

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on

Patient and Caregiver Support for Serious Illness (PACSSI)

Submitted by American Academy of Hospice and Palliative Medicine (AAHPM)

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March 26, 2018

Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- PRT Evaluation Using the Secretary's Criteria
- Key Issues Identified by the PRT

Preliminary Review Team (PRT) Composition and Role

- PTAC Chair/Vice Chair assigns two to three PTAC members who have no conflicts of interest (including at least one physician) to serve as the PRT for each complete proposal. One PRT member is selected to serve as Lead Reviewer.
- PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- After reviewing the proposal, additional information provided by the submitter, information from other materials gathered, and public comments received, the PRT rates the proposal on each of the Secretary's criteria and prepares a report of its findings to the full PTAC. The report is posted to the ASPE PTAC website at least three weeks prior to public deliberation by the full Committee.
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Proposal Overview

- Five-year demonstration of payment for palliative care services for beneficiaries with:
 1. Serious, potentially life-limiting illnesses; or
 2. Multiple chronic conditions with functional limitations
- Participating beneficiaries must meet detailed diagnostic, functional status, and healthcare utilization criteria in one of two clinical complexity “Tiers”
- Payment includes:
 - Two different tier-based monthly care management payments
 - Two different financial incentive tracks

Proposal Overview: Tier 1 Beneficiary Eligibility Criteria

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

Proposal Overview: Tier 2 Beneficiary Eligibility Criteria

Tier	Diagnosis of Serious Illness	Functional Status	Health Care Utilization
Tier 2: High Complexity	Same as Tier 1, excluding dementia as the primary illness	<p>Criteria for Non-Cancer Diagnosis: PPS of $\leq 50\%$ or ≥ 2 ADL limitations</p> <p>Criteria for Cancer Diagnosis: PPS of $\leq 60\%$ OR: ECOG ≥ 3 OR: ≥ 2 ADL limitations</p>	<p>Inpatient hospitalization in past 12 months AND one of the following:</p> <ul style="list-style-type: none"> - ED visit - Observation stay - Second hospitalization <p>Note: This criterion may be waived under certain circumstances.</p>

Proposal Overview - Care Model

➤ **Palliative care services to include:**

- Comprehensive interdisciplinary assessment (physical, psychological, social, spiritual, cultural, end of life, ethical, legal);
- Health care history, physical exam, medical decision-making, and prescription of medications;
- Care management:
 - care plan developed with input from all patient's providers;
 - services arranged from other providers (e.g., DME, PT/ST/OT, home health);
 - ongoing communication with other providers to ensure care delivery consistent with care plan;
- Patient and caregiver education, and psychosocial and spiritual care;
- Referral to other programs; e.g., Meals-on-Wheels, adult day care, Medicaid and transportation;
- 24/7 response to patient/caregiver requests for advice/assistance in managing conditions, functional limitations;
- Visits to patient in all sites of care (home, hospital, nursing home, etc.) as needed.

➤ **Services delivered by Palliative Care Teams (PCTs)** which must include a physician, nurse, social worker, and spiritual care provider. Other members (e.g., APRNs, physician assistants, pharmacists, counselors) self-determined by the PCT “as necessary and appropriate to address the needs of the local patient community.”

➤ **Certification.** One core interdisciplinary team member must be certified in palliative care.

Proposal Overview: Payment

- PCTs are the APM entities and receive payment for palliative care services.
- PCTs can be independent provider organizations or PCTs associated with hospices, home health organizations, hospitals, businesses focused on palliative care delivery, or integrated health systems.
- Payment differs according to the two different “Tiers” of patients and two different incentive “Tracks.”

Proposal Overview Payment (cont.):

➤ **Two different tier-based monthly care management payments:**

- In Year 1: Tier 1 base payment = \$400 per beneficiary per month (PBPM); Tier 2 = \$650 PBPM.
- Base payments adjusted up or down based on Geographic Practice Cost Indices used to adjust Work RVUs of Medicare PFS.
- Facility-based patient payments reduced by 20% to reflect lower costs due to services otherwise provided by facilities.
- Base payments increase annually based on annual increase in PFS conversion factor.

