses), social workers, spiritual care providers, physician assistants, pharmacists, counselors and others, as needed and appropriate to address the needs of the local patient community. However, each PCT must have at least one MIPS eligible clinician as part of its team structure.
The APM bases payment on cost/utilization and quality measures	Each PACSSI Track includes an accountability structure that considers both quality and spending. PCTs would be assessed for performance on total cost of care relative to a benchmark, as well as for performance on quality measures regarding patient experience of palliative care, processes of care, and health care utilization at the end of life. Under Track 1, high performing PCTs would receive payments of up to 4 percent of total PACSSI care management fees received for a year, and poor performers would be required to pay back up to 4 percent.

	Under Track 2, PCTs would be eligible to receive shared savings or would be required to share in risk, based on performance for total cost of care relative to a benchmark. The potential for savings and the amount at risk would vary based on quality performance.

Appendix 6: Determining PACSSI's Advanced APM Status

To support the delivery of high-quality, effective care driven by value rather than volume, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created financial incentives for clinicians to substantially participate in payment models that meet certain criteria. CMS called these models "Advanced Alternative Payment Models" or "Advanced APMs," and specified the eligibility criteria to achieve Advanced APM status in final rulemaking last year (81 FR 77008 – 77831).

AAHPM believes it is important to create opportunities for palliative care practitioners to join Advanced APMs in order to succeed under the MACRA framework. As such, we have designed Track 2 of the PACSSI model with this aim in mind. The table below details finalized criteria for Advanced APMs and how AAHPM proposes to address each criteria under PACSSI Track 2.

Advanced APM Final Criteria 42 CFR 414.1415	**Approach Established under PACSSI Track 2**
Use of certified electronic health record technology (CEHRT)	
To be an Advanced APM, an APM must require at least 50 percent of eligible clinicians in each participating APM Entity group to use CEHRT to document and communicate clinical care to the patients or other health care providers.	AAHPM requests an exemption from the CEHRT requirement to qualify as an Advanced APM. In general, PCTs experience a great deal of difficulty in adopting *certified* EHR Technology (CEHRT). For example, HHS does not certify CEHRT for hospice settings, where PCTs regularly practice. PCTs may also have limited control over the adoption of CEHRT if they practice in facility-based settings. Many PCTs may also be part of small practices, for which CMS has proposed a hardship exemption under MIPS starting with the 2018 performance year.
Payment based on quality measures	
To be an Advanced APM, an APM must include quality measure results as a factor when determining payment to participants under the terms of the APM.	The PACSSI accountability structure includes assessment of performance on quality measures when determining final payment amounts. Specifically, PCTs would be eligible to receive shared savings or would be required to share in risk, based on performance for total cost of care relative to a benchmark. The potential for savings and the amount at risk would vary based on quality performance.
At least one of the quality measures upon which an Advanced APM bases the payment must have an evidence-based focus, be reliable and valid, and meet at least one of the following criteria:	Under PACSSI Track 2, PCTs would be assessed for performance on quality measures regarding patient experience of palliative care, processes of care, and health care utilization at the end of life. While many of the measures are currently in testing phases, five of the process measures included in the calculation of quality performance assessment for the purposes of determining payments are from the *Measuring What Matters*

(i) Used in the MIPS quality performance category (ii) Endorsed by a consensus-based entity (iii) Developed under section 1848(s) of the Social Security Act (iv) Submitted in response to the MIPS Call for Quality Measures (v) Any other quality measures that CMS determines to have an evidence-based focus and to be reliable and valid.	list, based on their clinical importance, evidence of feasibility, demonstration of important gaps in care, and variance across diverse settings.
The quality measures upon which an Advanced APM bases payment must include at least one outcome measure.	The PACSSI model includes quality measures regarding patient experience of palliative care, processes of care, and health care utilization at the end of life. Both the patient experience of palliative care measures and the measures of health care utilization at the end of life include outcome measures, for which performance is tied to payment.
Financial Risk	
To be an Advanced APM, an APM must, based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified QP Performance Period, do one or more of the following: (i) Withhold payment for services to the APM Entity or the APM Entity's eligible clinicians (ii) Reduce payment rates to the APM Entity or the APM Entity's eligible clinicians; or (iii) Require the APM Entity to owe payment(s) to CMS.	PACSSI Track 2 includes a shared savings and shared risk accountability structure based on total cost of care. If actual expenditures under the model exceed a pre-set benchmark reflecting expected expenditures, PCTs would be required to owe payments to CMS. Payments due would depend on the extent to which spending exceeds the benchmarks, as well as performance on quality measures.

The total amount an APM Entity potentially owes CMS or foregoes under an APM must be at least equal to either of the following: (i) 8 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities;[1] (ii) 3 percent of the expected expenditures for which an APM Entity is responsible under the APM.	Under PACSSI Track 2, PCTs would be subject to shared risk payments. Risk would be based on spending above the benchmark, and could be as high as, for a given APM Entity, the lesser of 3 percent of total cost of care or 8 percent of the PCTs' total Medicare A and B revenues.

[1] In the 2017 QPP final rule, the stated 8 percent of revenues option was finalized for performance years 2017 and 2018 only. In the 2018 QPP proposed rule, CMS proposes to extend the availability of this 8 percent of revenues option for two additional performance years, 2019 and 2020.

Appendix 7: Comparison of Models Submitted by AAHPM and the Coalition to Transform Advanced Care

AAHPM recognizes that this submission addresses many of the same concerns and gaps targeted in the proposal submitted by the Coalition to Transform Advanced Care (C-TAC) to the Physician-Focused Payment Model Technical Advisory Committee on February 7, 2017. To assist the PTAC in identifying the unique aspects of the AAHPM model relative the C-TAC model, we have prepared the table below, which – for the C-TAC proposal – reflects AAHPM's current understanding of the model.

Model	AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)	C-TAC Advanced Care Model (ACM)
Sponsor/ Overall	American Academy of Hospice and Palliative Medicine	Coalition to Transform Advanced Care
Eligible Participants/ APM Entities	Palliative care teams (PCTs) that have the capability to: - perform assessments and deliver services through an interdisciplinary care team structured in accordance with the essential elements of the National Consensus Project for Quality Palliative Care and - respond appropriately on a 24/7 basis to patient and caregiver requests, including face-to-face and telephonic responses PCTs could be working as independent provider organizations or be associated with hospices, home health organizations, hospitals, businesses focused on palliative care delivery, or integrated health systems.	Provider organizations: Hospitals, integrated health systems, medical groups, ACOs, home health agencies, hospices, and others. A consortium structure of several small practices is also permissible, or may serve as referring providers with a qualified ACM convener. Ancillary organizations such as health plans, care management, telehealth, EMT, and social services organizations may also participate in partnership with qualified provider entities.
Target Beneficiaries	Beneficiaries meeting criteria for serious illness, functional limitation, and health care utilization would be eligible to participate (see Table 1 in the AAHPM proposal). Patients would be categorized into one of two tiers (moderate or high) based on the complexity of their health care needs.	Advanced Illness Beneficiaries must meet the following 2 criteria: (1) Meet 2 of 8 specified clinical criteria (see Table 1 in the C-TAC proposal) (2) Have attestation from a clinician on likelihood of dying within 1 year

