



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Submitted via email to PTAC@HHS.gov

October 30, 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, SW
Washington, DC 20201

RE: Advanced Care Model Service Delivery and Advanced Alternative Payment Model

Dear Members of the Committee:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Coalition to Transform Advanced Care's proposal for an Advanced Care Model Service Delivery and Advanced Alternative Payment Model.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

This letter includes ASHA's comments related to the following areas:

- Health Care Provider's Perspective
- Payment Methodology; and
- Health Information Technology

Health Care Provider's Perspective

The purpose of the Advanced Care Model (ACM) and Advanced Alternative Payment Model (AAPM) is to address the gap in care for individuals with advanced illness in their last year of life through a palliative-focused episode of care in transition between the hospital and hospice. The ACM delivery structure includes 24/7 access to palliative care providers, registered nurses, and other health care providers. The ACM AAPM incentivizes clinicians to provide more home-based care to manage their sickest and most vulnerable patients. The expected benefits of the ACM AAPM for Medicare beneficiaries include improvements in:

- engaging the patient and their family;
- shared decision making between patients, caregivers, families, and physicians;
- coordinating care aligned with patient preferences;
- managing symptoms;
- preventing avoidable and unwanted hospitalizations or low-value treatment; and
- avoiding unwanted, futile end of life care.

ASHA appreciates the proposal's inclusion of a broad range of providers who have the competence and experience to be successful in the ACM AAPM. The ACM AAPM would be useful for diagnoses that include functional problems addressed by speech-language pathologists (SLPs).

Speech-language pathology services may be medically necessary for patients who experience a stroke, brain tumor, heart disease, or neurodegenerative diseases (e.g., Parkinson's disease). Although the SLP's role is short-term, it could make a significant difference in the patient's function and outcomes related to swallowing, communication, and cognition. Beyond making suggestions for diet modification, SLPs work with patients to develop safer swallowing strategies, and work with caregivers on feeding strategies to facilitate maximum oral intake. To assist the patient with communicating, SLPs may offer an augmentative and alternative communication (AAC) system or strategy. AAC is used to help patients communicate about their pain, medical needs, and preferences. For functional cognitive impairments, SLPs use visual or written cues as memory strategies to orient the patient and increase their involvement in their care. All of the above service can mitigate the patient's anxiety, agitation, or the need for additional resources.

For these reasons, ASHA requests that the Coalition to Transform Advanced Care (CTAC) and Physician-Focused Payment Model Technical Advisory Committee (PTAC) consider the integral role of speech-language pathology when reviewing this proposal. Speech-language pathology services directly impact each of the anticipated beneficiary improvements (i.e., patient and family engagement, symptom management). In addition, the ACM patient identification and eligibility criteria of functional decline and nutritional decline directly correlate to speech-language pathology services.

Payment Methodology

Individuals with advanced illness account for 25% of Medicare fee-for-service costs. This proposal is expected to reduce Medicare spending as a result of the improved care coordination and increased patient/caregiver engagement. CTAC proposes a \$400 per member per month (PMPM) payment for the ACM AAPM episode of care. This payment would convert the palliative care provider's fee schedule to a team-based, population health payment structure that rewards quality. Qualification as an AAPM also creates incentives for non-palliative care specialties to enhance care coordination.

While ASHA supports the goals of the ACM AAPM and agrees that better management and care coordination is needed, we find the proposed \$400 PMPM payment may be insufficient to incentivize widespread participation by palliative care providers. We request that CTAC and PTAC carefully review this proposal to ensure that the need to generate savings does not outweigh the need to ensure improved care and outcomes.

Health Information Technology

The proposal requires participating entities to utilize an electronic health record (EHR), which is consistent with AAPM requirements under the Quality Payment Program. However, CTAC is asking that the Centers for Medicare and Medicaid Services (CMS) consider the use of non-

certified EHR as a qualification for AAPM designation given that the ACM AAPM can be operated by provider entities other than physician practices. ASHA supports this request. The requirement for using certified electronic health record technology (CEHRT) to qualify as an AAPM should be eliminated because many non-physician clinicians, such as audiologists and SLPs, have been excluded from CMS initiatives to incentivize and expand the use of such technology.