➤ **PBPM payments replace E/M payments to PCTs.** Providers not part of a PCT can continue to receive E/M and other Medicare payments, but cannot bill for Chronic Care Management (CCM) or Complex CCM codes.

➤ **Two different financial incentive tracks:**

- Track 1: PCTs subject to positive and negative incentives of up to 4% of total PBPM payments received for the year. Based on performance on quality and spending in a year, Track 1 PCTs receive a lump sum payment, break even, or return funds to Medicare.
- Track 2 (voluntary track available in Year 3): Practices take on shared risk and savings based on Total Cost of Care:
 - Risk based on spending above a risk-adjusted benchmark, but limited to lesser of 3% of a TCoC benchmark or 8% of each PCT's total Medicare A and B revenues.
 - Shared savings based on spending below the benchmark and capped at 20% of the TCoC benchmark. Mechanisms such as outlier provisions and risk corridors would provide protections against catastrophic losses.
 - PCTs' eligibility for and extent of savings or risk depend on performance on quality measures.

Quality standards for participation and payment

- **Minimum participation standards.** PCTs must:
 1. Have written care plan approved by the patient by end of first month of service;
 2. Document that patient is assessed and has characteristics required for eligibility and assigned payment category;
 3. Have at least one face-to-face visit with each patient monthly. “Face-to-face visits . . . may be provided virtually;”
 4. Maintain documentation that it responded to all telephone calls from patients; and
 5. Participate in a PACSSI Learning Collaborative.
- **For Years 1 and 2, PCTs required to report only** (payment not tied to performance) on 15 measures of: satisfaction with care, communication, timeliness of care, adequacy of treatment for pain and symptoms, certain care processes, percent of patients who died receiving hospice care, and percent who died without any ICU days during the 30 days before death.
- **For Year 3, PCTs accountable for quality performance.** Payment based on a composite quality performance score that equally weights performance across: 1) patient/proxy-reported experiences with care; 2) PCT completion of certain care processes; and 3) patient utilization of hospice and ICU services at end of life.

Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets criterion and deserves priority consideration	Unanimous
2. Quality and Cost (High Priority)	Does not meet criterion	Unanimous
3. Payment Methodology (High Priority)	Does not meet criterion	Unanimous
4. Value over Volume	Meets criterion	Unanimous
5. Flexibility	Meets criterion	Unanimous
6. Ability to be Evaluated	Meets criterion	Unanimous
7. Integration and Care Coordination	Meets criterion	Unanimous
8. Patient Choice	Meets criterion	Unanimous
9. Patient Safety	Meets criterion	Unanimous
10. Health Information Technology	Meets criterion	Majority

Criterion 1. Scope (High Priority). Proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

PRT Conclusion: Proposal meets the Criterion and deserves priority consideration

- Experts recommend palliative care be offered independent of patient prognosis, beginning with diagnosis of serious illness and provided simultaneously with life-prolonging and curative therapies for persons with serious, complex, and life-threatening illness.
- In contrast, the Medicare hospice benefit and Medicare Care Choices Demonstration (MCCD) only provide payment for comprehensive palliative care to individuals certified as being in the last six months of life. The hospice benefit further requires participants to forego curative care, and the MCCD is only available to beneficiaries with advanced cancers, COPD, CHF, and HIV/AIDS.
- Evidence shows that palliative care services can improve patient experience, quality of care, and quality of life for patients with many different types of serious illness and reduce costs by eliminating avoidable or unnecessary care.
- Analyses commissioned by the PRT show that > 9 million Medicare beneficiaries have one or more of the diagnoses targeted in this proposed model. A significant proportion of these are likely to meet the additional functional and utilization criteria in the model to identify an appropriate population for palliative care services. This demonstrates significant unmet need despite existing models.
- PRT agrees that palliative care should be a more widely available Medicare benefit—available to individuals not yet eligible or willing to enroll in the hospice benefit, but who have one or more serious illnesses or multiple chronic conditions and could benefit from the provision of palliative care.

