



2200 River Plaza Drive
Sacramento, CA 95833

February 2, 2017

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

RE: Letter of Support-- Advanced Care Model (ACM)

Dear Committee Members,

I am writing on behalf of Sutter Health to express our full support of the Advanced Care Model submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) for review and approval. It is our strong belief that implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness.

The importance of the Advanced Care Model (ACM) cannot be understated. The ACM services represent industry-recognized standards drawn from numerous advanced illness and palliative care programs that already exist today in limited scale. The ACM alternative payment model provides the necessary and appropriate incentives for existing programs to fully broaden its reach and for new organizations to participate in value-based alternative payment. We appreciate the model's flexibility, its multiple strategies to ensure high quality from value-based payment to a comprehensive measurement framework, the opportunity for independent small practices to participate in advanced alternative payment, and the option for the ACM to integrate or dovetail with other alternative payment models such as the MSSP or CPC+ programs.

We believe the ACM is a natural and yet critical breakthrough to dramatically improve advanced illness and end of life care in America.

As Sutter Health's SVP Medical and Market Networks, I greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeff Burnich".

Jeff Burnich, M.D.
SVP Medical and Market Networks
Sutter Health

February 8, 2017

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

RE: Letter of Support-- Advanced Care Model (ACM)

Dear Committee Members,

We are writing on behalf of Spectrum Health Medical Group and Spectrum Health Continuing Care to express our full support of the Advanced Care Model submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) for review and approval. It is our strong belief that implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness.

The importance of the Advanced Care Model (ACM) cannot be understated. The ACM services represent industry-recognized standards drawn from numerous advanced illness and palliative care programs that already exist today in limited scale. The ACM alternative payment model provides the necessary and appropriate incentives for existing programs to fully broaden its reach and for new organizations to participate in value-based alternative payment. We appreciate the model's flexibility, its multiple strategies to ensure high quality from value-based payment to a comprehensive measurement framework, the opportunity for independent small practices to participate in advanced alternative payment, and the option for the ACM to integrate or dovetail with other alternative payment models such as the MSSP or CPC+ programs.

Spectrum Health Medical Group is a 1,300 provider, multispecialty, physician governed organization serving 12 counties in western Michigan. Spectrum Health Continuing Care has an emphasis on post-acute care services including home health, long term care and skilled nursing, as well as palliative/hospice care services. Both SHMG and SHCC focus on delivering the highest quality care to over 350,000 lives in the west Michigan community, and we appreciate the special needs those with advanced illness have. We believe the ACM is a natural and yet critical breakthrough to dramatically improve advanced illness and end of life care in America.

As Executive Leaders of Spectrum Health, we greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

Seth Wolk, MD, MHSA
System Chief Medical Officer, Spectrum Health
President, Spectrum Health Medical Group

Chad Tuttle
President, Spectrum Health Continuing Care
VP, Spectrum Health Rehabilitative Services



**American Hospital
Association®**

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March 2, 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 Ave. S.W.
Washington, D.C. 20201

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

Dear Committee Members,

On behalf of our nearly 5,000 member hospitals, health care systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) is pleased to express our full support of the Advanced Care Model (ACM) submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) for review and approval. It is our belief that implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness.

The ACM is designed to deliver 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. This integrative model focuses on a high-cost and high-need population, specifying care interventions that are based upon industry-recognized standards drawn from numerous evidence-based advanced illness and palliative care programs. In addition, the ACM will offer multiple pathways for organizations to incrementally add risk as existing or new APMs. This approach to alternative payment model provides needed and appropriate incentives for existing programs to broaden their reach and for new organizations to participate in value-based alternative payment programs. We applaud the model's multiple strategies for the ACM to integrate or align with other alternative payment models underway and believe the ACM offers a unique approach to dramatically improve advanced illness and end of life care in America.

Thank you for the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward. If you have any questions, please contact me or Diane Jones, senior associate director, at (202) 626-2305 or djones@aha.org.



Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development



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March 5, 2017

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

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

Dear Committee Members,

On behalf of the American Heart Association, I want to express our full support of the Advanced Care Model (ACM) submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) for review and approval. It is our strong belief that implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness.

The importance of the ACM cannot be understated. The ACM services represent industry-recognized standards drawn from numerous evidence-based advanced illness and palliative care programs that already exist. The ACM alternative payment model provides the necessary and appropriate incentives for existing programs to fully broaden their reach and for new organizations to participate in value-based alternative payment programs. We applaud the model's flexibility, its multiple strategies to ensure high-quality from value-based payment to a comprehensive measurement framework, the opportunity for independent small practices to participate in advanced alternative payment, and the option for the ACM to integrate or dovetail with other alternative payment models such as the MSSP or CPC+ programs.