Thank you for the opportunity to provide comments on the Coalition to Transform Advanced Care's proposal on the Advanced Care Model Service Delivery and Advanced Alternative Payment Model. If you or your staff have any questions, please contact Daneen G. Sekoni, MHS, ASHA's director of health reform analysis and advocacy, at dsekoni@asha.org.

Sincerely,

A handwritten signature in cursive script that reads "Gail J. Richard".

Gail J. Richard, PhD, CCC-SLP
2017 ASHA President

Via online submission to PTAC@hhs.gov

October 31, 2017

Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary of Planning and Evaluation, room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

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

Dear Committee Members:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and addressing the functional effects of illness, injury, and disability. Occupational therapy practitioners help to improve Medicare beneficiaries' quality of life and participation in meaningful life occupations as beneficiaries near the end of life. Given that occupational therapy is a recognized component of the Medicare hospice benefit in federal regulations, the profession and practitioners can play a critical role in end of life curative and palliative care. We appreciate the opportunity to comment on the Advanced Care Model (ACM) Service Delivery Payment Model submitted by Coalition to Transform Advanced Care (C-TAC).

I. Addressing the eligibility criterion of "Functional Decline"

The Preliminary Review Team (PRT) report notes that according to the proposal "once a potential participant is identified, the ACM entity screens the participant to ensure that s/he meets the eligibility criteria." As a threshold requirement, AOTA believes that occupational therapy practitioners must be included as recognized members in the ACM care team in order to thoroughly and accurately address the eligibility criterion of "Functional Decline."¹

Occupational therapy practitioners strive to help hospice patients, their family members, and their caregivers adjust to the patients' changing functional abilities and find ways to deal with the illness progression or dying process in a respectful and productive manner. AOTA's 2016 Statement, *Role of Occupational Therapy in End-of-Life Care* (AOTA Statement) elaborates on the occupational therapist role in treating individuals with life-threatening and life-limiting illness who often have difficulty participating in daily occupations because of decline in their

¹ ACM Proposal, p. 3, Table 1: "Description of ACM Criteria" describes "Functional Decline" as [n]ew, irreversible dependence in at least one ADL in the last 3 months.

motor, sensory, emotional, cognitive, or communication skills. By virtue of their holistic clinical training, occupational therapy practitioners are well-suited and an appropriate professional to be involved in the assessment or whether a patient falls into the Functional Decline criterion to participate in the ACM. The occupational therapy practitioner's ability to recognize functional deficits that interfere with performing ADL's is precisely what the ACM is trying to accomplish with this screening tool, and therefore it would be logical that their skill set be included in this manner.

II. Recognized certification in palliative care requirement

AOTA finds that recognized certification in palliative care is not necessary so long as the appropriate professionals are included in the ACM care team. As it is stated in the proposal, ACM care teams at a minimum would consist of a provider with palliative or hospice expertise, a registered nurse and licensed social worker. AOTA encourages C-TAC to see the value in including practitioners who are currently recognized to provide Medicare hospice care under current regulations as well as sub-regulatory guidance. As recognized practitioners for the purposes of Medicare reimbursement in both federal regulations² as well as within the CMS Medicare Benefit Policy Manual³, occupational therapists contribute their distinct services in the hospice setting with regard to physical, cognitive, and psychosocial function. Further emphasis of how all of these components extending to function are assessed is found in the *Occupational Therapy Practice Framework: Domain and Process*⁴ (the Framework) which states that every occupational therapy evaluation includes performing an occupational profile of the patient as the first step in the evaluation process and from there the practitioner can proceed to more effectively value and respect client input, while leading them to better and more informed interventions. The occupational profile assesses functional status across several domains, including physical, cognitive and psychosocial function, all critical to a patient's quality of life when dealing with a chronic, progressive disease.

Occupational therapy practitioners' primary focus is on patient-centered care in all interactions with patients, and hospice care is a perfect example of the guiding principles of the Framework at work. "Occupation takes on special significance at the end of life, because the client has a dual focus on living and dying."⁵ In hospice, occupational therapy practitioners help ensure that patients are able to do what is meaningful to them and their families in their final days in a way that maximizes function, manages pain and promote comfort. While a nurse may suggest that the patient lie on their side, an occupational therapy practitioner would quickly recognize that the patient could get relief by using a specific type of cushion to provide pressure relief and still allow the patient to sit in a chair for activities and visitors. Occupational therapy practitioners can also teach patients and their caregivers how to match activities and efforts to reduce situations

² See 42 C.F.R. § 418.202 (2015), wherein occupational therapy is included as a covered service for hospice patients.

³ Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9 § 40.1.8 (Physical Therapy, Occupational Therapy, and Speech-Language Pathology).

⁴ American Occupational Therapy Association, *Occupational Therapy Practice Framework: Domain and Process* (3rd edition) (2014).

⁵ The American Occupational Therapy Association. (2016). The role of occupational therapy in end-of-life care. *American Journal of Occupational Therapy*, 70 (Suppl. 2), 7012410075. <https://doi.org/10.5014/ajot.2016.706S17>

that can contribute to pain and discomfort. The practice of occupational therapy emphasizes the importance of establishing a therapeutic relationship with each patient and designing a treatment plan based on knowledge of the patient's environment, values, goals and desires.

While maintaining the importance of this relationship occupational therapy practitioners additionally recognize the independent nature of relationships at end of life and caregivers' potential need for support in their caring role.⁶ Rather than focusing exclusively on the needs and wishes of one person in a relationship or drawing a sharp distinction between caregivers and care recipients, occupational therapy practitioners extend services to these co-clients in their own right.⁷

Occupational therapy practitioners recognize the purpose of end-of-life occupations as twofold: (1) providing a means of self-expression and engagement while (2) serving as a vehicle by which the client finds peace with the dying process and prepares for death."⁸ Practitioners in this instance will not only consider illness in the form of physical pain or difficulties stemming from environmental and contextual factors but will also take into account personal factors that may be limiting a patient's abilities and satisfaction when performing desired occupations.⁹ Loss of physical abilities and occupational roles can result in social death and isolation before biological death (Kaye, 2006).¹⁰ Moreover, occupational therapy practitioners can equally play an important part in the bereavement process by way of assisting families in deciphering opportunities where occupations may be used in the psychological process of letting go of relationships.¹¹

III. Issue of Explicitly Using Utilization Measures

AOTA agrees with the PRT's concern with regard to the fact that the majority of quality measures in the ACM proposal are utilization measures as opposed to explicit measures of quality of care. AOTA recommends that the ACM move away from utilization measures as the majority of quality measures and develop and/or look to true "functional status quality measures" that are already developed for the occupational therapy profession, as well as for other therapy disciplines, to measures functional decline.

Improved quality of life is a primary outcome of all occupational therapy interventions. Occupational therapy practitioners believe that engaging in occupations underlies health and quality of life. At the end of life, when clients often face the loss of previously established occupational roles, occupations, and performance abilities, their need to identify and sustain meaningful engagement is heightened. AOTA strongly supports the important efforts to carefully collect and examine assessment and quality data with a focus on the patient issues that occupational therapy addresses in end of life care, notably functional decline in this instance.

⁶ *Supra* n.4 at 3

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 4

¹¹ *Id.*

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Thank you for the opportunity to comment on the ACM Service Delivery and Advanced Alternative Payment Model proposal for PTAC. AOTA looks forward to a continuing dialogue with CMS and external health care entities on APMs that are intended to more efficiently and more effectively improve quality and cost outcomes for advanced illness and end-of life care.

Sincerely,

A handwritten signature in black ink, appearing to read "Ashley Delosh". The signature is written in a cursive, flowing style.

Ashley Delosh, JD
Regulatory Analyst

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November 1, 2017

Physician-Focused Payment Model Technical Advisory Committee
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RE: Comments on Revisions to the Advanced Care Model (ACM)

Dear Committee Members,

Thank you for the opportunity to comment on the revised Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model. We have written to you previously regarding the ACM^{i,ii,iii} and want to reiterate our support for the revised ACM model while highlighting opportunities for improvement.

The Center to Advance Palliative Care (CAPC) remains committed to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, prognosis, or care setting. Palliative care is a relatively new (ABMS approved in 2007) team based specialty, training clinicians in the essential knowledge and skills necessary for quality of care and quality of life during serious illness. These skills include safe and effective pain and symptom management; expert communication about matching care plans to the priorities of the patient and the family; assuring continuity and coordination over time and across settings; and ongoing support for family caregivers and the social determinants of health.

