

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

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In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) Proposal Review Process described in *Physician-Focused Payment Models: PTAC Proposal Submission Instructions* (available on the ASPE PTAC [website](#)), physician-focused payment models (PFPMs) that contain the information requested by PTAC's *Proposal Submission Instructions* will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on PTAC. This report is provided by the PRT to the full PTAC for the proposal identified below.

### A. Proposal Information

- 1. Proposal Name:** Patient and Caregiver Support for Serious Illness (PACSSI)
- 2. Submitting Organization or Individual:** American Academy of Hospice and Palliative Medicine (AAHPM)
- 3. Submitter's 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.”

## B. Summary of the PRT Review

| <b>Criteria Specified by the Secretary<br/>(at 42 CFR§414.1465)</b> | <b>PRT Conclusion</b>                               | <b>Unanimous or<br/>Majority<br/>Conclusion</b> |
|---|---|---|
| <b>1. Scope (High Priority)</b>                                     | Meets criterion and deserves priority consideration | Unanimous                                       |
| <b>2. Quality and Cost (High Priority)</b>                          | Does not meet criterion                             | Unanimous                                       |
| <b>3. Payment Methodology (High Priority)</b>                       | Does not meet                                       | Unanimous                                       |

|   | critterion      |           |
|---|-----------------|-----------|
| <b>4. Value over Volume</b>                 | Meets criterion | Unanimous |
| <b>5. Flexibility</b>                       | Meets criterion | Unanimous |
| <b>6. Ability to be Evaluated</b>           | Meets criterion | Unanimous |
| <b>7. Integration and Care Coordination</b> | Meets criterion | Unanimous |
| <b>8. Patient Choice</b>                    | Meets criterion | Unanimous |
| <b>9. Patient Safety</b>                    | Meets criterion | Unanimous |
| <b>10. Health Information Technology</b>    | Meets criterion | Majority  |

### C. PRT Process

The proposal, “*Patient and Caregiver Support for Serious Illness (PACSSI)*” (available on the ASPE PTAC [website](#)) was received by PTAC on August 16, 2017. The PRT conducted its work between October 2, 2017 and February 12, 2018. During this time, the PRT reviewed the proposal, the results of an environmental scan (described below) pertaining to the proposal, and all public comment letters received on the proposal. It also commissioned and reviewed analyses of Medicare data pertaining to beneficiaries with the targeted conditions and their utilization of hospital, emergency department, hospice, nursing facility and home health services. The PRT also consulted with a physician who is board-certified in hospice and palliative medicine to receive input on clinical issues in palliative care and received input from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) to better understand key aspects of (and potential effects of) the proposed model.

The PRT’s summary and evaluation of the proposal with respect to the Secretary’s criteria for physician-focused payment models (PFPMs) are below. The environmental scan, public comments, data analyses, and transcript of the PRT’s conversation with the palliative care physician are available on the ASPE PTAC [website](#).

#### 1. Proposal Summary:

The proposed payment model, *Patient and Caregiver Support for Serious Illness (PACSSI)*, is a five-year demonstration of payment for palliative care services to Medicare beneficiaries who have either serious, potentially life-limiting illnesses or multiple chronic conditions coupled with functional limitations. These beneficiaries are defined as those who meet diagnostic, functional status, and healthcare utilization criteria specified below, grouped into two “tiers” of individuals according to the complexity of their conditions:

### PACSSI Eligibility and Tiering Criteria

| Tier                              | Diagnosis of Serious Illness   | Functional Status  | Health Care Utilization  |
|-----------------------------------|--|--|--|
| Tier 1:<br>Moderate<br>Complexity | <p><b>EITHER:</b> One of the following diseases, disorders, or health conditions:</p> <ol style="list-style-type: none"> <li>1. Metastatic Cancer</li> <li>2. Pancreatic, Gastrointestinal, Lung, Brain, or Hematologic cancers</li> <li>3. Heart Failure with Class III or IV level function under the New York Heart Association Functional Classification</li> <li>4. Heart Failure with Left Ventricular Assist Device</li> <li>5. Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis)</li> <li>6. Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool or <math>\geq 2</math> Activities of Daily Living (ADL) limitations</li> <li>7. Progressive Neurologic Disorder (e.g. Cerebrovascular Accident, Parkinson's Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy)</li> <li>8. Hepatic Failure (Cirrhosis)</li> <li>9. End Stage (V) Renal Disease (excluding patients on dialysis)</li> <li>10. Protein-Calorie Malnutrition</li> <li>11. Cachexia</li> <li>12. Hip Fracture (with functional decline)</li> </ol> <p><b>OR:</b> Diagnosis of three or more chronic conditions defined in the Dartmouth Atlas:</p> <ol style="list-style-type: none"> <li>1. Malignant Cancer, Leukemia</li> <li>2. Chronic Pulmonary Disease</li> <li>3. Coronary Artery Disease</li> <li>4. Congestive Heart Failure</li> <li>5. Peripheral Vascular Disease</li> <li>6. Severe Chronic Liver Disease</li> <li>7. Diabetes with end organ damage</li> <li>8. Renal Failure</li> <li>9. Dementia</li> </ol> | <p><b>Criteria for Individuals with a Non-Cancer Diagnosis:</b></p> <p><b>EITHER:</b> <i>Palliative Performance Scale</i> (PPS) score of <math>\leq 60\%</math><br/> <b>Or:</b> <math>\geq 1</math> Activities of Daily Living (ADL) limitation<br/> <b>Or:</b> <math>\geq 1</math> Durable Medical Equipment (DME) order (oxygen, wheelchair, hospital bed)</p> <p><b>Criteria for Individuals with a Cancer Diagnosis:</b></p> <p><b>EITHER:</b> PPS of <math>\leq 70\%</math> or Eastern Cooperative Oncology Group (ECOG) scale of performance score <math>\geq 2</math><br/> <b>Or:</b> <math>\geq 1</math> ADL limitation<br/> <b>Or:</b> DME order (oxygen, wheelchair, hospital bed)</p> | <p><b>One significant health care utilization in the past 12 months, which may include:</b></p> <ul style="list-style-type: none"> <li>- Emergency Department (ED) visit</li> <li>- Observation stay</li> <li>- Inpatient hospitalization</li> </ul> <p><i>Note: This criterion may be waived under certain circumstances.</i></p> |
| Tier 2:<br>High<br>Complexity     | Same as Tier 1, excluding dementia as the primary illness  | <p><b>Criteria for Non-Cancer Diagnosis:</b><br/>PPS of <math>\leq 50\%</math> or <math>\geq 2</math> ADL limitations</p> <p><b>Criteria for Cancer Diagnosis:</b><br/>PPS of <math>\leq 60\%</math><br/> <b>OR:</b> ECOG <math>\geq 3</math><br/> <b>OR:</b> <math>\geq 2</math> ADL</p>  | <p>Inpatient hospitalization in past 12 months <b>AND</b> one of the following:</p> <ul style="list-style-type: none"> <li>- ED visit</li> <li>- Observation stay</li> <li>- Second hospitalization</li> </ul>   |

|  |  |             |  |
|--|--|-------------|--|
|  |  | limitations | <i>Note: This criterion may be waived under certain circumstances.</i> |
|--|--|-------------|--|

Palliative care services covered by the proposed payment methodology include:

- Comprehensive interdisciplinary assessment of the patient and his or her palliative care needs, including physical, psychological, social, spiritual, cultural, care at the end of life, and ethical and legal aspects of care;
- A health care history, physical exam and medical decision-making;
- Care management services including: developing a coordinated care plan with input from all of the patient’s physicians and providers and that is consistent with the patient’s care goals, 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 and to update the care plan as conditions warrant;
- Patient and caregiver education 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;
- Symptom assessment and prescribing of medications as needed;
- Psychosocial and spiritual care;
- Arranging for services from other providers in order to implement the care plan, including DME as well as physical, occupational, or speech therapy and home health services;
- Referrals to other programs that may provide support, such as Meals-on- Wheels, adult day care, Medicaid, transportation, and prescription assistance programs;
- Providing 24/7 response to patient and caregiver requests for advice and assistance in managing issues associated with patients’ health conditions and functional limitations; and
- Visiting the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns.

