AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

March 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
PTAC@hhs.gov

Letter of Intent – American Academy of Hospice and Palliative Medicine:
PAYMENT REFORMS TO IMPROVE CARE FOR PATIENTS WITH SERIOUS ILLNESS

Dear Committee Members,

On behalf of the American Academy of Hospice and Palliative Medicine (AAHPM), I would like to express intent to submit a Physician-Focused Payment Model for PTAC review on or before September 15, 2017.

Payment Model Overview: 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 healthcare system. Numerous research studies and pilot projects demonstrate that high-quality, interdisciplinary palliative care services can provide significant benefits for patients, caregivers and payers, including: reducing pain and suffering related to serious illness; reducing burdens on caregivers that can worsen health and decrease employment and productivity; reducing avoidable emergency department, hospital, and intensive care unit stays; increasing days at home for patients with serious illness, thus reducing expensive post-acute care such as skilled nursing facility stays; and reducing overall healthcare costs while improving patient and caregiver quality of life.

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. Fee-for service payments are available only to physicians and billing practitioners and are insufficient to support the other essential aspects of palliative care, including nursing, psychosocial and spiritual care services. Payment for these interdisciplinary services is available to Medicare beneficiaries through the hospice benefit; however, hospice care is only available to patients with a life expectancy of six months or less who also must give up most disease-focused treatments. 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.

Data show that up to 5 percent (2.75M) of Medicare beneficiaries could benefit from palliative care services each year. These services would improve quality of care and quality of life for patients suffering with many different types of serious illness – such as cancer, COPD, heart failure, and dementia – who currently receive healthcare services in a wide range of settings, including small independent practices, larger physician groups, hospitals, post-acute care facilities, and integrated health systems. AAHPM proposes two new payment models to enable patients with serious illness to receive palliative care in all of these settings.

Palliative Care Support to a Medical Home (PCS) payments are designed to allow palliative care teams to provide support to medical home or accountable care organizations in addressing unmet needs of patients with serious illness who are assigned or attributed to those accountable providers. Two types of PCS services would be supported: *PCS Assessment and Planning Services* (PCS-AP), which are one-time payments to provide

comprehensive assessment and care planning services; and *PCS Monthly Support Services* (PCS-MS), which are monthly payments to allow for co-management of patients with ongoing needs. Both PCS-AP and PCS-MS payments would be tiered based on patient complexity, functional status and intensity of interdisciplinary services required. PCS services would be subject to quality measurement, but PCS payments would not qualify as an Alternative Payment Model (APM) under MACRA because they do not require palliative care teams alone to assume "more than nominal" financial risk. Rather, they are designed to assist other quality- and cost-accountable providers in the care of their patients with serious illness.

Patient and Caregiver Support for Serious Illness (PACSSI) payments would qualify as a MACRA APM and are designed to allow palliative care teams themselves to become accountable for the care they provide to patients with serious illness and their caregivers. Monthly PACSSI payments would support interdisciplinary palliative care teams and would likewise be tiered based on patient complexity, functional status and intensity of interdisciplinary services required. In addition, payments would be adjusted up or down based upon performance on both quality and cost measures related to the services delivered. There would also be an option for palliative care teams to receive ***PACCSI Bundled Payments***, which would require greater accountability for service delivery and total cost of care.

Goals of the Models: Once implemented, these models will achieve the following goals: 1) enable accountable entities (like qualified medical homes) to access palliative care assessment, planning and/or support services for their patients; 2) enable palliative care teams themselves to take accountability as qualified APM providers for patients who are still receiving treatment but need the kind of care coordination and services that a palliative care team can offer; and 3) provide flexible payment structures to adequately support the interdisciplinary palliative care services needed by patients and their caregivers at all stages of serious illness and care needs.

Expected Participants: 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.

Implementation Strategy: 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 APM Task Force worked to craft the models we propose, including gathering member and stakeholder input. Our Task Force represents the abovementioned diversity of palliative care teams serving Medicare beneficiaries in many communities across the country. These providers and others are interested in implementing the PCS and/or PACSSI models if they are made available.

Timeline: Several pilot sites would be ready to implement PCS and PACSSI payment models as early as 2018.

AAHPM APM Task Force: **Phil Rodgers, MD,** *Chair* (University of Michigan Health System, Ann Arbor, MI); **Janet Bull, MD** (Four Seasons Compassion for Life, Flat Rock, NC); **Todd Coté, MD** (Bluegrass Care Navigators, Lexington, KY)**; Kyle Edmonds, MD** (UC San Diego Health, San Diego, CA); **Arif Kamal, MD** (Duke University, Durham, NC); **Dana Lustbader, MD** (ProHEALTH Care, New York, NY); **James Mittelberger, MD** (Optum Center for Palliative and Supportive Care, Minneapolis, MN); **Joe Rotella, MD** (American Academy of Hospice and Palliative Medicine, Louisville, KY); **Christian Sinclair, MD** (The University of Kansas Health System, Kansas City, KS); **Bruce Smith, MD** (Regence BlueShield, Seattle, WA); **Donald Taylor, Jr, Ph.D** (Sanford School of Public Policy, Duke University, Durham, NC); **Joan Teno, MD** (University of Washington, Seattle, WA); **Ruth Thomson, DO** (Ohio's Hospice, Dayton, OH); **Rodney Tucker, MD** (The University of Alabama at Birmingham, Birmingham, AL); **Martha Twaddle, MD** (Aspire Health, Chicago, IL); and **Gregg VandeKieft, MD** (Providence St. Joseph Health, Olympia, WA).

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Thank you for your consideration,

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President, American Academy of Hospice and Palliative Medicine