Model	**AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)**	**C-TAC Advanced Care Model (ACM)**
Target Beneficiaries *(cont'd.)*	Patients would have to designate the PCT as the patient's primary provider of care management and palliative care services, agree to work with the PCT to develop a care plan, and adhere to the care plan to the best of their ability.	Participants would be identified by the ACM entity, and the ACM entity would be subject to data analysis to monitor the enrollment process. Early program discharges are permissible. Enrolled individuals who pass away within a 12-month period will remain attributed.
Service Delivery Reforms	PCTs would be responsible for education, assessment, care planning, care coordination, and delivery of palliative care services, as well as responding on a 24/7 basis to requests from patients or caregivers. This would include coordinating and communicating with the patient's other physicians and providers, as well as arranging for services from other providers. PCTs would be responsible for making visits to the patient in all sites of care as needed to respond appropriately to problems and concerns; telephonic responses would also be included. PCTs would be able to organize themselves and determine the appropriate level of representation across multiple disciplines, including physicians, nurses (including advanced practice nurses), social workers, spiritual care providers, physician assistants, pharmacists, counselors and others, as needed and appropriate to address the needs of the local patient community.	The care model includes team-based care across care settings using interdisciplinary teams; concurrent palliative care and curative treatment; advanced care planning; patient and family engagement; comprehensive care management using a unified care plan; home and telephonic visits; and 24/7 clinician access. The team composition must include a provider with palliative or hospice care expertise, a registered nurse, and a licensed social worker, and may include other clinicians and non-clinicians practicing within their state's scope of practice licensure. Would require reporting via a new ACM encounter code.

Model	**AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)**	**C-TAC Advanced Care Model (ACM)**
Service Delivery Reforms *(cont'd.)*	Would require monthly submission of a claim to receive PACSSI monthly payments.	
Payment Reforms	Monthly PACSSI care management payments would support interdisciplinary PCTs. Base payment amounts are as follows: - Moderate complexity tier: $400 PBPM - High complexity tier: $650 PBPM Payments would also differ based on site of care (domiciliary versus facility-based) and would be geographically adjusted. PACSSI payments would replace E/M services as well as CCM, complex CCM, TCM, and ACP services. Other clinicians would not be paid for CCM or complex CCM codes, consistent with requirements under the Medicare Physician Fee Schedule. Payments would be terminated following disenrollment from the model due to death, hospice election, discharge due to improved health status, or voluntary disenrollment. Payments to PCTs would be subject to risk based on quality and cost, as follows: - PACSSI Track 1 – Payment Incentives: PCTs would be subject to positive and negative payment incentives of up to 4 percent of total	Provides a $400 PMPM, wage adjusted, for up to 12 months (capped). - PMPM would replace FFS payments for palliative care providers - PMPM would end when beneficiary elects hospice, leaves the service area, dies, or is discharged due to improved health. Provides for shared savings in the first year, moving to shared risk in the second year. - Shared risk/savings would be based on total cost of care in the last year of life (including PMPM fees), based on enrollees who died within the performance year - 75-85% shared savings/loss rate - 30% cap on shared savings - 10% cap on shared losses - 4% total loss and MLR Additional specifications, including outlier adjustments, are also included. The shared savings analysis is applied to enrollees who have died by the end of the performance year, including discharged enrollees.

Model	AAHPM’s Patient and Caregiver Support for Serious Illness (PACSSI)	C-TAC Advanced Care Model (ACM)
Payment Reforms *(cont’d.)*	PACSSI care management fees received for a year. - PACSSI Track 2 – Shared Savings and Shared Risk (available starting in Year 3): PCTs would take on shared savings and shared risk based on total cost of care, with sharing and risk amounts subject to quality adjustments. Under both tracks, spending would be assessed based on total cost of care, which would include spending for the monthly PACSSI care management fees. Total cost of care benchmarks would be subject to a +/-4.0 percent minimum loss rate to account for potential variation in spending due to small sample sizes and change under Track 1. A similar minimum loss rate could also be applied in Track 2. Under Track 2, risk would be limited to the lesser of 3 percent of the total cost of care benchmark or 8 percent of each PCT’s total Medicare A and B revenues. Additional risk parameters include: - 20% cap on shared savings - Shared savings and shared loss rates would vary based on risk corridors and quality performance (e.g. up to 80% of shared savings and as much as 60% of shared losses). - Outlier provisions would also apply.	ACM entities that do not achieve shared savings would have a 6-month correction period; if they cannot perform under two-sided risk after this period, they would be required to drop out. The ACM also provides for a partial advanced APM incentive payment – 5% bonus for advanced illness professional fees.
Incorporation of Risk?	Yes, starting with Year 1 for PACSSI Track 1, linked to monthly care management fees.	Yes, starting with year 2. See above discussion of payment reforms.

Model	AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)	C-TAC Advanced Care Model (ACM)
Incorporation of Risk? *(cont'd.)*	For PACSSI Track 2, which becomes available in Year 3, risk is tied to total cost of care.	
Quality	Minimum performance standards would be required for participation (care planning, documentation, face-to-face visits). For quality accountability tied to payment, the model includes three categories of measures: - Patient-reported outcomes regarding experience of palliative care using survey instruments; - Completion of care processes that are proven to drive quality; and - Utilization of health care services at the end of life. Certain measures are tied to payment in the first two years of the model, while others are only pay-for-reporting until Year 3 when benchmarks have been established. Table 3 in the AAHPM proposal details measures and their pay-for-performance status under the model.	Includes a set of quality metrics, including some which would determine extent of shared savings (not fully specified). Measures are divided into three categories: quality, access, and person-centeredness. Measures include claims and EHR measures, as well as patient survey measures. Measures that address quality, access, and patient-centeredness would be tied to payment, including claims-based outcome measures such as hospital admissions, ED visits, and ICU days in the last 12 months of life, as well as hospice length of stay. Additional quality and access metrics would be tracked for quality monitoring purposes, including hospitalization rates and ER visits per 30 days per 100 enrollees, and 30-day readmission rates.
Use of CEHRT	Requires electronic reporting of quality data using one of the submission methods currently accepted for quality reporting under the Merit-Based Incentive Payment system.	Requires use of EHRs, but requests waiver of requirement to use certified EHRs given potential non-physician/non-hospital participants.
Overlap with Other Models	Patients would be required to receive all care management services via PACSSI, such that overlap with other models would be difficult.	May function as a subset of broader APMs such as a Medicare Shared Savings Program ACO. PMPM payments would be made, but risk would be rolled up to the ACO level.