CAPC has supported the development and expansion of thousands of palliative care programs across the country, and have worked with standards-setting bodies to ensure the high quality of palliative care delivery in all settings. As a result, we have a keen understanding of the needs of the seriously ill population and the capabilities of palliative care providers working across care settings. While the revised proposal does an admirable job of incorporating CAPC's and the PTAC's feedback, we ask you to consider two remaining areas of concern, noted below.

Downside Risk Requirements

We appreciate C-TAC's thoughtful revisions to its approach for downside risk, particularly by including a 40-60 percent shared loss rate based on quality performance and minimum quality standards, capping the loss to \$100 PMPM, and delaying the implementation of shared losses until year 3. While this does make the model more accessible to more providers, it will still require substantial reserves, along with a sizable scope to ensure a sufficient risk pool. We remain concerned that the extent of potential downside risk poses too high a barrier to entry, and will skew care delivery to for-profit, multi-state entities, while limiting its practicality for rural areas and small-scale programs.

To address this barrier, *we strongly recommend that the ACM include additional options with narrower risk corridors.* Large scale programs can participate as proposed, while smaller and rural programs could then participate with more limited risk. The proposal submitted by the American Academy of Hospice and Palliative Medicine (AAHPM) may offer some ideas for narrowing risk.

Beneficiary Eligibility Criteria

We appreciate C-TAC's acknowledgment that patients with greater than one-year prognosis may benefit from the ACM, and its proposed modification to allow the payment to extend beyond 12 months if needed (counting all PMPM payments when determining the total cost of care for payment adjustments). We also appreciate the change to an "opt-out" program, avoiding forcing beneficiaries' to acknowledge a short prognosis in order to be eligible for services (this requirement is one of the major barriers to timely access to hospice in the U.S.).

We recognize that targeting eligibility to a 12-month prognosis is consistent with the existing literature demonstrating reductions in unnecessary spending in this cohort. However, we remain concerned that far too many Medicare beneficiaries with serious illness, functional and cognitive decline, and overwhelmed family caregivers – as many as 13% of all Medicare beneficiaries (4.6 million people including nursing home residents) according to a recent research brief from the Long Term Quality Alliance^{iv} – are in need of palliative care but ineligible for the ACM. Absent an alternative payment model, access to high-quality palliative care remains a challenge for those with high symptom burden, functional and/or cognitive impairment, multi-morbidity, and multi-year survival. Therefore, *we urge the PTAC to continue exploring models of effective palliative care payment for the remaining seriously ill beneficiaries who are expected to live for several years with their conditions.* A second tier seems appropriate, and the proposal submitted by AAHPM may offer an opportunity to add a second tier for the remaining beneficiaries.

* * * * *

In closing, we continue to strongly support alternative payment models which enable comprehensive care of those with serious illness. Palliative care comprises the essential knowledge and skills required for serious illness care, and has been proven to improve quality-of-life and quality-of-care, and in so doing, avoid unnecessary spending. For these models to be successful in improving care quality and patient outcomes while reducing overall cost, they must be accessible to palliative care providers working in diverse markets and address the needs of all seriously ill beneficiaries regardless of prognosis.

We sincerely appreciate the PTAC's thoughtful work, and thank you again for the opportunity to submit these comments. Please do not hesitate to contact myself or Allison Silvers, Vice President of Payment and Policy at Allison.Silvers@mssm.edu if we can provide any further assistance.

Sincerely,



Diane E. Meier, MD
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Cc: Allison Silvers
Khue Nguyen, CTAC
Jackie Kosinski, AAHPM

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ⁱ CAPC. Letter of Support – Advanced Care Model. February 3, 2017.

ⁱⁱ AAHPM, CAPC. Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model. March 6, 2017.

ⁱⁱⁱ CAPC. Requested Modification to the Advanced Care Model (ACM): Two-Tier Pricing Model. April 19, 2017.