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

Criterion 2. Quality and Cost (High Priority). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Conclusion: Proposal does not meet the Criterion

PRT has significant concerns about how quality is measured and monitored. Similar concerns were expressed in some public comments:

1. Insufficient outcome measures. Model proposes only two outcome measures (“adequacy of treatment for pain and symptoms” and help with “pain” and “trouble breathing”). Need for more robust outcome measures; e.g., NIH 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.

2. Timing of measurement. Measurement limited to “front” and “back” end of service; i.e., through an “admission survey,” “completion of activities within 15 days of enrollment,” and “after death.” Measures do not assess care during the greatest portion of beneficiary enrollment. “Post-death” measures are also at risk for confounding because: “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.”

3. Insufficient utilization measures. Of the three proposed utilization measures, two address hospice utilization and one addresses ICU days. All measures include only enrollees who died. There are no reliable benchmarks for these utilization measures, and there is risk of unintended consequences when attempting to reward cost reduction from decreased utilization.

4. Potential variation in PCTs and minimal standard for contact with beneficiaries. Proposal states, “At a minimum, one of the core interdisciplinary team members must have certification in palliative care to support specialty level practice.” Because 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 provider type has the certification. 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 also were not discussed.

Criterion 2. Quality and Cost (High Priority) (cont.)

Concerns about how payment methodology would calculate, achieve, and reward savings:

- 1. Potential susceptibility to bias** in beneficiary enrollment decisions; and potential to incentivize enrollment of patients expected to be lower cost. Interaction between this model and hospice care also likely to be significant; and cost estimates might be unduly influenced when the APM entity is a hospice. Decisions concerning patient admission to hospice will affect both model and hospice revenue and costs.
- 2. Risk of “Upcoding” patients.** Higher monthly payment for “Tier 2” patients (\$650 v. \$400) incentivizes assigning beneficiaries to “High Complexity Tier” and (palliative care consultant stated performance on functional scales can fluctuate day-to-day).
- 3. No specifics on how spending benchmarks and risk adjustment to be calculated and no minimum savings or loss rate before risk sharing starts.** “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.”
- 4. Lack of a confidence interval around savings or loss threshold.** Typically, payment rewards or penalties are incurred when costs exceed a benchmark by some degree. Model would also share a higher portion of savings or loss in the first five percentage points than it does after savings or losses exceed 5%—inverted from how most Medicare models are set up. Model would pay more for random small gains or losses.
- 5. Proposed risk sharing is asymmetric, favoring savings over losses;** i.e., in Track 2 the maximum “downside” risk is 3% of benchmark but the maximum financial reward is 20% of benchmark. At high quality scores, marginal loss sharing is between 30-40% while savings are shared at 70-80%.

Criterion 3. Payment Methodology (High Priority). 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 PFPM cannot be tested under current payment methodologies.

PRT Conclusion: Proposal does not meet the Criterion

Many of the concerns for Criterion 2 are a function of the payment methodology – and are why the PRT finds the model also does not meet Criterion 3:

1. The narrow dividing line between Tier 1 and Tier 2 payments means that patients could easily be scored into Tier 2. Related, no data was given for how the \$400 and \$650 per month management fees were derived.
2. The payment methodology lacks confidence intervals around benchmarks for payment, providing no mechanism to account for random variation.
3. The payment methodology is inverted; i.e., would pay more for smaller gains compared to benchmarks and less for greater accomplishments. This may inadvertently discourage providers from focusing on reducing total cost of care.
4. In 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.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion: Proposal meets the Criterion

- 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.

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

PRT Conclusion: Proposal meets the Criterion

- 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.

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

PRT Conclusion: Proposal meets the Criterion

1. The PRT again noted 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.
2. Additional concern is that it would be difficult to build valid comparison groups because of the potential for enrollment bias previously discussed and varying eligibility criteria, and because much of the information in the "Functional Status" eligibility criteria would not be contained in administrative datasets.
3. The lack of confidence intervals around benchmarks for payment also would make evaluation difficult. However, the PRT took note of the two-year benchmarking period and viewed this as an opportunity to address concerns such as around confidence intervals.