Model	AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)	C-TAC Advanced Care Model (ACM)
Overlap with Other Models *(cont'd.)*	AAHPM is developing another new payment model, known as Palliative Care Support to Medical Home (PCS), which is designed to interface with other alternative payment models to improve quality and cost performance. PCS does not have the potential to qualify as an alternative payment model, and so will not be part of the PTAC submission. PCS is outlined in an appendix to the PACSSI proposal.	Under other models such as Bundled Payments for Care Improvement, Comprehensive Primary Care+, Oncology Care Model, and Independence at Home, providers would have the option to migrate from the model to the ACM once beneficiaries become clinically appropriate.

Appendix 8: Letters of Support

On the pages that follow, the American Academy of Hospice and Palliative Medicine (AAHPM) is pleased to include letters of endorsement for our proposal. We believe AAHPM's open and inclusive development process helped to yield this diverse and impactful demonstration of support for the *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model. Supporters include organizations that are willing to participate in PACSSI, should it be recommended for testing by the PTAC and implemented by the Centers for Medicare & Medicaid Services, as well as organizations that would encourage their members to do so.

These organizations include:
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Home Care Medicine
American Geriatrics Society
American Society for Clinical Oncology
Association of Professional Chaplains
Bluegrass Care Navigators
Center to Advance Palliative Care
Coalition to Transform Advanced Care
Compassus
Four Seasons Compassion for Life
Health Care Chaplaincy Network
Home Centered Care Institute
Hospice and Palliative Nurses Association
Hospice of Michigan
Kindred at Home
National Association for Home Care & Hospice
National Coalition for Hospice and Palliative Care
Physician Assistants in Hospice and Palliative Medicine
ProHEALTH Care
Social Work Hospice and Palliative Care Network

NATIONAL COALITION
FOR HOSPICE AND
PALLIATIVE CARE

August 14, 2107

Physician Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Advisory Committee Members:

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit this letter of support for the American Academy of Hospice and Palliative Medicine (AAHPM) Patient and Caregiver Support for Serious Illness (PACSSI) payment model. New payment mechanisms, based on patient need and disease severity, are required to provide palliative care services to patients in all stages of serious illness who are not yet eligible or willing to enroll in hospice care. The PACSSI model would provide tiered monthly PACSSI care management payments to support interdisciplinary palliative care teams (PCTs) as they deliver community-based palliative care to patients who meet eligibility criteria that include a diagnosis of a serious illness or multiple chronic conditions, functional limitations, and health care utilization. PACSSI care management payments would replace and supplement payment for evaluation and management (E/M) services.

The Coalition is composed of the nine leading national hospice and palliative care organizations dedicated to advancing care of patients, families and caregivers living with serious illness, as well as those facing the end of life. The organizations that form the Coalition represent more than 5,000 physicians and 1,000 physician assistants, 11,000 nurses, 5,000 professional chaplains, more than 5,000 social workers, researchers, 1,600 palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of patients and families. Our combined membership represents the interdisciplinary hospice and palliative care team which is person and caregiver-centered.

Serious Illness and the Role of Palliative Care

One of the key priorities of our interdisciplinary Coalition is to improve patient access to palliative care for people with serious illness. Palliative care focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis)[1] and can be provided along with curative treatment in multiple settings. The goal is to improve quality of life for both the patient and their caregivers.

Multiple studies show that with palliative care, patients with serious illness and their families can *avoid* receiving poor-quality health care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other

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[1] Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. J Clinical Oncol 2012; 30: 880-887.

caregivers.[2,3] By focusing on priorities that matter most to patients and their caregivers, palliative care has been shown to improve both quality of care and quality of life. [4,5] In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.[6] Last year, the American Heart Association / American Stroke Association stated that palliative care can be a helpful complement to current care practices and can improve quality of life for cardiovascular disease and stroke patients, caregivers, and providers.[7] Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.[8] AAHPM's submission to the Advisory Committee includes numerous other examples and cited studies related to the effectiveness of palliative care within the serious illness population.

Yet despite the demonstrated benefits of palliative care, millions of Americans do not have access to these services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.[9] These patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse interdisciplinary palliative care services.

Potential Solutions

The Coalition supports AAHPM's PACSSI payment model as it begins to close key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients by the right personnel, such as nurses, case managers, social workers, and/or chaplains.

- **Interdisciplinary Palliative Care Team (PCT):**

  The capability to perform assessments and deliver services through an interdisciplinary team structured in accordance with the essential elements of the National Consensus Project, Clinical Practice Guidelines for Quality Palliative Care (http://www.nationalcoalitionhpc.org/guidelines-2013/); PCTs can include currently non-billing clinicians (e.g. nurses, social work or spiritual care professionals) who otherwise are not reimbursed under the Medicare program, as they work in conjunction with patients' other care providers and provide psychosocial and spiritual support. Participating PCTs would be required to demonstrate:

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[2] Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. JAMA. 2004 Jan 7; 291(1):88-93.

[3] Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. The Milbank Quarterly. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

[4] Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) Cancer 437-45 (2009).

[5] Casarett D, et al., Do palliative consultations improve patient outcomes? 56 J Am Geriatric Soc'y 593, 597-98 (2008).

[6] Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733-742.

[7] Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association http://circ.ahajournals.org/content/early/2016/08/08/CIR.0000000000000438 Aug 16.

[8] Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. www.innovations.ahrq.gov/content.aspx?id=3370.

[9] IOM (Institute of Medicine). 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

- **24/7 Availability:**

  The capability to respond appropriately on a 24/7 basis to patient and caregiver requests for advice and assistance in managing issues associated with the patient's health conditions and functional limitations is essential. Appropriate response includes the ability to provide face-to-face services in all care settings when needed (either in person or through videoconference services) as well as telephonic responses.

The flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies, including rural settings. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to the largest number of patients and caregivers possible.

AAHPM's submission includes information indicating that this model will generate significant net savings for the Medicare program, in excess of any costs incurred for the PACSSI care management fees, based on several studies to date that have demonstrated reductions in cost paired with improvements in quality.

Stakeholder Engagement

This model addresses a significant need in the serious illness community and reflects the interest and input of a broad range of stakeholders including the nine national organizations within our Coalition as well as many other organizations. Several of these stakeholders represent sites that would be ready to pilot this model as early as 2018. Additionally, this model is transferrable to other payers, including private payers and publicly funded programs like Medicaid and TRICARE/Veterans Administration, for patients who meet the eligibility criteria.

Importance of Quality Metrics

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of the field, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure. Importantly, the PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than 7 days.

Our Coalition, representing the interdisciplinary hospice and palliative care field, will encourage and help educate our membership about the benefits of participation in PACSSI, should it be recommended for testing by PTAC and approved and implemented by CMS. Thank you for the opportunity to submit a letter of support from our Coalition to the Physician Focused Payment Model Technical Advisory Committee. I would be happy to speak with you about our support for AAHPM's PACSSI proposal or connect you with the leadership of our Coalition. Please contact me at amym@nationalcoalitionhpc.org or 202.306.3590 if you have any questions about our support of this proposal.

