

# 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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February 13, 2018

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:** *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*
- 2. Submitting Organization or Individual:** Coalition to Transform Advanced Care (C-TAC)
- 3. Submitter's Abstract:**

"Building from successful, scalable advanced illness and community-based palliative care programs, the Coalition to Transform Advanced Care (C-TAC) proposes an advanced illness care and advanced alternative payment model, the Advanced Care Model (ACM), for a Physician-Focused Payment Model.

The Advanced Care Model provides a population health management approach for the advanced illness population, focused on the last year of life. The expected impact for ACM beneficiaries are improvements in (1) patient and family engagement, (2) shared-decision making among patients, families and their physicians, (3) coordinated care that aligns with patient preferences, (4) symptom management, (5) prevention of avoidable and unwanted hospitalizations or low-value treatment, and (6) prevention of unwanted futile care at the end of life.

The ACM integrates with existing APMs and contributes to their success. By creating an integrative model that is focused on a high-cost and high-need population, the ACM

provides a mechanism to risk-stratify a broader Medicare population, specifies effective care interventions, and creates additional financial incentives for existing APMs. In addition, the ACM will offer multiple pathways for organizations to incrementally add risk by participating in the ACM as a new AAPM or as a layer within the MSSP. Primary care providers and specialists can participate in the ACM APM for physician-focused payment incentives under the Quality Payment Program. Furthermore, the ACM meets the requirements for an advanced APM, with the potential to qualify participating palliative care providers and specialists.

The ACM meets these outcomes by delivering and ensuring comprehensive, person-centered care management; multidisciplinary team-based care; concurrent curative and palliative treatment; care coordination across all care providers and settings; comprehensive advance care planning; shared decision making with patient, family, and providers; and 24/7 access to clinical support. ACM services continue until the beneficiary dies, enrolls in hospice, moves outside the service area or chooses to dis-enroll from the ACM.

The goals of the ACM payment structure are (1) to pay for improvement in quality at equal or lowered cost, (2) to convert palliative care provider’s fee schedule to a team-based, population health payment structure that rewards quality, (3) to create additional incentives through advanced APM status for broad participation of non-palliative care specialties involved in the care of advanced illness, (4) to utilize a pay-for-quality payment structure that incentivizes quality, and (5) to set appropriate incentives and financial risk. Ultimately, the ACM is a much-needed, innovative advanced APM, specifically designed to improve quality for a highly vulnerable population with advanced illness.”

## B. Summary of the PRT Review

<b>Criteria Specified by the Secretary (at 42 CFR§414.1465)</b>	<b>PRT Conclusion</b>	<b>Unanimous or Majority Conclusion</b>
<b>1. Scope (High Priority)</b>	Meets criterion and deserves priority consideration	Unanimous
<b>2. Quality and Cost (High Priority)</b>	Meets criterion	Unanimous
<b>3. Payment Methodology (High Priority)</b>	Meets criterion	Unanimous
<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 and deserves priority consideration	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	Unanimous

## C. PRT Process

The proposal, “*Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*” (available on the ASPE PTAC [website](#)) was received by PTAC on October 5, 2017. (The proposal is a revision of an earlier submission by C-TAC with the same title reviewed by PTAC on September 7, 2017.) The PRT conducted its review of the revised proposal between October 25, 2017 and February 13, 2018. During this time, the PRT reviewed the proposal, the submitter’s responses to questions posed by the PRT, all public comment letters received on the proposal, and the results of a PRT-commissioned literature review on patient perspectives on learning disease prognosis. The PRT also consulted with the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) to better understand key aspects (and potential effects) of the proposed model.

The PRT’s summary of the proposal and evaluation of the proposal compared to the Secretary’s criteria for physician-focused payment models (PFPMs) are below. The literature review on patient perspectives on learning disease prognosis and public comments received on the proposal are available on the ASPE PTAC [website](#).

### 1. Proposal Summary:

The *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* is a proposed payment model for delivery of palliative care services to Medicare beneficiaries who are in the last 12 months of life. Beneficiaries in the last 12 months of life are predicted to be those who meet criteria in at least two of the four health or health care utilization categories in the table below, plus an additional screening question.