The PRT grappled with the extent to which the PACSSI model meets this criterion and 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.

PRT Conclusion: Proposal meets the Criterion

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.

PRT Conclusion: Proposal meets the Criterion

Concerns:

- Proposal emphasizes “process” as opposed to “outcome” measures, and provides limited evaluation of patient experience or patient reported outcomes.
- Many enrollees may have long periods of survival. The proposed measures (with attention to the “front’ and “back” end of enrollment) may not call attention to the unique needs and preferences of individual patients throughout enrollment.
- Public comments also called for the proposed model to be more patient- and family-centered with respect to care planning and shared decision-making by:
 1. Requiring greater involvement of patients and caregivers in developing and executing care plans
 2. Incorporating shared decision-making into the proposed palliative care services and quality metrics.

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

Criterion 9. Patient Safety. How well does the proposal aim to maintain or improve standards of patient safety?

PRT Conclusion: Proposal meets the Criterion

- 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) do aim to improve standards of patient safety.

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

PRT Conclusion: Proposal meets the Criterion

- Health Information Technology (HIT) will be used to facilitate service delivery, monitoring, data capture, and data exchange, and to support remote telemonitoring services to provide care on a 24/7 basis.
- Care teams required to electronically report quality data through one of the submission methods currently used in 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 to meet this criterion because this proposed model fundamentally requires information to be shared across multiple providers and practice settings, but the proposal does not discuss if or how HIT will be used to accomplish this.

Additionally, public comments called attention to the following uses 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; and
- Allowing response on a 24/7 basis to requests for information and assistance from the patient or caregiver or from providers who are caring from the patient (including but not limited to telephone calls, secure emails, patient portal messages, electronic alerts).

Key Issues Identified by the PRT

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 several key concerns about the proposed model.

1. Model is overly complex, having multiple paths to eligibility with two tiers of eligibility, and two different payment tracks.
2. The proposed model's approach to quality assurance and measurement, including:
 - 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.

Key Issues Identified by the PRT (cont.)

3. With respect to payment methodology, PRT concerned about:

- Narrow dividing line between Tier 1 and Tier 2 payments, and the ease with which patients could be scored into Tier 2.
- Absence of confidence intervals around benchmarks for payment provides no mechanism for accounting for random variation.
- 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.
- Methodology would pay more for smaller gains compared to benchmarks and pay 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% – inverted from how most Medicare models set up.
- Proposed risk sharing is asymmetric, favoring savings over losses.

Questions?

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on **Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model**

Submitted by the Coalition to Transform Advanced Care (C-TAC)

Bruce Steinwald, MBA (Lead Reviewer)
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Proposal Overview

- Payment for palliative care services to Medicare beneficiaries in last 12 months of life (beneficiaries who meet at least 2 of 4 criteria 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
2 hospitalizations in the last 12 months OR 1 emergency room (ER) visit and 1 hospitalization in the last 6 months OR 2 ER visits in the last 3 months	New, irreversible dependence in at least 1 Activity of Daily Living (ADL) in the last 3 months	Involuntary lean body weight loss of $\geq 5\%$ in the last 3 months	Performance on the Palliative Performance Status (PPS) scale of ≤ 60 OR Performance on the Karnofsky Performance Scale (KPS) of ≤ 60 OR Performance on the Eastern Cooperative Oncology Group (ECOG) Performance Status scale of ≥ 3

- Additional screening question of “Would you not be surprised if the patient died in the next twelve months?” must be answered in the affirmative.

Proposal Overview cont.

➤ Covered services:

1. **Palliative/comfort-based care and promotion of evidence-based, disease-modifying treatments** that align with patient's personal preferences;
2. **Comprehensive care coordination and case management** of beneficiary's total healthcare needs (curative and palliative) and services including physician, hospital, post-acute care, and social services;
3. **Advanced 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.**

➤ Services continue until beneficiary dies, enrolls in hospice, disenrolls or moves out of the ACM service area.

Proposal Overview cont.