Sincerely,

Amy Melnick

Amy Melnick, MPA
Executive Director
National Coalition for Hospice and Palliative Care
www.nationalcoalitionhpc.org

National Coalition for Hospice and Palliative Care member organizations are:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- Association for Professional Chaplains (APC)
- Center to Advance Palliative Care (CAPC)
- Health Care Chaplaincy Network (HCCN)
- Hospice and Palliative Nurses Association (HPNA)
- National Hospice and Palliative Care Organization (NHPCO)
- National Palliative Care Research Center (NPCRC)
- Physician Assistants in Hospice and Palliative Medicine (PAHPM)
- Social Work Hospice and Palliative Care Network (SWHPN)

C-TAC
COALITION TO TRANSFORM
ADVANCED CARE

August 13, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary of Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201
PTAC@hhs.gov

RE: Letter of Support—Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members:

On behalf of the Coalition to Transform Advanced Care (C-TAC), we would like to express our enthusiastic support for the American Academy of Hospice and Palliative Medicine (AAHPM) on their physician-focused payment model, PACSSI.

Today, many individuals with advanced illness receive care that is fragmented, uncoordinated, or inadequate to meet their growing needs and personal wishes. To meet these needs, we must transform care delivery by "breaking down a range of silos between 'curative' and palliative care, between professional groups to foster interdisciplinary practice, and between traditional medical and social services" (IOM Report: Dying in America). Furthermore, we must support payment models that enable this type of care. The PACCSI model aligns with this vision and many specific elements of C-TAC PTAC proposal, the Advanced Care Model.

We look forward to continued efforts with AAHPM and the PTAC to support national implementation of new care and alternative payment models to ensure all Americans with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with the goals and values and honors their dignity.

Sincerely,

Tom Koutsoumpas
C-TAC Co-chair
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Khue Nguyen
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August 11, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

re: Letter of Support-Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

On behalf of AMDA-The Society for Post-Acute and Long-Term Care Medicine, we are writing to express our support for the American Academy of Hospice and Palliative Medicine's (AAHPM) draft proposal for an alternative payment model for palliative care, titled "The Patient and Caregiver Support for Serious Illness" (PACSSI).

The Society is the only medical specialty society representing the community of over 50,000 medical directors, physicians, nurse practitioners, physician assistants, and other practitioners working in the various post-acute and long-term care (PA/LTC) settings. The Society's 5,500 members work in skilled nursing facilities, long-term care and assisted living communities, CCRCs, home care, hospice, PACE programs, and other settings.

Many patients with serious illness and their caregivers are not well served in the current fee-for service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. AAHPM's PACSSI payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time.

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure.

The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. Smaller or less risk-ready practices can participate and grow in Track 1, where PACSSI payments are adjusted based on quality and cost. Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality.

The Society looks forward to participating and encouraging our members to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Sincerely,

H White C Laxton

Heidi K. White, MD, MHS, MEd, CMD
President

Christopher E. Laxton, CAE
Executive Director

AAHCM
AMERICAN ACADEMY OF
HOME CARE MEDICINE

August 14, 2017

Physician Focused Payment Model Technical Advisory Committee
C/0 U.S. DHHS Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue
Washington, DC 20201
PTAC@HHS.gov

Re: Letter of Support for the **Patient and Caregiver Support for Serious Illness (PCSSI)** Physician Focused Payment Model

Dear Committee Members:

On behalf of the American Academy of Home Care Medicine (AAHCM), we write to offer our enthusiastic support for the **Patient and Caregiver Support for Serious Illness (PCSSI)** physician-focused payment model proposal. The AAHCM is the professional association that represents physicians, nurse practitioners, physician assistants, social workers, and others working in the field of home-based medical care.

Our support for **PCSSI** aligns with the mission of the AAHCM to deliver on the promise of interdisciplinary, team-based, high-value care in the home for all people in need – especially the most vulnerable. **PCSSI** is a patient focused, interdisciplinary, multi-site model that includes the home, and is of high-value (i.e. projected to save in costs). The AAHCM believes the implementation of **PCSSI** will improve patient care outcomes, enhance the care experience for patients and families, and reduce total costs. These outcomes are the focus of the Medicare Access and CHIP Reauthorization Act as well as core elements of the nation's Triple Aim goals.

Specifically, the **PCSSI** proposal satisfies PTAC criteria in several ways:

- **Value over Volume:** Many patients with serious illness who present the need for palliative care along with their caregivers are not well served by the current fee-for service payment system, which does not adequately pay for community-based, interdisciplinary palliative care services. Numerous studies have shown community based palliative care improves quality of life, controls cost, and shows improved patient and caregiver satisfaction. The **PACSSI** two-track model includes evidence based incentives that supports value over volume.

- **Flexibility:** Each of the two-track structures of the **PACSSI** model will allow participation by palliative care teams of various sizes and types that serve Medicare beneficiaries in differing markets and geographies. This will allow a **PACSSI** demonstration to gather important data and experience from diverse settings, and provide valuable services to the largest number of patients and caregivers possible. This flexibility is especially important to encourage the development of the home care medicine workforce necessary for the care and management of the sickest and most expensive Medicare beneficiaries who are home-limited.

- **Quality and Cost:** Each PACSSI program must meet a set of minimum requirements relating to care plan development, monthly face to face encounters, 24/7 availability and service documentation, and learning collaborative participation and others. Programs must also meet a set of 10 service elements to support high quality palliative care across settings. Finally, each of the **PACSSI** tracks includes risk based payment to support improvement in patient/caregiver reported outcomes, care processes, and utilization/cost.

- **Payment Methodology**: **PACSSI** provides for two payment tracks each of which includes predictable financing so that a variety of practices will have the resources necessary to develop infrastructure and to provide the most appropriate care to the patients, such as nurses, case managers and telehealth. This innovative approach also expands the CMS APM portfolio to increase opportunities for practices of various sizes to participate and become Qualifying Participants under Advanced Alternative Payment Models.
- **Scope**: The flexible, two-track structure of the **PACSSI** model provides for eligibility of beneficiaries with serious illness that are experiencing ongoing decline as well as beneficiaries whose functional status (without underlying serious conditions), improves over time. Combined with the two-track payment model; **PACSSI** will help Medicare beneficiaries with serious illness get the right care, in the right place including the home, at the right time
- **Ability to be evaluated**: Each of the **PACCSSI** tracks includes proposed outcomes, care processes and utilization measures so that benchmarking and quality improvement can occur. The implications of evaluation is meaningful as it provides for program termination through to reward and shared savings for satisfying the quality and financial measures.
- **Integration and Care Coordination**: Required elements that each **PACSSI** programs must satisfy include coordination of care across all providers with input into the patient care plan, development of the care team specific to meet the needs of the individual patient, and coordination of providers outside of the program as well as coordination across settings.
- **Patient Choice**: **PACSSI** includes requirements for patient consent to participate with a **PACSSI** program, comprehensive multidimensional assessment, the ability to terminate the relationship at any time, and elimination of co-payments that could infringe on participation. Additionally, quality measures recognize the needs and preferences of individual patients.
- **Patient Safety**: **PACSSI** incorporates patient safety through elements that each program must meet including minimum beneficiary numbers, the multidimensional assessments, quality measures that include patient/caregiver satisfaction to counter any potential for stinting on care, and hospice utilization measures to assure that programs are not holding onto participants or delaying access to hospice, in addition to processes of care measures.
- **Health Information Technology (HIT)**: **PACSSI** programs are required to use HIT to coordinate care and data exchange, provide 24/7 access, support tele-monitoring, and to report quality measures through one acceptable means of MIPS reporting.