As the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, the American Heart Association is committed to funding innovative research, fighting for stronger public health policies, and providing critical information and tools to patients and their families to save, improve and extend the quality of lives. This includes addressing barriers that prevent many cardiovascular and stroke survivors from taking full advantage of the care and support options to help them manage their advanced illness and deteriorating health. We

*"Building healthier lives,
free of cardiovascular
diseases and stroke."*

life is why™ es por la vida™ 全為生命™

Please remember the American Heart Association in your will.



believe the ACM is a natural and yet critical breakthrough to dramatically improve advanced illness and end of life care in America.

As Executive Vice President for Advocacy and Health Quality, I greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Schoeberl", with a stylized flourish at the end.

Mark Alan Schoeberl
Executive Vice President, Advocacy & Health Quality
American Heart Association
7272 Greenville Avenue
Dallas, Texas 75231-4596
Tel: 214-706-1299
Cel: 214-684-1283
email: mark.schoeberl@heart.org



March 6, 2017

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 Ms. Page:

On behalf of the American Academy of Hospice and Palliative Medicine (AAHPM) and the Center to Advance Palliative Care (CAPC), we are pleased to provide the Physician-Focused Payment Model Technical Advisory Committee (PTAC) with feedback on the “Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model” as submitted by the Coalition to Transform Advanced Care (C-TAC). We share C-TAC’s belief that the current Medicare payment system raises significant barriers to better care for patients with serious illness, as well as C-TAC’s desire to develop better models of payment to overcome those barriers.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our core mission is to expand access of patients and families to high-quality palliative care and advance the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research and public policy. Our more than 5,000 members include not only physicians but 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 patients and caregivers that AAHPM members serve every day.

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, prognosis, or care setting, or state of the disease. We do this not only by providing the training, tools and technical assistance to clinicians and programs, but also by acting as a catalyst to change. Serving as a convening, organizing and dissemination force for the field, we collaborate with leaders, innovators and partners to foster connection and cross-fertilization.

On behalf of our organizations, we applaud C-TAC’s proposal to create a physician-focused payment model (PFPM) to support their Advanced Care Model (ACM). The proposal has many elements that we endorse, including: a patient-centered, community-based focus that prioritizes individual preferences; a foundation in comprehensive team-based care; an emphasis on advance care planning and shared

decision-making; 24/7 availability of support to address patient and caregiver needs; flexible payments to allow both responsiveness and innovation in care delivery models; and accountability for both quality and cost of care delivered to patients with advanced illness.

We also acknowledge the successes cited in C-TAC's proposal by some organizations which have successfully implemented ACM or similar models, as well as the other organizations that have expressed interest in ACM (Table 3 in the proposal) and/or provided letters of support. Many leaders and clinicians within these organizations are AAHPM members, and we offer our strong support for their success in delivering the best care possible to patients and their caregivers.

It is important to note that the organizations stating interest in C-TAC's ACM are generally large (800-34,000 physicians, with \$37M- \$64B in annual revenues) and are already either structured to manage significant financial risk (like health plans and integrated health systems), or they are participating in other risk-bearing demonstrations or arrangements (like Accountable Care Organizations or Shared Savings Programs). Their size, market position and experience with accountability may make them well suited to the proposed ACM model, in which participants become responsible for total cost of care in year one (with shared savings incentives) and then are required to move into two-sided risk in year two and beyond.

While CTAC's proposed PFPM may allow select providers to participate successfully, we note several barriers to participation by many other palliative care providers who provide care to patients throughout the course of serious illness:

- 1. Target Population.** The ACM model is focused on care for Medicare beneficiaries within the last 12 months of life. While this cohort must be included in any successful palliative care delivery and/or payment model, it excludes a critical population with significant unmet palliative care needs who are expected to survive more than a year. A recent robust analysis demonstrated that the majority of seriously ill older adults—identified by functional limitation, diagnosis severity and utilization—were not in the last year of life, and their 1-year mortality rate ranged from just 13 to 28 percent.¹ Other studies have found that among those patients that represent the top 5 percent of the U.S. population in terms of total health care spending, only 11 percent are in the last year of life.² These data do not discount the value of high-quality palliative care for patients in the last year of life; rather, they highlight the need to extend that care earlier in the course of serious illness. As a result, a successful PFPM for palliative care should support providers to meet patient and caregiver needs throughout the course of serious illness, not just in the last 12 months of life.
- 2. Level of Accountability.** As noted above, the proposed model requires that participants assume responsibility for both quality and total cost of care. This 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. In fact, C-TAC's proposal points out that interested organizations have already gained risk-sharing (and/or risk-bearing) experience within integrated health systems and/or Medicare Advantage plans, and we hope that these experiences can translate into success with traditional, fee-for-service Medicare populations.

¹ Kelley AS, et al. *HSR: Health Services Research* 52:1, Part 1 (Feb 2017); DOI: 10.1111/1475-6773.12479

² Institute of Medicine. 2015. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Appendix E, pp. 478–531. Washington, DC: The National Academies Press

We are concerned, however, that C-TAC's ACM proposal does not allow many other types of palliative care providers to participate, including many in smaller practices, highly competitive markets, rural areas, or those primarily participating in traditional Medicare, which continues to cover 70 percent of all beneficiaries. These providers often cannot assume accountability for total cost of care for many or most of the patients they serve, which would prevent them from successful participation in the proposed PFFM.