➤ Services delivered by:

1. **An ACM care team** that includes a Registered Nurse (RN), licensed social worker, and 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:
 - a. May include primary care and specialty providers involved in patients' care.
 - b. Commit to identifying patients for enrollment in the ACM and ACM quality goals;
 - c. Agree that their enrolled patient population will be attributed to the ACM;
 - d. May participate in additional payment of shared risk from the ACM, by establishing arrangements with the ACM Entity; and
 - e. May clinically integrate with the ACM Entity.

Proposal Overview: Payment

Payments made to ACM Entities (physician practices, hospitals, accountable care organizations (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 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.

Proposal Overview: Payment (cont.)

Payment includes:

- 1. Wage-adjusted \$400 Per Member Per Month (PMPM) payments of indefinite duration.** The “episode” is defined as the total cost of care (TCoC) for the last 12 months of life, as long as a PMPM was paid for at least one of these months, and regardless of how many months the beneficiary was enrolled in the ACM program; e.g.,
 - 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.
 - If a beneficiary disenrolls in the third month 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.

All PMPM payments (including those in excess of 12 months) are all included in the episode costs.

- 2. Bonus payments or shared losses based on TCoC for last 12 months of life.** A 4% minimum shared savings/loss rate; i.e., bonus payments would trigger only if savings is at least 4% of a risk-adjusted, TCoC spending target; shared losses would trigger only if excess spending is at least 4% 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.

Proposal Overview: Payment (cont.)

3. **Quality bonus payments** (funded by savings) with 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** 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. **A remediation period** for low quality performers or when expenditures are significantly higher than expected. An ACM Entity would 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.**

Quality Measures and Monitoring

- **13 measures determine bonuses in first two years.** Measurement at one month after admission (or earlier) and after discharge/end of the episode, of:
 - 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.
- **Quality monitoring program operated by CMS** would analyze for outliers in areas such as: all-cause unplanned admissions, ambulatory sensitive conditions, hospice enrollment, and enrollees with > 12 months enrollment.
- **A yearly operational plan** must be submitted by each ACM Entity that shows: participating providers and contractors; how ACM services are to be provided and care guidelines; staffing plan & training; patient identification and notification process; and plans for performance management, physician engagement, risks and barriers mitigation, and financial risk management.
- **Outlier ACM Entities** in one or more areas and with below average performance receive an audit and remediation period. ACM Entity required to leave the program if positive trend not achieved within 6 months and significant improvement within a year.

Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR§414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets criterion and deserves priority consideration	Unanimous
2. Quality and Cost (High Priority)	Meets criterion	Unanimous
3. Payment Methodology (High Priority)	Meets criterion	Unanimous
4. Value over Volume	Meets criterion	Unanimous
5. Flexibility	Meets criterion	Unanimous
6. Ability to be Evaluated	Meets criterion	Unanimous
7. Integration and Care Coordination	Meets criterion and deserves priority consideration	Unanimous
8. Patient Choice	Meets criterion	Unanimous
9. Patient Safety	Meets criterion	Unanimous
10. Health Information Technology	Meets criterion	Unanimous

Criterion 1. Scope (High Priority). Proposal aims to broaden or expand CMS' APM portfolio by either: (1) addressing an issue in payment policy in a new way, or (2) including APM Entities whose opportunities to participate in APMs have been limited.

PRT Conclusion: Proposal meets Criterion and deserves priority consideration

- PRT agrees with proposed model that palliative care should be a more widely available Medicare benefit—available to individuals not eligible or willing to enroll in hospice.
- Medicare payment policy and CMS' APM portfolio do not adequately provide for palliative care:
 - Although the hospice benefit and Medicare Care Choices Demonstration provide for 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 requires participants to forego curative care in order to receive hospice services; and
 - Medicare Care Choices Demonstration only available to beneficiaries with certain diagnoses: advanced cancers, chronic obstructive pulmonary disease, congestive heart failure and HIV/AIDS.

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

Criterion 2. Quality and Cost (High Priority). The proposal is anticipated to (1) improve health care quality at no additional cost, (2) maintain health care quality while decreasing cost, or (3) both improve health care quality and decrease cost.