In conclusion, **PACSSI** meets a major patient care need that is currently not being met in a medical/payment organized manner. It pays providers for services in an innovative, two track structure to encourage practices of various types and sizes to participate through an outcomes-based model that satisfies the PTAC criteria. Together with other models, such as Independence at Home (IAH), which specifically supports the care of patients in the home, **PACSSI** will be part of the national trend reflecting that appropriate and safe care in the community and in the home is an appropriate and desired best practice of high value.

The AAHCM strongly supports the **PACSSI** proposal, and appreciates your consideration of its advancement.

Sincerely,

Eric DeJonge

Mindy Fain, M.D.
President, AAHCM

K. Eric DeJonge, M.D.
President-Elect, AAHCM

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www.americangeriatrics.org

August 9, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: Letter of Support – Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

On behalf of the American Geriatrics Society (AGS), we are writing to express our support of the American Academy of Hospice and Palliative Medicine's (AAHPM's) attached proposal for a physician-focused payment model titled *Patient and Caregiver Support for Serious Illness (PACSSI)*.

The AGS is a not-for-profit organization comprised of nearly 6,000 geriatrics healthcare professionals who are devoted to improving the health, independence, and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the Medicare Physician Fee Schedule.

Many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. Numerous studies have shown community-based palliative care improves quality of life and control costs. We believe that the *PACSSI* payment model holds promise for closing key reimbursement gaps to help Medicare beneficiaries with serious illness gain increased access to interdisciplinary palliative care.

The AGS would alert our members of the opportunity to participate in *PACSSI*, should it be recommended for testing by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and implemented by the Centers for Medicare and Medicaid Services (CMS).

If you have any questions, please contact AGS Director of Public Affairs and Advocacy Alanna Goldstein, MPH, by phone at 212-308-1414 or by email at agoldstein@americangeriatrics.org.

Sincerely,

Debra Saliba

Nancy E. Lundebjerg

Debra Saliba, MD, MPH, AGSF
President

Nancy E. Lundebjerg, MPA
Chief Executive Officer

ASCO®
American Society of Clinical Oncology

August 11, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
C/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Letter of Support – American Academy of Hospice and Palliative Medicine (AAHPM)'s Proposal for a Physician-Focused Payment Model – Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

I am writing on behalf of the American Society of Clinical Oncology (ASCO) to express our support for the AAHPM's proposal for a physician-focused payment model. ASCO is the national organization representing over 40,000 physicians and cancer care providers. ASCO members are dedicated to the improvement of patient outcomes and are committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans, including Medicare beneficiaries.

We believe the approval and implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness, particularly those with cancer.

Expanding the cancer patient access to interdisciplinary palliative care services will have a dramatic impact on both improving quality of care while reducing costs. Many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. Cancer patients are included in this number and benefit greatly from these services. Numerous studies have shown community based palliative care improves quality of life and control costs.

AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI) payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients, such as nurses, case managers, and telehealth. The PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than 7 days. Further, we feel this model works very well for the needs of oncologists and their patients.

Our organization would look forward to participating and encouraging our members to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Best regards,

Stephen S. Grubbs, MD, FASCO
Vice President – Clinical Affairs

August 8, 2017

Association of Professional
CHAPLAINS
Healing through Spiritual Care

Physician-Focused Payment Model Technical
Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and
Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Committee Members,

On behalf of the Association of Professional Chaplains® (APC®), I am writing you to **express our support of the proposal for a physician-focused payment model titled Patient and Caregiver Support for Serious Illness (PACSSI).**

APC is the largest organization that represents professional chaplains with over 5,500 members. Professional chaplains serve in a variety of settings including hospitals, hospice, and palliative care. Our Board Certified Chaplains have undergone extensive education and training in their effort to best fulfill the spiritual needs of those in their care and their families.

APC supports the PACSSI proposal because many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. Numerous studies have shown community based palliative care improves quality of life and controls costs. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients, such as nurses, case managers, and chaplains.

In addition to offering a new model for palliative care, the flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to the largest number of patients and caregivers possible. The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure.

Our organization would look forward to participating/encouraging our members to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Sincerely,

Kimberly M Murman

Kimberly Murman, BCC
President, Association of Professional Chaplains

Hospice of the Bluegrass is now
BLUEGRASS
care
navigators
Expert. Connected. Care.

August 10, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear PTAC,

It is with the highest recommendation that we support the AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI). Bluegrass Care Navigators is a large, nationally-recognized, non-profit hospice organization that has also been serving our communities in Kentucky with non-hospice palliative care services since 1999. These community-based, interdisciplinary services have always been financially challenged under current fee-for-service payment systems as they typically only partially cover the palliative and nurse practitioners of the team. A high-quality team of physicians, nurses, social workers and chaplains, working together, is essential to improving quality of life to patients and their families. The PACSSI payment model will close key reimbursement gaps to the Medicare beneficiaries by allowing a palliative team to work within the model to individualize the palliative needs of the serious ill patient and their families. This model will allow the palliative team to utilize the necessary resources such as telehealth and case management for each beneficiary.

As a large hospice organization, we appreciate access to palliative services can increase the timeliness to hospice referral for beneficiaries supporting right care at the right time in the right place. As we know, hospice care still struggles with patients coming to hospice services in the last few days of life which does not allow for enough entitled support to patient and families. We feel PACSSI will allow us to expand and increase our non-hospice palliative services in all our communities especially throughout the rural Appalachian areas we serve.

Over the years, we have done pilot projects and tested our palliative team models in hospital, clinics, nursing homes and homes. We have collected data and measured outcomes to not only show quality of care and patient satisfaction but also cost-savings to healthcare organizations we partner with. We have always been frustrated with the challenge of sustainability on the fee for service system while offering such high-quality care and support to current healthcare providers. The PACSSI flexible, two track system will allow sustainability of these and other models while maintaining important quality measures and high quality outcomes. Our experience shows the PACSSI payment incentives are well structured in both quality and cost performance. We appreciate the option of both Track 1 and Track 2 which allow flexibility of care based on the patient and family needs.

Bluegrass Care Navigators fully supports PACSSI and we look forward to the opportunity to participate in the PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Respectfully Submitted,

Liz Fowler, MPH
President and CEO

Todd Cote, MD, HMDC, FAAFP, FAAHPM
Chief Medical Officer

Center to
Advance
Palliative Care
capc

55 West 125th Street
13th Floor
New York, NY 10027
TEL 212-201-2670
FAX 212-426-1369
capc.org

August 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary of Planning and Evaluation Office of Health Policy
200 Independence Ave S.W.
Washington, D.C. 20201
PTAC@ghha.gov

RE: Letter of Support – AAHPM's Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee Members,

I am writing on behalf of the Center to Advance Palliative Care (CAPC) to express our support for an advanced alternative payment model targeted to Medicare beneficiaries with serious illness. The AAHPM *Patient and Caregiver Support for Serious Illness (PACSSI)* closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time.

The flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in diverse markets and geographies. This will allow a PACSSI demonstration to gather important data and experience from a range of settings, and—more importantly—provide valuable services to the largest possible number of beneficiaries and their family caregivers.

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, prognosis, or care setting, or stage of the disease. "Serious illness" is defined as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their caregivers. (modified from Kelley AS. Defining "serious illness." J Palliat Med. 2014;17(9):985)

We do this not only by providing training, tools and technical assistance to clinicians and programs, but also by acting as a catalyst for change. Serving as a convening, organizing and dissemination force for the field, we collaborate with leaders, innovators and partners to foster connection and cross-fertilization.

As the Director of CAPC, I appreciate the opportunity to comment on AAHPM's proposal and would be willing to speak to the Committee to answer any questions.

Sincerely,

Diane E. Meier

Diane E. Meier, MD
Director
Center to Advance Palliative Care
55 West 125th Street, Suite 1302
New York, NY 10027
Diane.Meier@mssm.edu
(212) 201-2675

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10 Cadillac Drive, Suite 400
Brentwood, TN 37027
615-377-7022
compassus.com

August 9, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: AAHPM: *The Patient and Caregiver Support for Serious Illness (PACSSI).*

Dear Committee:

Compassus is delighted to support this very thoughtful, comprehensive proposal from AAHPM: *The Patient and Caregiver Support for Serious Illness (PACSSI).*

Despite active innovation in many markets, patients with serious illness and their caregivers are not well served in the current system. This proposal aligns with patient centered goals included in the CTAC Advanced Care Model submission, as well as bicameral and bipartisan legislation, The Patient Choice and Quality ***Care*** Act of 2017 to address this gap and to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time.

Compassus is a nationwide network of community-based post-acute care services primarily focused on hospice, palliative and home health care. The Nashville, Tennessee-based company was founded in 2006, but its roots in hospice reach back to 1979. Today, the company operates more than 165 hospice, palliative and home health programs in 30 states across the U.S. Our mission is to honor life and offer hope to individuals facing serious or terminal illness.

Central to any public policy changes related to the advanced or serious illness population are eligibility criteria to identify this population and quality metrics to improve care coordination, including improved transition to hospice. We appreciate the approach and emphasis in the *PACSSI* model.

We encourage the PTAC to accelerate consideration and approval of the AAHPM Physician-Focused Payment Model to address the urgent needs of the advanced or serious illness population.

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Brentwood, TN 37027
615-377-7022
compassus.com

Please contact Craig Jeffries, SVP Public Policy (828 772 2843 Craig.Jeffries@Compassus.com) if we can provide other support or answer any questions.

Sincerely,

James A. Deal
Chief Executive Officer

FOUR·SEASONS
Compassion for Life

August 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Physician-Focused Payment Model Technical Advisory Committee:

This letter is to express Four Seasons Compassion for Life's support of the American Academy of Hospice and Palliative Medicine's (AAHPM) Patient and Caregiver Support for Serious Illness (PACSSI) payment model. Four Seasons, incorporated in 1979, is a non-profit organization that provides hospice and palliative care services in eleven predominately rural counties in Western North Carolina. Four Seasons received the Circle of Life Award in 2009 for quality and innovation in the delivery of palliative care, and is led by a team of recognized industry leaders. The CEO, Chris Comeaux, was the 2005 recipient of the Peter Keese Leadership award; Dr. John Morris, the Palliative Care Medical Director, won the 2011 Carolina Center for Hospice and End of Life Care Sharon O. Dixon Award; and Dr. Janet Bull, the CMO, received the 2012 Hastings Center Cuniff-Dixon Physician Award to Honor Excellence in End of Life Care, was one of the 30 Visionaries recognized in the field, and is currently the president of AAHPM.

In response to the need for better care for the seriously ill population in its community, Four Seasons started its palliative care program in 2003. Despite financial losses, Four Seasons expanded and improved its palliative care program by scaling to rural parts of Western North Carolina, where access to both palliative and hospice care was limited. A significant challenge faced in the seriously ill population is that many patients tend to enter hospice late in the course of their illness. The AAHPM's PACSSI model encourages the appropriate use of hospice care with a focus to increase patients' hospice care to greater than 7 days. In addition, financial resources under PACSSI can be tailored to best meet the specific needs of each patient we serve. As an example, in rural areas, the use of telehealth has proved successful as a way to deliver more efficient care to our palliative care patients.

In 2014, Four Seasons was a recipient of a Center for Medicare & Medicaid Innovation (CMMI) Award focused on expanding community-based palliative care, improving patient outcomes, improving patient/family satisfaction, reducing healthcare costs, and defining a new payment methodology. The CMMI project has expanded to include four collaborating organizations and patients are served across the continuum of care settings that include home, clinic, hospital, nursing home, and assisted living facilities. To date over 5,000 patients have been enrolled in the project. Four Seasons data on quality and cost has been used to help inform AAHPM's PACSSI payment model.

Palliative care has been shown to improve patient outcomes while reducing overall Medicare expenditures. However, the current fee-for-service reimbursement reality of Medicare is inadequate to support community-based palliative care. AAHPM's PACSSI payment model will close key reimbursement gaps to help Medicare beneficiaries with serious illness receive high-quality palliative care. In addition, the structure of the PACSSI model will allow participation by various sizes and types of palliative care teams and serve Medicare beneficiaries in many different markets and geographies, allowing for the sustainability of palliative care in communities like ours. The incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. Four Seasons would look forward to participating in PACSSI should it be recommended for testing and implemented by CMS.

Sincerely,

DocuSigned by:
Chris Comeaux
64A4238431D6420...

Chris Comeaux
CEO/President – Four Seasons

HealthCare
Chaplaincy
Network™

August 8, 2017

Physician-Focused Payment Model
Technical Advisory Committee
c/o U.S. DHHS Assistant Secretary for
Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Sir/Madam,

It is with great pleasure and enthusiasm that HealthCare Chaplaincy Network submits this letter of support for the AAHPM's *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model. We have been honored to be included as a stakeholder in its development and excited about the possibilities for improved care offered by the final proposal.

Many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system. It is now well documented that the spiritual and emotional dimensions of care, while shown repeatedly to make major contributions to positive health outcomes and cost savings, are particularly neglected in the current payment model. Clearly a major cause of this neglect is the lack of inclusion of reimbursement for spiritual and emotional care in most current models. Current payment models also do not adequately reimburse community-based, interdisciplinary palliative care services that generally include care for the emotional and spiritual domains. Numerous studies have shown community based palliative care improves quality of life and controls costs.

The PACSSI payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time. The proposal attends to all the dimensions of care including the spiritual and the social. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients, such as nurses, case managers, social work, spiritual care professionals, and telehealth.

The PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than 7 days.

The flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to largest number of patients and caregivers possible. Within this model, HCCN looks forward to continuing to develop innovative models for integrating effective and efficient spiritual care.

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure.

The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. We appreciate the option for smaller or less risk-ready practices to participate and grow in Track 1, where PACSSI payments are adjusted based on quality and spending measures. We also believe that Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality.

HCCN looks forward to supporting the PACSSI model and continuing to help develop innovative models for delivering the spiritual care component of that model, should it be recommended for testing by PTAC and implemented by CMS.

We support this proposal without reservation and encourage the PTAC to recommend it for testing.

Sincerely,

Rev. Eric J. Hall
President and Chief Executive Officer

HCCI
HOME CENTERED CARE
INSTITUTE

1900 East Golf Road, Suite 480
Schaumburg, IL 60173
P 630.283.9200 F 630.283.9201
HCCInstitute.org

August 4, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy,

The purpose of this letter is to support AAHPM's Proposed APM for Palliative Care. The Home Centered Care Institute is a non-profit dedicated to increasing the workforce needed to advance the important work of home-base primary and palliative care. This has been shown to improve quality of care of mainly homebound patients and their caregivers while dramatically reducing costs by enabling patients to age and die in place and avoid hospitals and nursing homes.

I have personally done over 32,000 house calls. Most of my work involves palliative care and end-of-life care. Twenty-five percent of our complex, mostly elderly patients die annually. In 2015 of 230 deaths, 80% died at home and 76% were on hospice; 66.4% were on hospice >14 days which has been shown to provide better quality end-of-life care at reduced costs.

Many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. Numerous studies have shown community-based palliative care improves quality of life and control costs. AAHPM's *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients, such as nurses, case managers, and telehealth. The PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than seven days. The flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to largest number of patients and caregivers possible.

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure. The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. We appreciate the option for smaller or less risk-ready practices to participate and grow in Track 1, where PACSSI payments are adjusted based on quality and spending measures. We also believe that Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality. Our organization would look forward to encouraging our members to participate.

We encourage you to support this important APM.

Sincerely,

T Cornwell MD

Thomas Cornwell, MD
CEO

HPNA
Hospice & Palliative Nurses Association
Advancing Expert Care in Serious Illness

August 8, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Committee Members,

The Hospice and Palliative Nurses Association (HPNA) is the national nursing organization that supports the specialty of palliative nursing, which includes hospice and palliative nurses. Our vision is to transform the care and culture of serious illness.

HPNA has a very collaborative relationship with the American Academy of Hospice and Palliative Medicine (AAHPM) and we work closely on initiatives to help enhance the patient care provided by our members. We are both committed to enhancing the care delivery system to increase access to quality palliative and end of life care for individuals with a serious illness and their families.

HPNA endorses the Patient and Caregiver Support for Serious Illness (PACSSI) proposed by AAHPM. The proposed model will allow flexibility in providing the services that best meet the needs of individuals and their families. The payment model provides the potential to close key reimbursement gaps that will allow Medicare beneficiaries with a serious illness receive the right care, in the right place, at the right time.

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure.

We support this initiative and believe it will enhance the care and services provided to individuals and their families and will enhance our ability to implement enhanced quality measurements.

Sincerely,

Donna Morgan — Sally Welsh

Donna Morgan, RN, BSN, CHPN, CHPCA
President, Hospice and Palliative Nurses Association

Sally Welsh, MSN, RN, NEA-BC
Chief Executive Officer

Hospice of Michigan

August 9, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Committee members:

On behalf of Hospice of Michigan and Arbor Hospice, an independent not-for-profit hospice provider headquartered in Ann Arbor, I am pleased to add endorsement to the AAHPM proposed alternative payment model under consideration by your committee. We historically join with our partners at the University of Michigan in promoting research and testing of care models to improve the quality and availability of palliative and end-of-life care in Michigan communities.

We know that many patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse community-based, interdisciplinary palliative care services. Numerous studies have shown community based palliative care improves quality of life and control costs. Changes to payment incentives are critical to changing professional and public attitudes about the approach to life-limiting illness.

AAHPM's *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time.

By using the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients, such as nurses, case managers, and telehealth.

The PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than 7 days. Improved quality of life and diminished use of futile care are likely results.

The structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to largest number of patients and caregivers possible

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure.

The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. We appreciate the option for smaller or less risk-ready practices to participate and grow in Track 1, where PACSSI payments are adjusted based on quality and spending measures. We also believe that Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality.

Hospice of Michigan and Arbor Hospice would look forward to an application to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Michael Paletta MD FAAHPM
Vice President, Medical Affairs
Chief Medical Officer
Hospice of Michigan and Arbor Hospice
2366 Oak Valley Dr. Ann Arbor, MI 48103
313.578.5031
mpaletta@hom.org

Kindred
Healthcare

August 11, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Delivered Electronically

Ref: *Patient and Caregiver Support for Serious Illness (PACSSI)*, a proposed Alternative Payment Model submitted by the American Academy of Hospice & Palliative Medicine (AAHPM)

To whom it may concern:

This letter is respectfully submitted on behalf of Kindred at Home, a division of Kindred Healthcare, which is the nation's leading provider of post-acute care services. Kindred Healthcare provides care and services to more than one million patients each year in their own homes and in nearly 2,540 post-acute care locations throughout 45 states. We are focused on delivering post-acute care throughout the full continuum of care. Kindred's continuum includes 81 long-term acute care hospitals, 19 freestanding inpatient rehabilitation hospitals, 102 hospital-based acute rehabilitation units, 386 home health locations, 177 hospice locations, 61 community care locations, and a variety of palliative care services provided across these settings.

Kindred is pleased to offer this letter of support for AAHPM's *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model proposal. We understand that the current fee-based reimbursement system for patients with serious illness does not adequately cover community-based palliative care services. *PACSSI*, as an alternative payment model, would help improve access for Medicare beneficiaries in receiving interdisciplinary palliative care. The addition of nursing, social work, and spiritual care to such interdisciplinary palliative care has been to be more effective in terms of overall cost, patient and caregiver satisfaction, and outcomes that meet the patient's goals of care. *PACSSI*, through better access to palliative care, will also improve timely referral to hospice services for those patients nearing the end of life.

We look forward to working with AAHPM and DHHS to advance high-quality palliative care services for those in need.

Sincerely,

Ronald J Crossno, MD HMDC FAAHPM
Chief Medical Officer, Kindred at Home

Rothman, MD.

Marc Rothman, MD, CMD
Chief Medical Officer, Kindred Healthcare

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Denise Schrader, RN MSN NEA-BC
Chairman of the Board

Val J. Halamandaris, JD
President

August 9, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Health Policy
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: AAHPM-Proposed APM for Palliative Care – Patient and Caregiver Support for Serious Illness (PACSSI)

Members of the Committee:

The National Association for Home Care & Hospice (NAHC) is the largest national organization representing home health, hospice, and home care providers; home caregiving staff; and patients and their families. As part of our mission, we advocate for policy changes designed to improve the quality, coordination, and continuity of care for individuals with serious and advanced illness. In this capacity, we are writing to lend our enthusiastic support to the Patient and Caregiver Support for Serious Illness (PACSSI) proposal, an alternative payment model proposal submitted for your consideration by the American Academy of Hospice and Palliative Medicine (AAHPM).