^{iv} Windh J, et al., “Medicare spending on older adults who need long-term services and supports, Long Term Care Quality Alliance Research Brief, published Oct 30, 2017



November 01, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Ave. SW, Washington, DC 2020

RE: Coalition to Transform Advanced Care (C-TAC) Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model

Dear Committee members:

The National Partnership for Women & Families appreciates the opportunity to comment on the Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model submitted by the Coalition to Transform Advanced Care (C-TAC). The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to health care services to be both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to promoting models of care delivery and payment that provide women and families access to comprehensive, high quality and well-coordinated patient- and family-centered care.

In general, we strongly support efforts to improve quality for individuals with advanced illness. In the current system, the management of advanced chronic illnesses too often falls into a critical gap. We applaud C-TAC for developing a thoughtful proposal to address this gap and provide care that is better aligned with patients' values, needs, preferences and goals. We support C-TAC's intention to develop a model that moves the focus of care for late-stage chronic illness out of the hospital and into the patient's home and community. We also appreciate the focus on multidisciplinary team-based care; social workers, spiritual care professionals and other community service providers have a significant effect on a patient's quality of life and are often critical to achieving the goals of an advanced care plan.

We appreciate the proposal's thoughtful consideration of how to accurately identify individuals with advanced illness. We want to help more people access coordinated care services, and believe the proposed combination of disease-centered tools with the "surprise question" is an innovative approach. We hope to see the "surprise question" eventually expanded to include the patient and/or caregiver response (*Would you be surprised if the patient died in the next 12 months?*).

Lastly, we strongly support prioritizing patient- and caregiver-centered experience and outcomes as the suggested pay-for-quality measures. Employing patient-reported outcome

(PRO) tools and collecting PRO data are of the highest value to consumers and patients, and are fundamental to patient-centered care, shared decision-making and care planning.

Recommendations & Feedback

Focus on Beneficiary Protection

We understand why this submission focuses on beneficiary protection. However, as consumer advocates, we believe that the real aim of innovative care models is to improve health outcomes and patient experience and would encourage CTAC to emphasize these elements.

ACM Enhanced Services

We applaud C-TAC for recognizing that comprehensive care management services must reflect engagement with the patient and her choices, preferences and values. We support the enhanced package of care delivery services the interdisciplinary team would be charged with providing, including person-centered care management, advance care planning, and 24/7 access to a clinician. However, we encourage C-TAC to provide more specificity regarding the activities that would qualify for this package. We offer ideas for consideration below.

Systematic Advanced Care Planning

While we appreciate the proposal's focus on engaging patients and caregivers to establish clear goals and preferences for treatment and interventions, we encourage C-TAC to involve patients and caregivers in translating goals into a coordinated advanced care plan. Creating such plans *with* patients and families (rather than for them) will result in plans that are more effective in achieving individual goals and slowing functional decline.

Shared Decision Making

We also agree that shared decision making is a crucial aspect of high-quality person-centered care. Meaningful shared decision-making facilitates bidirectional communication between providers and patients about the risks, benefits and alternatives of proposed treatment. It means the provider and patient/caregiver share in the process of deciding what is best for the patient based on her individual goals, preferences and values. We encourage C-TAC to specify further the kinds of shared decision making that would qualify for enhanced services. For example:

- Whether the patient/caregiver was informed about all the reasonable options, including doing nothing, and told what is known about the potential risks, benefits and alternatives to those options.
- Whether the patient/caregiver was meaningfully involved in the decision making process, which includes the opportunity to discuss the options, ask questions and express her or his preferences about which path to follow.
- Whether the patient/caregiver had enough support and advice to make a choice about a treatment recommendation/care plan.

Patient and Family Engagement

We agree that integrative models such as the ACM hold great potential to improve patient and family engagement, but underscore that such improvements are not an automatic byproduct of new payment and delivery approaches. Genuine patient and family

engagement goes beyond engaging patients at the clinical care level, such as the shared care planning and decision-making activities outlined in the proposal. Patients and families bring unique experiences, insights and perspectives to their own health care and to broader discussions of care process redesign and improvements at system levels. For example:

- **Care redesign/improvement.** For example, are beneficiaries/patients involved in analyzing feedback surveys and recommending solutions to improve patients' experience of care? Are consumers involved in quality improvement and patient safety work groups or task forces?
- **Governance.** For example, does the ACM have a Patient and Family Advisory Council (PFAC), and/or include a proportionate number (at least two) of beneficiary/family caregivers on key governance and decision-making bodies?
- **Community.** For example, does the provider leverage partnerships and relationships with community-based and consumer organizations to meet the goals of patients' advanced care plans?