**ACM Criteria for Identifying Individuals in Last 12 Months of Life**

1. Acute Care Utilization	2. Functional Decline	3. Nutritional Decline	4. Performance
<p>2 hospitalizations in the last 12 months</p> <p><b>OR</b></p> <p>1 emergency room (ER) visit and 1 hospitalization in the last 6 months</p> <p><b>OR</b></p> <p>2 ER visits in the last 3 months</p>	<p>New, irreversible dependence in at least 1 Activity of Daily Living (ADL) in the last 3 months</p>	<p>Involuntary lean body weight loss of &gt; 5% in the last 3 months</p>	<p>Performance on the <i>Palliative Performance Status (PPS)</i> scale of <math>\leq 60</math></p> <p><b>OR</b></p> <p>Performance on the <i>Karnofsky Performance Scale (KPS)</i> of <math>\leq 60</math></p> <p><b>OR</b></p> <p>Performance on the <i>Eastern Cooperative Oncology Group (ECOG) Performance Status</i></p>

			scale of $\geq 3$
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An additional screening question of “Would you not be surprised if the patient died in the next twelve months?” is posed and must be answered in the affirmative in order for a patient to be eligible for the program.

Services covered by the proposed payment include:

1. Provision of palliative/comfort-based care and promotion of evidence-based disease-modifying treatments that align with the patient’s personal preferences;
2. Comprehensive care coordination and case management of the beneficiary’s total healthcare needs (both curative and palliative) and services including physician and other eligible clinician, hospital, and post-acute care, and social services;
3. Systematic advance care planning in which patients, families, and the patient’s healthcare providers reflect on the patient’s goals, values, and beliefs; discuss how they should inform current and future medical care; and use this information to accurately document future health care choices, after an exploration of the patient’s and caregivers knowledge, fears, hopes, and needs;
4. Shared decision-making between the advanced illness beneficiary/caregivers/family and the ACM care team in designing and implementing the ACM care plan; and
5. 24/7 access to a clinician.

These services would continue until the beneficiary dies, is enrolled in hospice, disenrolls or moves out of the ACM service area. Services would be delivered by:

1. An ACM care team that includes a registered nurse, a licensed social worker, and a provider with board-certified palliative care expertise. ACM teams may also include other clinicians practicing within their scope of licensure and non-clinicians.
- AND
2. Participating physicians and other eligible clinicians who may include primary care and specialty providers involved in patients’ care. Participating physician providers:
    - a. commit to identifying patients for enrollment in the ACM and ACM quality goals;
    - b. agree that their enrolled patient population will be attributed to the ACM;
    - c. may participate in additional payment of shared risk from the ACM, by establishing arrangements with the ACM entity; and
    - d. may clinically integrate with the ACM entity.

Payments under the model would be made to ACM entities which can be physician practices, hospitals, ACOs, health systems, hospices, home health agencies and other entities as long as the entity:

1. Is a Medicare provider;
2. Has a system for administering billing/financial transactions between the ACM entity and CMS;

3. Has a system to distribute payments, or shared risks between the ACM entity and participating physicians, other eligible professionals, and/or other health care organizations;
4. Has a data system to generate and submit reports required by the ACM and to share reports generated from the ACM entity and CMS to participating physicians, eligible professionals, and/or other health care organizations;
5. Has appropriate licenses to deliver ACM services, either directly or under arrangements with other providers;
6. Has a defined network of participating physicians and other eligible professionals with a reasonable projected advanced illness patient volume to operate the ACM services;
7. Demonstrates feasibility to assume financial risk and be accountable for quality; and
8. Satisfies directly or through arrangements, all ACM service and operational requirements.

Payment would consist of:

1. Wage-adjusted \$400 Per Member Per Month (PMPM) payments of indefinite duration. The “episode” is defined as the total cost of care for the last 12 months of life, as long as a PMPM was paid for at least one of these months. Total costs of care for the last 12 months of life are included in the episode cost regardless of how many months the beneficiary was enrolled in the ACM program; and all PMPM payments (including those in excess of 12 months) are all included in the episode costs regardless of whether those ACM payments are received in the last 12 months of life. The proposal states, “The ACM entity . . . remains accountable for a beneficiary’s last 12 month of life cost if the ACM beneficiary is served by the ACM entity at any point during the ACM beneficiary’s last 12 months of life.” For example, if a beneficiary is enrolled and disenrolls in the third month in order to enroll in hospice and then dies nine months later, all costs for the last 12 months of life will be included in the model’s episode costs even though the patient disenrolled after the third month. Similarly, if an enrollee dies after being enrolled in the ACM model after only one month, the ACM entity is accountable for the costs of the month of enrollment and the preceding eleven months.
2. Quality bonus payments or shared losses based on the total cost of care for the last 12 months of life with a 4 percent minimum shared savings/loss rate; i.e., a bonus payment would trigger only if savings is at least 4 percent of a risk-adjusted, total-cost of care spending target. Similarly, a shared loss rate would trigger only if the excess spending is at least 4 percent of the spending target. However, the bonus payment would be based on the full savings amount and the shared loss rate would be based on the full loss amount.
3. Quality bonus payments (funded by savings) would be subject to a maximum bonus of \$250 PMPM; CMS would keep a proportion of savings when the quality bonus payment rate is less than 100% and would keep all savings in excess of \$250 PMPM.
4. A 40-60 percent shared loss rate would be based on quality performance and compliance with a minimum quality standard (the ACM provider’s attestation that the patient’s care plan is consistent with his/her preferences), up to a maximum loss rate of

\$100 PMPM. CMS will partially share the loss up to \$100 PMPM and all losses in excess of this amount.

5. Upside quality bonus payments would be operational in Years 1-2; shared loss would begin in Year 3.
6. There would be a remediation period for low quality performers or when expenditures are significantly higher than expected. An ACM entity will be required to leave the program if corrective actions do not show positive trends within six months and significant improvement within a year.
7. Payment would replace the ACM entity's palliative care provider evaluation and management (E&M), Chronic Care Management, Complex Chronic Care Management, Transitional Care Management, and Advance Care Planning payments.

Thirteen quality measures are proposed for use in determining bonus payments in the first two years. These measures would be measured at one month after admission to the program (or earlier) and after discharge/end of the episode. The 13 measures address: access and timeliness of care; getting help for pain, trouble breathing and anxiety/sadness; medication reconciliation post hospital discharge; utilization of ICU and hospice care; communication; ACM provider attestation that the patient's care plan is consistent with their preferences; care coordination; and, overall satisfaction with care received from the ACM team. Five additional measures are proposed for use beginning in Year 3 after testing in Years 1 and 2.

In addition, the model proposes an additional quality monitoring program to be operated by CMS that would analyze for outliers in such areas as: all-cause unplanned admissions, ambulatory sensitive conditions, hospice enrollment, and proportion of ACM enrollees with more than 12 months of enrollment. Additionally, each ACM entity would be required to submit a yearly operational plan that delineates participating providers and contractors, how ACM services will be provided including care guidelines, staffing plan including training, patient identification and notification process, performance management plan, physician engagement plan, risks and barriers mitigation plan, and financial risk management plan. ACM entities that are outliers in one or more areas and exhibit below average performance under the ACM pay for quality structure would trigger an audit. A remediation period would ensue for any identified issue and the ACM entity would be required to leave the program if a positive trend is not achieved within six months and significant improvement within a year.

## **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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The PRT finds that Medicare payment policy and CMS' APM portfolio do not adequately provide for the provision of palliative care to Medicare beneficiaries. 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).

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.

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: Meets criterion**

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The PRT found that this revised proposal is an improvement over the initial ACM proposal noting the addition of several new proposed quality measures; i.e., a measure of medication reconciliation post-discharge from a hospital, three new measures addressing effective communication from the care team, and a measure of caregiver support to be field-tested.

The PRT's concerns are about:

- **Timing of measurement.** The timing of proposed measurement is limited to the “front” and “back” end of service; i.e., at the first month of enrollment or sooner and after discharge or end of the episode. The PRT is concerned that the measures do not obtain patient evaluation of quality of care provided during the greatest portion of their enrollment.
- **Insufficient utilization measures.** The two proposed utilization measures address hospice utilization of three days or more and admission to the ICU in the last 30 days of life. Both address only the experience of enrollees who die. The PRT believes that a broader set of utilization measures are needed. For example, the PRT noted that the proposal calls for CMS to monitor “All-cause unplanned admissions for ACM beneficiaries” and ambulatory sensitive conditions and wonders why these or similar utilization measures are not proposed as part of the pay-for-quality measures. Further, there are no reliable benchmarks for the two proposed 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 also was concerned that there is no minimal standard for contact with beneficiaries and expressed a desire for greater use of measures of health outcome and shared decision-making. Finally, the PRT was concerned that the identified “Minimum Quality Standard Measure” (i.e., ACM provider “YES” / “NO” attestation that patient’s care plan is consistent with preferences) is perhaps too minimal.