In enacting the Medicare Hospice Benefit 35 years ago, the U.S. Congress not only addressed a serious deficit in care coverage by creating a comprehensive benefit offering palliative, medical, and bereavement services to individuals nearing the end of live and their loved ones, but also started the decided shift in focus of health care payments toward the concept of prospectively-set rates and away from cost-based reimbursement. This shift led the way to a complete overhaul of the way our health care system pays for services. Perspectives on payment policy continue to evolve, as evidenced by the growth in value-based purchasing programs and experimentation with different models of care, such as those under consideration by this Advisory Committee.

While great advances have been made in the way that we deliver and finance health care in the United States, there remains a serious gap for individuals with advanced illness who are not yet determined to be in the final six months of life. The current structure of fee-for-service Medicare offers these individuals very limited access to the coordinated, interdisciplinary services that have been proven to reduce acute care exacerbations and other burdensome care transitions, and also help control costs. To address this need, many providers offer palliative care services in one form or another under currently-covered services (home health, hospital, physician services). While these efforts offer some relief to those patients fortunate enough to have access to them, they are subject to the strictures of existing eligibility criteria and allow for only limited testing of their effectiveness in addressing patient and caregiver needs and improving the overall health care delivery system.

It is our firm belief that implementation of the PACSSI proposal and close analysis of its impact on the care needs of individuals with advanced illness are essential to improving our health care system's responsiveness to the needs of individuals with advanced illness and addressing one of the most pressing health care challenges facing our nation at this time. For these reasons, we lend our support to the PACSSI proposal put forth by the AAHPM, and we urge the Advisory Committee to approve it as a Physician-Focused Payment Model.

We appreciate your consideration of this strong endorsement, and ask that you contact us if we can be of assistance in any way.

Sincerely,

Theresa M. Forster
Vice President for Hospice Policy & Programs

PAHPM
PHYSICIAN ASSISTANTS IN HOSPICE AND PALLIATIVE MEDICINE

August 14, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Re: Patient and Caregiver Support for Serious Illness (PACSSI)

On behalf of the Physician Assistants in Hospice and Palliative Medicine (PAHPM), we write to offer our support for *Patient and Caregiver Support for Serious Illness (PACSSI),* an alternative payment model proposal developed by the American Academy of Hospice and Palliative Medicine (AAHPM).

PAHPM is a non-profit specialty organization affiliated with the American Academy of Physician Assistants that represents physician assistants specializing in hospice and palliative medicine who practice in clinical, research, and education settings. Each day, our members see the value of palliative care in reducing pain and suffering and improving quality of life for patients with serious and life-threatening conditions, as well as their families and caregivers. These observations are borne out in numerous studies that demonstrate palliative care's positive impact on quality and cost of care, as well as caregiver burden.

The PACSSI proposal will go a long way toward expanding Medicare beneficiaries' access to vital community-based interdisciplinary palliative care services which are not well supported under reimbursement mechanisms. Under the PACSSI model, these reimbursement gaps will be addressed and palliative care teams of various sizes and types will be able to utilize those resources most appropriate to provide patients with serious and advanced illness the care they need when and where they will most benefit. We further appreciate that the model encourages the appropriate referral to hospice care.

PAHPM looks forward to encouraging our members to participate in PACSSI, should it be recommended for testing by PTAC and implemented by the Centers for Medicare and Medicaid Services. In the meantime, we would be pleased to answer any questions the Committee may have.

Sincerely,

Richard D. Lamkin

Richard D. Lamkin, MPH, PA-C
President
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Dana Lustbader, M.D.
Chief of Palliative Care

August 11, 2017,

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W. Washington, D.C. 20201

Physician-Focused Payment Model Technical Advisory Committee:

This letter serves to wholeheartedly express ProHEALTH Care's support of the American Academy of Hospice and Palliative Medicine's (AAHPM) Patient and Caregiver Support for Serious Illness (PACSSI) payment model. ProHEALTH Care is a large multispecialty physician group comprised of 800 physicians and other staff who serve over 1.5 million patients in the New York City metropolitan area. ProHEALTH participates in eight shared savings programs including the Medicare Shared Savings Program (MSSP) ACO and has been a top performer in terms of quality and savings achieved.

In an effort to better meet the needs of people with serious illness or multiple chronic conditions, ProHEALTH developed a home palliative care program comprised of specially trained physicians, nurses and social workers. ProHEALTH provides home palliative care throughout New York City and Long Island. The program serves a wide demographic, in particular Queens which is known for the 143 different languages that are spoken there. A palliative care clinic also provides ongoing pain and symptom management to patients receiving chemotherapy for cancer. The team provides 24/7 coverage and also utilizes telemedicine for video calls to support patients and their family caregivers who are often feeling burdened or overwhelmed.

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Chief of Palliative Care

ProHEALTH is a recipient of the NCQA grant to develop quality metrics for palliative care delivered in the community including at home, SNF or clinic. Through this grant, ProHEALTH will establish a patient and family advisory board to ensure the development of palliative care services matches actual patient and family needs across the diverse patient population of New York.

The AAHPM's PACSSI model encourages care that best meets the needs of seriously ill patients. As an example, the provision of 24/7 access to team members who can answer questions for patients rather than reflexively directing patients to the ER where they will likely spend the night or be admitted to the hospital, often unnecessarily.

People with serious illness who receive palliative care live longer and have a better quality of life. Our group demonstrated in the MSSP ACO population, patients served by home palliative care had a 34% reduction in hospital admissions, improved quality of life and cost $12K less when compared to usual care (Lustbader et al. J Palliat Med 2017).

The challenge for physician groups like ProHEALTH is that fee-for service rewards more care, not better care. The PACSSI model proposed by AAHPM supports high level palliative care which improves quality of life for seriously ill people and their family caregivers.

Sincerely,

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SWHPN
Social Work Hospice &
Palliative Care Network
swhpn.org

August 12, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Committee Members,

On behalf of the Social Work Hospice and Palliative Care Network (SWHPN), we are pleased to support *Patient and Caregiver Support for Serious Illness (PACSSI)*, the American Academy of Hospice and Palliative Medicine's (AAHPM) proposed APM for palliative care.

SWHPN is the primary professional association of social workers in hospice and palliative care. We advocate the inclusion and payment for psychosocial services as a critical component of hospice and palliative care services, and their provision by qualified social workers on the professional team. We endorse AAHPM's integration of psychosocial care provided by qualified social workers, and a funding mechanism to support its inclusion. Our organization would look forward to encouraging our members to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Please let us know if we can provide additional information.

Sincerely,

Grace Christ

Grace Christ, PhD
Chair

Gary L. Stein

Gary L. Stein, JD, MSW
Vice Chair