PRT Conclusion: Proposal meets Criterion

With respect to Quality: Revised proposal an improvement over initial ACM proposal, containing several new proposed quality measures (medication reconciliation post hospital discharge, three new measures of effective communication, and a measure of caregiver support for field-testing). PRT concerns are:

- **Timing of measurement.** Measurement limited to “front” and “back” end of service; i.e., at the first month of enrollment or sooner, and after discharge or end of the episode. Measures would not obtain patient evaluation of care provided during the greatest portion of enrollment.
- **Insufficient utilization measures.** Two proposed utilization measures address hospice utilization of three days or more and admission to the ICU in last 30 days of life. Both address only enrollees who die. Broader utilization measures are needed; e.g., proposal calls for CMS to monitor “All-cause unplanned admissions for ACM beneficiaries” and ambulatory sensitive conditions. These or similar measures are not proposed as part of the pay-for-quality measures. Further, there are no reliable benchmarks for the two utilization measures and a risk of unintended consequences because patient utilization can appropriately vary from an established benchmark.
- **Need for greater use of measures of health outcome and shared decision-making.**
- **No minimal standard for contact with beneficiaries**
- **“Minimum Quality Standard Measure”** (i.e., ACM provider “YES” / “NO” attestation that patient’s care plan is consistent with preferences) perhaps too minimal.

Criterion 2. Quality and Cost (High Priority) cont.

With respect to “Cost,” concerns are:

- **Potential for enrollment bias** from participants targeting more favorable risk populations and from enrollment choices made by beneficiaries who happen to be engaged by participants.
- **Only a portion of the enrolled population is annually governed by a given year’s risk arrangement** because although 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.
- **Episode regression approach proposed for determining spending targets** appears to only calculate savings or losses for beneficiaries who happened to die in the given year’s performance period, which means that a portion of the fees and spending are not included in that year’s risk-sharing calculations.

Criterion 3. Payment Methodology (High Priority). 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 PFPM cannot be tested under current payment methodologies.

PRT Conclusion: Proposal meets Criterion — with five caveats:

- 1. Concern about holding APM Entities accountable for total cost of care for enrollees' last 12 months of life, even when enrollees not enrolled in the model for some or majority of these months; e.g.,**
 - If a beneficiary enrolls in the model, disenrolls in the third month to enroll in hospice, and then dies nine months later, all costs for the last 12 months of life will be included in the entity's episode costs, even though the patient disenrolled after the third month.
 - 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.

PRT is concerned about the validity and fairness of holding providers accountable for periods of time in which they are not involved in enrollees' care.

- 2. Concern about the episode regression approach** as discussed under Criterion 2. The proposed episode regression approach for determining spending targets appears to only calculate savings or losses for beneficiaries who die in the performance period, which means a large portion of the fees and spending remains unmanaged from a risk-sharing standpoint.

Criterion 3. Payment Methodology (cont.)

Caveats (cont.):

- 3. Concern about role of hospices.** In the model, hospices can be both APM Entity providing palliative care and participating in shared savings, and a hospice to which the APM Entities' enrollees are discharged. The 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.
- 4. 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.
- 5. Large fee with skewed risk sharing and limited downside risk increases chance that overall model would increase spending.** 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 die in the performance period. Thus, only a fraction of the \$100 is at risk over the whole enrolled population. Also, sharing of savings is very aggressive, up to 100% after a 4% threshold is met, whereas loss sharing tops out at 60% after the same 4% threshold is exceeded on the downside.

Criterion 4. Value over Volume. The proposal is anticipated to provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion: Proposal meets Criterion

- **Incentives to APM:** Financial incentives to ACM Entities to deliver high quality care through PMPM reimbursement and potential quality bonuses.
- **Incentives to practitioners:** Participating PCPs / specialists:
 - Can access the Quality Payment Program (QPP) APM incentives
 - May participate in additional payment or shared risk from the ACM APM, by establishing arrangement(s) with the ACM Entity.
- **Non-financial incentives focusing on the interdisciplinary team:** Enable “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. . . A survey of physicians using the ACM showed that over $\frac{3}{4}$ reported that the intervention reduced their workload.”