With respect to the “cost” component of the criterion, the PRT notes that enrollment would still be subject to bias from participants targeting more favorable risk populations as well as enrollment choices made by beneficiaries that happen to be engaged by participants. Also, while beneficiaries who survive through the performance period incur the \$400 PMPM fee spending, they do not appear to be included in the shared savings/loss calculation, so only a portion of the enrolled population is effectively governed by a risk arrangement.

Further, the model proposes an episode regression approach for determining spending targets. However, this appears to only calculate savings or losses for beneficiaries who happened to die in the performance period, which means a portion of the fees and spending remains unmanaged from a risk-sharing standpoint.

**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: Meets criterion**

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The PRT finds that this proposed model meets this criterion with the following five caveats:

First, the PRT is concerned about the part of the payment model that holds APM entities accountable for the total cost of care for enrollees in their last 12 months of life, even when the enrollees are not enrolled in the model for some or even the majority of these months. As described in the summary of the model above, if a beneficiary enrolls in the model program and disenrolls in the third month in order to enroll in hospice and then dies nine months later, all costs for the last 12 months of life will be included in the model’s episode costs, even though the patient disenrolled after the third month. Similarly, if an enrollee dies after being enrolled in the ACM model after only one month, the ACM entity is accountable for the costs of the month of enrollment and the preceding eleven months. The PRT has concerns about the validity and fairness of holding providers accountable for periods of time in which they are not involved in enrollees’ care.

Second as discussed under Criterion 2, the PRT has concern about the use of an episode regression approach for determining spending targets as this appears to only calculate savings or losses for beneficiaries who happened to die in the performance period, which means a large portion of the fees and spending remains unmanaged from a risk-sharing standpoint.

Third, the PRT is concerned about the role of hospices in this model. As proposed, hospices can be both the APM entity providing palliative care under the model and participating in shared savings, and a hospice to which the APM entities' enrollees are discharged. This dual role of hospices raises concern about the possibility of triple financial incentives affecting care; i.e., a financial incentive to encourage discharge to hospice when the PMPM payment is thought insufficient, the financial incentive of the hospice to control spending under its per diem payment, and the additional financial incentive of the hospice to control costs in the last month of life because of the effects on the hospice's potential for shared savings as an APM entity.

Fourth, the PRT is concerned that capping shared savings at \$250 PMPM may be an insufficient financial incentive. However, the PRT notes that limiting the shared savings does mitigate some potential problems of inaccuracy in estimating the baseline for calculating the shared savings.

Fifth, the proposed model has asymmetrically higher upside than downside risk, and risk is limited to a subset of the population that died. Whereas the base \$400 fee is paid for every enrolled member per month, the max bonus of \$250 PMPM or loss of \$100 PMPM appear to only apply to beneficiaries who happened to die in the performance period. In effect, only a fraction of the \$100 is at risk over the whole enrolled population. Also, sharing of savings is very aggressive, up to 100 percent after a 4 percent threshold is met, whereas loss sharing tops out at 60 percent after the same 4 percent threshold is exceeded on the downside. The large fee with skewed risk sharing parameters and limited downside risk increases the chance that the overall model would drive spending increases.

#### **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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The proposed model provides financial incentives to deliver high quality care through the use of PMPM reimbursement and a potential quality bonus **for the ACM entity**. Regarding incentives **to practitioners** to deliver high-quality health care, the proposal states that:

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

- (4) The **participating** PCPs [primary care providers] and or specialists, by virtue of their collaboration, can access the QPP APM incentives,
- (5) The **participating** PCPs and or specialists may participate in additional payment or shared risk from the ACM APM, by establishing such arrangement(s) with the ACM entity” (emphasis added).

The proposal also describes the use of non-financial incentives available to deliver high quality care as focusing on the interdisciplinary team, which “enables participating physicians and other providers to participate in care at home without having to do multiple house calls themselves. ACM team members act as the physician’s eyes, ears and hands through face-to-face and virtual visits at the patient’s residence. Team members are also trained to manage pain and other symptoms, and actively collaborate, within limits of their license, with recommendations to physicians who may lack training and experience in palliative care. Team input to physicians provides invaluable information about the patient’s home environment, family and caregiver stressors and other non-medical determinants of health. A survey of physicians using the ACM showed that over ¾ reported that the intervention reduced their workload.”