These services would be delivered by Palliative Care Teams (PCTs) consisting of varying types of providers. The proposal states that, “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.” In response to a question from the PRT, the submitter clarified that, “A physician must be part of the team, along with a nurse, a social worker, and a spiritual care provider. . . At a minimum, one of the core interdisciplinary team members must have certification in palliative care to support specialty level practice.”

PCTs would serve as the Alternative Payment Model (APM) entities and receive the Medicare payment for the palliative care services. 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.

Payment would be made in one of two ways or “tracks”:

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

Under both tracks, based on the patient’s eligibility and categorization into one of the two eligibility tiers described above, PCTs would receive monthly PACSSI care management payments 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.
- Base payment amounts would be adjusted upward or downward based on the existing Geographic Practice Cost Indices used to adjust the Work Relative Value Units component of the current Medicare Physician Fee Schedule (PFS).
- Payments for facility-based patients would be reduced by 20 percent to reflect lower costs of providing palliative care in a facility due to the existence of supportive care services otherwise provided by facilities.
- Base payment amounts would be increased annually based on the annual increase in the PFS conversion factor.

The monthly PACSSI payments would replace payment for Evaluation and Management (E/M) services to the PCT. However, 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 other Medicare-covered services they provide to the patient, except that such non-PACSSI providers could not bill for Chronic Care Management or Complex Chronic Care Management codes.

The two different payment tracks would differ with respect to how PCTs are held accountable for spending (total cost of care for enrolled patients) and quality. Under Track 1, PCTs would be subject to positive and negative payment incentives of up to 4 % of total PACSSI care management fees received for the year. Based on final performance determinations for quality and spending in a given year, Track 1 PCTs would either receive a lump sum payment amount, break even, or be required to return funds in a lump sum to the Medicare program.

Track 2 is a voluntary track available to PCTs in Year 3. Under this track, practices would take on shared risk and savings based on total cost of care. Risk would be based on spending above a 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.

Quality standards for participation and payment include standards for participation and additional quality metrics for use in determining payment. Minimum standards for participation are that PCTs would be required to:

1. Have a written care plan developed for each patient and approved by the patient by the end of the first month of services;
2. Document that the patient had been assessed and determined to have the characteristics required for eligibility for payment and for the assigned payment category;
3. 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;"
4. Maintain documentation that it had responded to all telephone calls from patients.
5. Participate in a PACSSI Learning Collaborative.

PCTs failing to meet these participation standards would be terminated from the model.

Quality measures upon which PCT performance would be measured and payments based would be of three types: 1) patient or proxy-reported experiences about several aspects of their palliative care; 2) PCT completion of certain care processes; and 3) utilization of hospice and ICU services by patients at the end of life. Because several of the 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. For Years 1 and 2, PCTs would be required to report 15 applicable measures addressing: satisfaction with care, communication, timeliness of care, adequacy of treatment for pain and symptoms, certain care processes, percentage of patient who died receiving hospice care, and percentage who died without any ICU days during the 30 days before death, but payment will not be tied to performance on these measures. For Year 3, when all measures have established benchmarks, PCTs' accountability for quality performance and payment would be based on a composite score that equally weights performance across each of the three categories.