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

PRT Conclusion: Proposal meets Criterion

The proposed model is designed to be flexible in several ways:

1. ACM model is designed to care for patients with a broad range of advanced illness (cancer and non-cancer) as well as geriatric frailty in rural or metropolitan areas.
2. Model 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.
3. Model proposes a consortium structure to support aggregation of small physician practices to achieve necessary volume.
4. ACM Entities would have flexibility over how they organize the entity and distribute payments among participating providers and contractors.
5. Various mechanisms are proposed for ACM implementation including: (1) as a stand-alone APM, (2) as part of the Medicare Shared Savings Program, 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 PFPM.

PRT Conclusion: Proposal meets Criterion

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,
- (5) reducing 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.

1 – 4 to be evaluated through provider reporting and beneficiary and family caregiver surveys. Performance targets will be set over time for use by Year 3.

5 – 8 can be evaluated through use of claims data compared to a risk-adjusted standard.

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.

PRT Conclusion: Proposal meets Criterion and deserves priority consideration

Proposal: “A core function of the ACM is to ensure . . . explicit and well-documented care plans . . . in place for all beneficiaries, and to reconcile all input from PCPs, specialists and hospitalists . . . into a single plan of care that is easily understood by patients, family members and caregivers . . . This unified care plan is . . . transmitted to all involved clinicians . . . across inpatient, ambulatory, home and long-term care settings.” Proposal identifies 14 care coordination processes; e.g.,

- Interdisciplinary team visits
- Providing comprehensive transitional and post-acute care
- Establishing efficient and reliable handoff processes among teams & settings
- Facilitating advance care planning over time, at the patient’s own pace, in all settings
- Employing standardized, proactive telemanagement procedures
- Assuring adequate family and caregiver support
- Integrating facility and community social services into the clinical workflow
- Engaging principal primary and specialty physicians as core members of the clinical team
- Helping patient and family navigate among disparate providers
- Optimizing EHR as a reliable communications channel among clinical settings

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.

PRT Conclusion: Proposal meets Criterion.

Despite the advantages for patient choice inherent in the model's Integration and Care Coordination criterion, the PRT had some concerns about the use of predicted prognosis as an eligibility criterion in the model:

- The model's approach to communicating prognosis may not be sufficiently patient-centered, could have unintended adverse consequences for some patients, and thereby might 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. Some 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. How well does the proposal aim to maintain or improve standards of patient safety?

PRT Conclusion: Proposal meets Criterion

PRT found:

- The model's provision of home-based care would allow ACM teams to assess and manage 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.
- 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.

PRT Conclusion: Proposal meets Criterion.

PRT concluded this on the basis of:

- The 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.

Key Issues Identified by the PRT

- PRT's most positive observations on the proposal derive from the needs of the target population; e.g., Medicare beneficiaries with advanced progressive illness not eligible for hospice care.
- Integrating curative services paid for by traditional FFS with patient-centered palliative care covered by a PBPM payment can improve patient experience of care and conserve resources.
- PRT generally found that the payment methodology incentives, including shared savings and risk sharing incentive for providers, are congruent with the model's coordinated-care objectives.
- Improvements in the current model (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.

Key Issues Identified by the PRT (cont.)

PRT retains a number of reservations about the model, as described on prior slides. For example:

- 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.

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

Questions?

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Review Team Findings on **Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home**

Submitted by Personalized Recovery Care, LLC

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March 26, 2018

Presentation Overview

- Preliminary Review Team (PRT) Composition and Role
- Proposal Overview
- Summary of the PRT Review
- Key Issues Identified by the PRT
- PRT Evaluation Using the Secretary's Criteria

Preliminary Review Team Composition and Role

- The PTAC Chair/Vice Chair assigns three PTAC members, including at least one physician, to each complete proposal to serve as the PRT. One PRT member is assigned to serve as the Lead Reviewer.
- The PRT identifies additional information needed from the submitter and determines to what extent any additional resources and/or analyses are needed for the review. ASPE staff and contractors support the PRT in obtaining these additional materials.
- After reviewing the proposal, additional materials gathered, and public comments received, the PRT prepares a report of its findings to the full PTAC. The report is posted to the ASPE PTAC website three weeks prior to public deliberation by the full Committee.
- The PRT report is not binding on PTAC; PTAC may reach different conclusions from that contained in the PRT report.