The PRT concludes that this proposal meets this criterion.

**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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The PRT noted that, as describe in the proposal, the ACM model is designed to be flexible in several ways. First, the ACM model is designed to care for patients with a broad range of advanced illness, including cancer and non-cancer disease as well as geriatric frailty in rural or metropolitan areas. The model also would be open to a broad range of providers who could serve as ACM APM entities including physician groups, ACOs, hospitals, hospices, home health agencies and other organizations. Third, the ACM model proposes a consortium structure to support aggregation of small physician practices to achieve necessary volume. Further, ACM entities have flexibility over how they organize the entity as well as distribute payments among participating providers and contractors. Lastly, the submitters propose various mechanisms for ACM implementation including: (1) as a stand-alone APM, (2) as part of MSSP, and/or (3) overlapping with another model such as the Oncology Care Model.

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

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**PRT Qualitative Rating: Meets criterion**

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The PRT notes that the proposed model identifies eight targets for improving quality of care and cost: (1) patient and family engagement, (2) shared-decision making among patient,

family and their physicians, (3) coordinated care that aligns with patient preferences, (4) symptom management, and reducing (5) avoidable and unwanted hospitalizations or low-value treatment, (6) unwanted futile aggressive care at the end of life, (7) ineffective, suboptimal end-of-life hospice care, and (8) Medicare expenditures.

The proposal states that the first four will be evaluated through use of provider reporting and beneficiary and family caregiver surveys. Performance targets will be set over time for use by Year 3. Goals 5 through 8 can be evaluated through use of claims data compared to a risk-adjusted standard.

The PRT believes that the proposed model 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 and deserves priority consideration**

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The proposal states that, “A core function of the ACM is to ensure that explicit and well-documented care plans are in place for all beneficiaries, and to reconcile all input from PCPs, specialists and hospitalists so that orders, medications, appointments and other critical elements are unified into a single plan of care that is easily understood by patients, family members and caregivers so that they can understand how best to navigate their own complex and unique systems of care. This unified care plan is documented in the medical record and transmitted to all involved clinicians to ensure all needed services are delivered in a coordinated manner across inpatient, ambulatory, home and long-term care settings.” It also identifies 14 processes through which care coordination can be accomplished:

1. “Furnishing high-impact interdisciplinary team visits in hospital, office/clinic and home
2. Providing comprehensive transitional and post-acute care
3. Establishing efficient and reliable handoff processes among teams and settings
4. Facilitating advance care planning over time, at the patient’s own pace, in all settings
5. Eliminating unwanted or duplicative visits and interventions
6. Employing standardized, proactive telemanagement procedures
7. Ensuring effective and timely communication across all clinical settings
8. Engaging principal primary and specialty physicians as core members of the clinical team
9. Helping patient and family navigate among disparate providers
10. Educating and supporting patients, family members and caregivers in self-management
11. Assuring adequate family and caregiver support to minimize hospital and SNF transfers
12. Extending the reach of palliative care from hospitals into the home and community
13. Optimizing EHR to serve as a reliable communications channel among clinical settings
14. Integrating facility and community social services into the clinical workflow”

The PRT concluded that the proposed model meets this criterion and deserves priority consideration.

**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 concluded that this proposed model meets this criterion, but remains concerned for several reasons about the use of predicted prognosis as the eligibility criteria for the model. First, the PRT notes the position of multiple palliative care experts that palliative care should not be tied to prognosis (See, for example, Meier, D., et al. (2017). A National Strategy For Palliative Care. *Health Affairs*, 36(7) at: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0164>)

Moreover, evidence reviewed by the PRT shows that the accuracy of predicting prognosis is limited, even with the use of the “surprise question.” For example, a meta-analysis reviewed by the PRT finds that, “The surprise question performs poorly to modestly as a predictive tool for death, with worse performance in noncancer illness. Further studies are needed to develop accurate tools to identify patients with palliative care needs and to assess the surprise question for this purpose.”(See, Downar, J. et al. (2017). The “surprise question” for predicting death in seriously ill patients: a systematic review and meta-analysis. *CMAJ*, 189(13) at: <http://www.cmaj.ca/content/189/13/E484>)