Excluding these diverse practices will not only limit the number of beneficiaries and caregivers able to benefit from potentially valuable services, but it will also limit the breadth of data and experience gained by participating palliative care providers. Including these diverse practices in any PFFM or demonstration will not only increase access to palliative care by Medicare beneficiaries, but also allow a richer analysis of a broader range of intervention that can better inform policymaking.

- 3. Payment Methodology.** C-TAC's ACM proposal suggests a wage-adjusted \$400 per-enrolled-beneficiary-per month (PEBPM) payment, with shared savings incentives in year one, followed by mandatory shared two-sided risk in years two and beyond. We support the concept of monthly payment for many palliative care services, as it allows palliative care teams flexibility in delivering interdisciplinary services to patients and families based upon their needs, as opposed to a traditional fee-for-service model. We also believe that some palliative care teams would be potentially well-supported by this payment methodology.

We are concerned, however, that a single PEBPM with a shared savings component moving quickly to two-sided risk will be neither feasible nor sustainable for many palliative care teams. First, many palliative care teams work in consultative and/or co-management roles with other providers who are primarily accountable for the cost and quality of care for their patients with serious illness. The proposed model would not provide a mechanism for those palliative care teams to work with other accountable providers to improve their performance on quality and cost. Rather, the single proposed PEBPM assumes that the palliative care team itself is taking full accountability for total cost of care, and is priced accordingly. As a result, there is no way to adjust payment to reflect variable intensities of service throughout the course of serious illness. The proposed model thus lacks a flexible mechanism to support palliative care providers to add value in consultative or co-management roles, particularly earlier in the course of illness.

Second, many more palliative providers will not be able to enter into two-sided risk in year two—as required by the proposal—given the abovementioned inability to take accountability for total cost of care. Even those providers in organizations and/or markets with the potential of taking “downside risk” would have difficulty doing so after just one year of participation. As a result, participation in the proposed PFFM would be limited to just the few programs already able to assume downside risk before entering the model. While these select providers may in fact deliver high-value palliative care under the proposed model, they are just one sector of diverse palliative care community that is ready to participate in new payment models.

Lastly, many providers will be unable to succeed in a shared savings model. Some lack control over substantial amounts of spending for their patients, while others practice in regions or markets where care is already efficient and costs are lower, providing little opportunity for savings. Still others will find it difficult to invest in the capacity necessary to participate in a model that allows them to keep only part of the savings they generate.

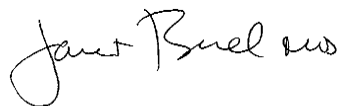
In summary, AAHPM and CAPC believe that the PFFM proposed by C-TAC to support their Advanced Care Model (ACM) is thoughtfully constructed and emphasizes many key aspects of high-quality care for patients with serious illness. C-TAC's proposed PFFM may successfully support the select palliative care providers who have the size, scope and market position to implement it to serve the portion of the seriously ill population within the last 12 months of life. However, truly successful PFFMs for palliative care must also support participation by palliative care teams of all sizes, working in diverse markets and diverse relationships to other providers, which CTAC's model does not allow. This flexibility in payment models is essential to support personalized, high-quality, interdisciplinary palliative care to the largest possible number of Medicare beneficiaries and their caregivers, from diagnosis with serious illness through end of life.

In the coming days, AAHPM will submit a letter of intent (LOI) to PTAC regarding our proposal for Payment Reforms to Improve Care for Patients with Serious Illness. Our proposed portfolio of payment models is designed to be flexible and offer multiple options for participation, and thus maximize access to high-value palliative care services for Medicare beneficiaries. This flexibility is achieved through mechanisms that enable palliative care teams to partner with other accountable providers, as well as through tiered payment structures that allow intensity of palliative care services to meet the changing needs of individual beneficiaries throughout their course of serious illness.


It is important to note that AAHPM's proposal also includes full-risk options that would enable successful participation by organizations implementing C-TAC's ACM model, while also providing critical opportunities for many more palliative care teams to participate in different markets and in different collaborations with accountable providers.

AAHPM and CAPC very much appreciate the opportunity to provide these comments, as well as PTAC's work to evaluate proposals for new care and payment solutions to overcome barriers to better care for Medicare beneficiaries. Our organizations stand ready to work with you and others to develop and implement such solutions for Medicare beneficiaries with serious illness, as well as their caregivers. Please direct questions or requests for additional information related to these comments to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841, and Allison Silvers, CAPC Vice President of Payment and Policy at allison.silvers@mssm.edu or 212-824-9572.

Sincerely,



Janet Bull, MD MBA HMDC FAAHPM
President
American Academy of Hospice and Palliative Medicine



Diane E. Meier, MD FACP FAAHPM
Director
Center to Advance Palliative Care