## **2. Additional Information Reviewed by the PRT: Environmental Scan**

### **Environmental Scan and Literature Review**

ASPE, through its contractor, conducted an abbreviated environmental scan related to this proposal following receipt of the letter of intent (LOI). Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the LOI. The key words and combinations of key words were used to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the

proposed model in the LOI or subject matter identified in the LOI. Key terms used included “MedPAC,” “Hospice Payment,” “Medicare,” “Palliative Care,” “Hospice,” “Medicare Care Choices Model,” “Medicare Physician Fee Schedule,” “Advanced Care Planning,” “End of Life Care,” “Payment Reform,” “Hospice,” “Payment Method,” “Evaluation,” “Hospice Services,” “ACO,” “Hospice Accountable Care,” “End of Life Spending,” and “Payment.” This search produced nine documents from the grey literature and six peer-reviewed articles. The search and the identified documents were not intended to be comprehensive and were limited to documents that meet predetermined research parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI. This environmental scan is posted on the ASPE’s PTAC [website](#).

## **D. Evaluation of Proposal Against Criteria**

**Criterion 1. Scope (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.**

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**PRT Qualitative Rating: Meets criterion and deserves priority consideration**

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Although the Medicare hospice benefit and Medicare Care Choices Demonstration provide for the provision and payment of comprehensive palliative care, both are available only to individuals certified by their physicians as being in the last six months of life. The hospice benefit further requires participants to forego curative care in order to receive hospice services, and the Medicare Care Choices Demonstration is only available to beneficiaries with certain diagnoses: advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). These policies are contrary to recommendations by experts that palliative care should be offered independent of the patient’s prognosis, beginning concurrently with the diagnosis of serious illness, and provided simultaneous with life-prolonging and curative therapies for persons living with serious, complex, and life-threatening illness.

The PRT agrees with the proposed model that palliative care should be a more widely available Medicare benefit—available to individuals who are not yet eligible or willing to enroll in the hospice benefit, but who nevertheless have one or more serious illnesses or multiple chronic conditions and could benefit from the provision of palliative care. The environmental scan conducted for the PRT provided evidence that palliative care services can improve patient experience, 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 – and also reduce costs by eliminating avoidable or unnecessary care.

Further, the data analyses commissioned by the PRT show that more than 9 million Medicare beneficiaries have one or more of the diagnoses targeted in this palliative care



proposed model. A significant proportion of these are likely to meet the additional functional and utilization criteria set forth in the model to identify an appropriate population for palliative care services. This demonstrates a significant unmet need despite existing models.

For these reasons, the PRT finds that this proposed model meets Criterion 1 and deserves priority consideration.

**Criterion 2. Quality and Cost (High Priority Criterion). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.**

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**PRT Qualitative Rating: Does not meet criterion**

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The PRT has significant concerns that the proposed model might not improve health care quality at no additional cost, maintain health care quality while decreasing cost, or simultaneously improve health care quality and decrease cost. These concerns arise from 1) weaknesses in how the proposal would measure and monitor quality and 2) how the proposed payment methodology would calculate and reward savings and losses.

With respect to the proposed quality measures, the PRT found that the proposed model sets a “low bar” for measuring and improving quality. For example:

- **Insufficient outcome measures.** The model proposes only two outcome measures (“adequacy of treatment for pain and symptoms” listed in the proposal, and help with “pain” and “trouble breathing” identified in the submitter’s response to questions from the PRT). Given that the first benefit of palliative care identified in the proposal is “reducing pain and suffering,” the PRT expected to see more robust measures of these outcomes (and the other identified benefits of palliative care). For example, the proposal did not discuss available measures including any of the National Institutes of Health PROMIS® (Patient-Reported Outcomes Measurement Information System) measures, which include psychometrically tested and validated measures of many dimensions of patient suffering including: pain, sleep, anxiety, fatigue, social function, depression, sadness, dyspnea, nausea, vomiting, et al. In response to a question from the PRT, the submitter states that, “To date, the most useful outcome measures have been those based on post-death surveys of bereaved family members regarding their experience of hospice care,” but does not provide evidence in support of this statement.
- **Timing of measurement.** The timing of proposed measurement is limited to the “front” and “back” end of service; i.e., through an “admission survey,” “completion of activities within 15 days of enrollment,” and “after death.” The PRT is concerned that the measures do not assess the quality or experience of care provided during the greatest portion of beneficiaries’ enrollment and when treatment changes will occur. Further, the “post-death” measures have a risk of confounding since the submitter states that, “The expectation is that approximately 45-50% of participants will utilize hospice

services in a 12-month period,” and, “for all patients who die within seven days of discharge from PACSSI to hospice care, the Hospice CAHPS results are attributed to the PACSSI team as well as the hospice.”