Finally, the PRT wanted to better understand the process of communicating prognosis from a patient-centered point of view, and so commissioned a review of evidence about this. This review (available on the ASPE PTAC [website](#)) identified a number of issues with implications for the proposed model:

- Studies indicate that although the majority of patients would prefer to know their prognosis, a substantial minority of patients preferred not to be told this information.
- Little is known about the impact of learning prognosis on patients’ well-being, although the literature generally finds that patients who want prognostic information are better off after receiving it, in terms of satisfaction with treatment, anxiety, and depression. Patients receiving prognostic information, and generally honest and sympathetic discussion of their disease state, cited benefits such as empowered decision-making and ability to prepare for death.
- Patients who do not desire prognostic information most commonly cited the emotional burden associated with that knowledge as the reason for not wanting to have that conversation.
- Evidence indicates that patients have a high degree of variability in terms of how much they want to know about their prognosis, how they want it communicated, and when they want this information, with a general theme of flexibility and highly individualized processes for communicating prognostic information to patients.

- Although studies of *how* prognostic information should be communicated are limited, there is some evidence that patients would prefer more ‘qualitative’ information in this regard, such as whether they will live a ‘long’ time, as opposed to a more quantitative presentation (“you have x months or years to live”). Similarly, a number of studies have documented patient preference for a positive framing that focuses more on survival than mortality.
- There is a clear preference for the person who communicates prognosis to the patient to be a trusted provider with an existing relationship with the patient. Patients prefer to discuss prognosis with a provider with whom they already have an established relationship.

The PRT is concerned that the model’s approach to communicating prognosis may not be sufficiently patient-centered, could have unintended adverse consequences for the patient, and may thereby not facilitate patient choice. Using prognosis as an eligibility criterion in a palliative care model may impose a more specific and structured framework than current evidence supports. Patients may view such an approach to communicating prognosis as providing too much information, too soon, and/or from someone with whom the patient does not have a trusted relationship.

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

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**PRT Qualitative Rating: Meets criterion**

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The PRT found that the model’s provision of home-based care would allow ACM teams to assess and manage both clinical and social determinants of health, and changes in patient status more timely and closely. The coordination of care to be provided by the ACM team across the palliative care team and primary and specialty providers also should help avoid medical errors. Further, to the extent that this model helps avoid unnecessary hospital care, hospital acquired conditions are also avoided.

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

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**PRT Qualitative Rating: Meets criterion**

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The PRT finds that the proposed model meets this criterion on the basis of:

- Its requirement that participating entities utilize an EHR;
- The potential for communication and sharing of care plans between the ACM and the beneficiary’s usual care team through an electronic platform; and
- The submitter’s anticipation that telehealth technology, secured texting, videoconferencing and use of registry and/or health information exchange solutions will be leveraged to maximize efficiency of the ACM.

## **E. PRT Comments**

As was the case with the previous C-TAC proposal, submitted to PTAC on February 7, 2017, and reviewed at PTAC's public meeting on September 7, 2017, the PRT's most positive observations on C-TAC's current proposal derive from the needs of the target population, Medicare beneficiaries with advanced progressive illness who are not eligible for hospice care. Integrating curative services paid for by the traditional fee-for-service system with patient-centered palliative care covered by a per-beneficiary-per-month payment can improve the patient experience of care and conserve resources. The PRT generally found that the incentives of the payment methodology specified in the proposal, including a shared savings and risk sharing incentive for providers, are congruent with the model's coordinated-care objectives. In addition, improvements in the current model as compared to the previous proposal led the PRT to raise its evaluation in two high priority criteria. These improvements include increasing the transparency of information provided to beneficiaries and their families upon recruitment into the model, expanding the number and breadth of quality measures, and extending the PMPM payment to the entire period of participation rather than just the first 12 months for beneficiaries who live and participate in the model for more than 12 months.

Despite these improvements, the PRT retains a number of reservations about the model, as enumerated above. For example, the PRT is uncertain that the model would work equally well for beneficiaries with different progressive illnesses or by all types of providers who would be eligible to be the APM entity. The model could benefit from requiring more patient contact and collection of quality and utilization measures, especially during the interim period between enrollment and death or disenrollment. Finally, the PRT notes that estimating the baseline for evaluating the model's effect on total costs of care and shared savings calculation, and making sure that the model would not interfere with estimating the effects of other models operating in the same locale, will require considerable development beyond the methods specified in the C-TAC proposal.

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