The proposed ACM will be more likely to improve engagement if it views patients not only as “objects” of care, but also as partners in redesigning care and developing solutions to improve quality. We recommend that any approach to enhancing patient and family engagement begin with a self-assessment of current engagement practices in order to identify needs and gaps and inform improvement goals.

24/7 Access to a Clinician

We agree that ready access to care is a fundamental element of patient-centered care. We encourage C-TAC to consider how to provide 24/7 access in our increasingly digital health care environment, including availability by phone, email or video, in addition to in-person visits. Furthermore, beneficiary access to *information* – such as lab results, medication lists and progress notes – is critical. ACM clinicians should have processes in place for electronically communicating and sharing information with patients and their authorized caregivers. For example:

- Ensure that patients and authorized family caregivers have electronic access to the patient's electronic health record and are able to view, download and transmit the patient's health information.
- Enable two-way communication with patients outside of in-person encounters, for example through secure email messaging and/or patient portals.
- Offer patients and family caregivers the ability to contribute information (i.e., patient generated health data) to their medical record that is relevant to their care.

We know that giving consumers the tools to electronically access and manage their own health information is foundational to patient engagement and ensuring that patients receive high-quality care. A 2014 National Partnership survey clearly shows that patients' online access to health information has a positive impact on a wide range of activities that are essential to better care and improved health outcomes, including knowledge of health and ability to communicate with providers.¹

¹ National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>, pg. 29.

Role of Health Information Technology and Data Exchange

The kinds of enhanced services envisioned by this proposal are only possible if the participating team members are able to electronically communicate and share information. We encourage the CTAC to *require* data sharing between physicians and other clinicians within the ACM, and to encourage electronic communication with social workers and other community-based services. This stems from a fundamental belief that system transformation is only possible when built on a foundation of robust, person-centered health information technology.

Beneficiary Notification

We appreciate the thought provided to notifying individuals about ACM services. We encourage C-TAC to draw upon the following best practices for effectively communicating with older patients in its notifications to beneficiaries:

- **Notifications must be clear.** Notification letters to ACM participants should be clear and use language beneficiaries understand. Don't assume the average beneficiary knows jargon or is familiar with common health care acronyms. Clarity is particularly important when notifying patients and/or their families upon admission to the hospital, when a patient is often at their most vulnerable.
- **A notification letter must explain the beneficiary impact.** Individuals receiving notification letters about the ACM will want to know how this model will directly impact them. We recommend that the notification letter clearly explain:
 - Why the program matters for individuals, including how the ACM is intended to improve health care quality and coordination for patients;
 - That beneficiaries are not being enrolled in another coverage option without their permission;
 - What this program is not – i.e., that it is not Medicare Advantage or managed care. Even if physicians are in managed care, the notice should explain how the program is different from managed care; and
 - Whether there are any out-of-pocket costs associated with the program.
- **The look of the notification letter matters.** Just as important as what the letter says is how the information is presented. A notification letter should be brief (no more than one page front and back) and in language the average person can understand. Letters should also be culturally and linguistically appropriate. Use large type (no smaller than a 12 point font and preferably larger), double-spaced lines when possible, and plenty of white space.
- **Determine appropriate alternative notification procedures for patients entering the hospital unconscious or in a state where notification is not possible.** This may include notifying family members, or providing notification at a later stage of care – including with the transition of care information – when the patient has regained consciousness.
- **Assure beneficiaries that they will continue to receive the health care they want and need.** Individuals may be concerned that the ACM will prevent them from seeing their regular doctors. Clearly describe the protections that are in place,

and the monitoring systems that will identify and address issues or challenges as they arise.

- **Provide multiple avenues for beneficiaries to get questions answered.** Regardless of how well written the notification letter is, many beneficiaries will still have questions. Providing a toll-free phone number and a service representative to answer questions is important, but it will also be important to have a staff member on site at the hospital who is equipped to respond to patient questions. We also recommend posting clear information about the program and FAQs on a public-facing website, and making the link available on the notification.
- **Testing Notifications.** Testing a draft notification letter – the language as well as the format – is the best way to ensure the information meets the needs of your target audience.