- **Insufficient utilization measures.** Of the three proposed utilization measures, two address hospice utilization and one addresses ICU days. All of the measures include only enrollees who died. The PRT believes that a broader and more meaningful set of utilization measures are needed. Further, there are no reliable benchmarks for these utilization measures, and as such there is a risk of unintended consequences when attempting to control and reward cost reduction using utilization measures where patient utilization can appropriately vary from an established benchmark.

The PRT noted that similar concerns about the quality measures were expressed in some of the public comments received.

The PRT also was concerned about potential variation in the PCTs and the minimal standard for contact with beneficiaries. Specifically, the submitter states in its response to the PRT that, “At a minimum, one of the core interdisciplinary team members must have certification in palliative care to support specialty level practice.” Because the core team members consist of a physician, nurse, social worker, and a spiritual care provider, the degree of clinical expertise in palliative care can vary depending upon which of the provider types has certification in palliative care. Further, the standard for PCT contact with beneficiaries is that each PCT “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.” Because PCTs may consist of many different types of members with varying knowledge and skill levels, this standard may not be sufficient for monitoring a highly vulnerable population. The meaning and standards for “virtual” face-to-face visits was not discussed.

With respect to the cost component of the criterion, the PRT is concerned about the proposed model’s ability to achieve savings given the structure of the model and the proposed model’s treatment of savings and losses. First, the model may be susceptible to bias in beneficiary enrollment decisions, with the potential to incentivize the enrollment of patients expected to be of lower cost. Since the interaction between this model and hospice care is likely to be significant, cost estimates might be unduly influenced when the APM entity is a hospice and decisions concerning patient admission to hospice will affect both model and hospice revenue and costs.

The higher monthly payment for “Tier 2” patients (\$650.00 per month in contrast to \$400.00 per month) additionally incentivizes higher scores on “Function” to move a beneficiary into the “High Complexity Tier” which receives a higher monthly payment. As the palliative care expert consulted by the PRT stated, performance on, for example, the Palliative Performance Scale can fluctuate from day-to-day or week-to-week. Therefore, the higher score calculated may be intentional or inadvertent.

Additionally, there are no specifics offered on how the spending benchmarks and risk adjustment would be calculated and there is not a minimum savings or loss rate before risk sharing starts. In response to a question from the PRT, the submitter states, “Spending targets would be adjusted for . . . age; sex; primary diagnosis and comorbidities; functional status; dual eligibility; Part D enrollment; utilization of inpatient, outpatient observation, or emergency care in the 12 months prior to enrollment; and months of survival during the performance period . . . geographic variation and practice-specific characteristics. . . We believe that this would require a new risk-adjustment and benchmarking methodology developed specifically for the PACSSI model.”

Further, the lack of a confidence interval around the savings or loss threshold means that the model would pay more for random small gains or losses. The PRT notes that statistical confidence is typically limited within small deviations from a benchmark; payments rewards or penalties typically are incurred when costs exceed a benchmark by some degree. The model also shares a higher share of savings or loss in the first five percentage points than it does after savings or losses exceed plus or minus 5%. That is inverted from how most Medicare models have been set up.

Finally, the model’s proposed risk sharing is asymmetric, favoring savings over losses. Specifically, in Track 2 the maximum “downside” risk is only three percent of benchmark but maximum financial reward is 20 percent of the benchmark. At high quality scores, marginal loss sharing is only between 30-40% whereas savings are shared at 70-80%.

The PRT concluded that the model should aim to ensure “more for the money;” i.e., more ambitious performance standards and measures accompanied by a payment methodology that addresses the concerns above.

**Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.**

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**PRT Qualitative Rating: Does not meet criterion**

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Many of the concerns about the model’s ability to achieve cost savings, described under Criterion 2, are a function of the payment methodology – and are why the PRT finds that the model also does not meet Criterion 3.

The PRT underscores several of these concerns. First, it is concerned about the narrow dividing line between Tier 1 payments and Tier 2 payments, and the ease with which patients could be scored into Tier 2. Related to this, no data was given for how the \$400.00 and \$650.00 per month management fees were derived. Second, the payment

methodology's absence of confidence intervals around benchmarks for payment provides no mechanism for accounting for random variation. Further, in Payment Track 1 (in which all PCTs would participate in the first two years) the PRT questions whether four percent risk constitutes sufficient risk — especially when tied to relatively weak performance measures discussed under Criterion 2. Finally, the PRT emphasizes concern about the “inverted” nature of the payment methodology; i.e. paying more for smaller gains compared to benchmarks and paying less for greater accomplishments. This may inadvertently discourage providers from focusing on reducing total cost of care.

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**Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.**

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**PRT Qualitative Rating: Meets criterion**

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Notwithstanding the concerns expressed under Criteria 2 and 3, the PRT concluded that PACSSI's provision of care management payments (that can be used to provide services not otherwise reimbursable) to interdisciplinary Palliative Care Teams (as opposed to a single provider for his or her individual services), accompanied by financial incentives to meet certain experience of care and performance standards could incentivize members of the Palliative Care Team to deliver high-quality health care.

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**Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.**

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**PRT Qualitative Rating: Meets criterion**

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As stated with respect to Criterion 4, the deployment of interdisciplinary Palliative Care Teams and monthly care management payments that can be used to secure services not otherwise reimbursable provides greater flexibility in care delivery than payments to limited types of practitioners individually under the traditional Medicare fee schedule. The current Medicare Physician-Fee Schedule does not provide reimbursement for the provision of many nursing, social work, and spiritual services that are key components of palliative care. The PRT concluded that the design of the PACSSI model would provide much greater flexibility to practitioners to deliver high-quality health care.

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**Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.**

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**PRT Qualitative Rating: Meets criterion**

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The PRT grappled with the extent to which the PACSSI model meets this criterion. The PRT notes again that the model's goals, expressed in the performance measures, are generally weak, and is concerned about the relative lack of measures of the effects of the model on patients.

With respect to constructing an approach to evaluation, there also is concern that it would be difficult to build valid comparison groups because of the potential for enrollment bias previously discussed under Criterion 2, the varying eligibility criteria, and that much of the information in the “function” category would not be contained in administrative datasets. The lack of confidence intervals previously discussed also would make evaluation difficult. However, the PRT took note of the two-year benchmarking period and viewed this as an opportunity to address some concerns such as around confidence intervals.

The PRT concluded that this proposal minimally meets this criterion.

**Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.**

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**PRT Qualitative Rating: Meets criterion**

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As stated under Criteria 4 and 5, PACSSI’s provision of care management and use of interdisciplinary Palliative Care Teams is likely to encourage greater integration and care coordination among practitioners. In addition, the PRT notes that PCTs would be required to (among other services):

- “• 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; and
- 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 . . .”

While noting the lack of strong care coordination measures in the proposed quality measure set, the PRT concludes that the PACSSI model should likely encourage greater integration and care coordination among practitioners and across settings of patient care.

**Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.**

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**PRT Qualitative Rating: Meets criterion**

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The PRT also grappled with the extent to which PACSSI would support the unique needs and preferences of individual patients and how to know if those needs were met. The PRT has concerns about the proposal’s emphasis on process as opposed to outcome measures as discussed under Criterion 2, and the limited evaluation of patient experience or patient reported outcomes throughout the treatment process. In addition, public comments received on the proposal called attention to the need to strengthen the proposed model to be more patient- and family-centered with respect to care planning and shared decision-making by:

- Requiring greater involvement of patients and caregivers in developing and executing care plans by: changing standards from developing care plans for patients to developing these plans with patients and their families; reinforcing the role of patients and caregivers in tracking progress and updating the care plan as part of required services; and requiring patient/caregiver verification of a care plan that is consistent with their values and preferences, as well as the ability to provide updates to the plan, as a required care process.
- Incorporating shared decision-making into the proposed palliative care services and quality metrics (including surveys). The public commenter noted that shared decision-making goes significantly beyond “allowing” patients and families to ask questions. Rather, it facilitates bidirectional communication between providers and patients in which risks, benefits and alternatives of proposed treatment are discussed and the provider and patient/caregiver share in the process of deciding what is best for the patient based on his or her individual goals, preferences, and values.

Finally, the PRT notes that many enrollees may have long periods of survival, and the proposed measures (with their attention to the “front’ and “back” end of enrollment, as discussed in criterion 2, above) may not call attention to supporting the unique needs and preferences of individual patients throughout their enrollment.

In spite of these concerns, the PRT concluded that this proposed model would offer some degree of support of the unique needs and preferences of individual patients.

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**Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.**

**PRT Qualitative Rating: Meets criterion**

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The PRT has concerns about how the PCTs will work with the patients’ primary care providers, but concluded the model’s components that address care coordination (e.g., developing a coordinated care plan with input from all of the patient’s physicians and providers and communicating with the patient’s other physicians and providers on an ongoing basis) does aim to improve standards of patient safety.

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**Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.**

**PRT Qualitative Rating: Meets criterion**

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The PRT was divided on the extent to which the proposal meets the criterion. The proposal states in response to this criterion that:

“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.”

One PRT member concluded that this is insufficient for meeting this criterion because of a concern that this proposed model is one which fundamentally requires information to be shared across multiple providers and practice settings, and the proposal does not discuss if or how HIT will be used to accomplish this core function.

Additionally, public comments called attention to the role that HIT can play in supporting patients and their caregivers to achieve care plan goals noting that patients’ online access to health information has a positive impact on a wide range of activities affecting care and health outcomes, including knowledge of health and ability to communicate with providers. The commenter identified the following use of HIT not included in the proposal:

- allowing patients (and caregivers, as appropriate) to electronically access their clinical health information (lab results, medication lists, care plans, clinical notes, etc.), as well as relevant educational resources.
- enabling patients and caregivers (through patient portals or other patient-facing applications) to track and share information with providers in real time;
- allowing response on a 24/7 basis to requests for information and assistance from the patient or caregiver or from providers who are caring for the patient (including but not limited to telephone calls, secure emails, patient portal messages, electronic alerts).

## **E. PRT Comments**

The PRT recognizes the benefits of and need for high quality, interdisciplinary palliative care service for patients with potentially life-limiting conditions. However, the PRT has three main concerns about the proposed model. First, the model is overly complex, having multiple paths to eligibility with two tiers of eligibility, and two different payment tracks.

Further, the PRT has significant concerns about the proposed model’s approach to quality assurance and measurement, including: the minimal standard for contact with beneficiaries, insufficient attention to patient outcomes, weaknesses in the period of time to be captured in the measures, and insufficient utilization measures.

With respect to the payment methodology, the PRT is concerned about the narrow dividing line between Tier 1 payments and Tier 2 payments, and the ease with which patients could be

scored into Tier 2. The payment methodology's absence of confidence intervals around benchmarks for payment also provides no mechanism for accounting for random variation. The absence of a minimum savings or loss rate before risk sharing starts means that the model would pay more for random small gains or losses. The payment methodology also would pay more for smaller gains compared to benchmarks and paying less for greater accomplishments. Specifically, the model proposes to share a higher share of savings or loss in the first five percentage points than it does after savings or losses exceed plus or minus 5%. That is inverted from how most Medicare models have been set up. Finally, the model's proposed risk sharing is asymmetric, favoring savings over losses.

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