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Thank you again for the opportunity to provide input on the proposed ACM. We appreciate and support C-TAC's efforts to develop a model that improves care for seriously ill patients and their caregivers. We look forward to working with the PTAC, providers, and patients and families across the nation to develop physician-focused payment models that deliver high-quality health care.

If you have any questions about our comments and recommendations, please contact Katie Martin, vice president for health policy and programs, at kmartin@nationalpartnership.org or (202) 986-2600.

Sincerely,



Debra L. Ness, President



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

November 1, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Ann Page, Designated Federal Official
Office of Health Policy, Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted electronically via PTAC@hhs.gov

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

Dear Committee Members:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to provide the Physician-Focused Payment Model Technical Advisory Committee (PTAC) with feedback on the revised “Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model” as submitted by the Coalition to Transform Advanced Care (C-TAC).

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our 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. C-TAC’s proposal focuses on the very patients and caregivers AAHPM’s members serve each day.

Our members care for our nation’s sickest and most vulnerable patients, from diagnosis of serious illness through end of life, and represent the diversity of palliative care teams serving Medicare beneficiaries across many communities. They experience first-hand how the current Medicare payment system raises significant barriers to better care for patients with serious illness, and thus share C-TAC’s desire to develop better models of payment to overcome these barriers. AAHPM therefore commends C-TAC for making key revisions to their initial proposal, including changes to the eligibility and quality components of the ACM model as well as eliminating the 12-month limitation on services to beneficiaries. We further appreciate C-TAC’s significant efforts to address the very difficult task of developing methodology for measuring spending for seriously ill beneficiaries and establishing risk-adjusted benchmarks for analysis. We are very familiar with how challenging these tasks are, but also how critical they are to successful APM implementation and evaluation.

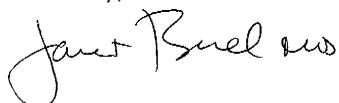
AAHPM does remain concerned that, even as revised, the ACM offers limited flexibility for practices at different levels of risk readiness or in different health care environments to engage in the model and therefore will exclude many seriously ill patients who could benefit from the valuable palliative care services and care coordination that it offers.

As noted in our comments on C-TAC's earlier PTAC submission, the ACM model provides significant opportunity for larger palliative care providers with the size, scope, experience and market position required to assume full risk for total cost of care. Participation in C-TAC's model requires that providers take downside risk, though, which is more than many providers can bear. Specifically, we believe the model would prohibit participation by many palliative care providers, particularly those in smaller practices, highly competitive markets, rural areas or underserved urban communities—and thus limit access to essential palliative care services for many seriously ill beneficiaries. Moreover, the ACM still concentrates on patients in the last 12 months of life (via the "surprise" question), which serves to further exclude the many seriously ill patients with significant unmet palliative care needs who are expected to live longer than a year.

Restricting in this way the patients and caregivers able to benefit from potentially valuable services under the ACM model will also limit the breadth of data and experience gained by participating palliative care providers. There is growing attention to value-based care delivery for seriously ill patients and caregivers by large health care providers, health plans (including MA plans) and policymakers. This attention is also highlighting remaining gaps in our understanding, including how to identify the right patients (eligibility), how to ensure they are receiving the right care (quality measurement), and how to ensure we are controlling costs (spending measurement and benchmarking). An alternative payment model demonstration focused on the seriously ill has the opportunity to generate invaluable data to narrow these gaps, but only if it allows participation by many types of palliative care providers, caring for patients throughout the course of serious illness, in communities of all types. We therefore urge the PTAC to help address the restrictions that remain in the C-TAC model so they will not serve to limit the knowledge we can gain—and ultimately use—to improve the care of seriously ill patients and their caregivers.

Thank you again for the opportunity to provide feedback on C-TAC's revised ACM model currently under review by the PTAC. As it aligns with AAHPM's core mission to expand access of patients and families to high-quality palliative care and advance the discipline of Hospice and Palliative Medicine, we are encouraged by the opportunities the model could provide for patients with serious and life-threatening conditions and the palliative care professionals who care for them, and our Academy leaders stand ready to collaborate with the Committee and C-TAC to address any issues discussed above. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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