Proposal Overview

The PRC Home Hospitalization Alternative Payment Model (PRC HH-APM) would provide new payments designed to allow Medicare beneficiaries, who would otherwise require inpatient hospitalization, to receive hospital-level acute care services in the home plus post-acute services.

Eligible Patients:

- Diagnosed with one or more acute or chronic health conditions encompassing more than 150 MS-DRGs;
- Meet clinical criteria for an inpatient admission;
- Could safely receive care at home instead of in the hospital, based on an assessment of their specific clinical conditions and home environment prior to admission; and
- Agree to accept care in the home instead of in the hospital.

30 Days of Services Supported by Home Hospitalization Payment:

- **Acute care phase:**
 - Admitting physician has telehealth visits with the patient at least daily
 - Registered nurse visits the patient's home at least twice daily
 - 24/7 phone response by a Recovery Care Coordinator (who would be a registered nurse)
 - 24/7 on-call physician access
 - Could begin episode in a Skilled Nursing Facility (SNF) rather than the patient's home
- **Post-acute care phase:**
 - Recovery Care Coordinator monitors and coordinates the patient's care under the model payment

Services Supported by Standard Medicare Payments:

- Acute care phase: Infusion, therapy, medical equipment, lab tests, imaging, specialist visits, etc.
- Post-acute phase: Primary care visits, specialist visits, home health services, etc.

Proposal Overview (continued)

Payment to Support PRC-HH Participants is Made in Two Parts:

- **A Bundled Home Hospitalization Payment**, equal to 70% of the MS-DRG payment for which a hospital would have been eligible under the Medicare Inpatient Prospective Payment System (IPPS) had the patient been admitted for inpatient care.
- **A Performance-Based Payment** based on:
 - a) The difference between the total actual spending (during the 30 day period beginning with the patient's admission to acute [hospital-level] care at home) and a "Target Bundled Rate" equal to 97% of the "Benchmark Rate," which is the average 30-day Medicare spending for the subset of patients who had been discharged from hospitals under the same MS-DRG and would have been eligible for home hospitalization.
 - If total actual Medicare spending exceeds the Target Bundled Rate, the APM participant will be responsible for paying Medicare the difference or 10% of the Benchmark Rate, whichever is less.
 - If total actual Medicare spending is below the Target Bundled rate, the participant would be eligible to receive an additional payment up to the difference or 10% of the Benchmark Rate, whichever is less.
 - b) The participant's performance on five quality measures. The maximum payment calculated based on actual spending compared to the Target Bundled Rate would be reduced by 20% for each of the five quality measures where the performance standard was not met.

Summary of the PRT Review

Criteria Specified by the Secretary (at 42 CFR §414.1465)	PRT Conclusion	Unanimous or Majority Conclusion
1. Scope (High Priority)	Meets criterion	Unanimous
2. Quality and Cost (High Priority)	Meets criterion	Unanimous
3. Payment Methodology (High Priority)	Meets criterion	Unanimous
4. Value over Volume	Meets criterion	Unanimous
5. Flexibility	Meets criterion	Unanimous
6. Ability to be Evaluated	Meets criterion	Unanimous
7. Integration and Care Coordination	Meets criterion	Unanimous
8. Patient Choice	Meets criterion	Unanimous
9. Patient Safety	Does not meet criterion	Unanimous
10. Health Information Technology	Meets criterion	Unanimous

Comparison of PRC-HH APM and Mt. Sinai HaH-Plus APM

Dimension	PRC HH-APM	HaH-Plus APM
Patient Eligibility	Patients in over 150 MS-DRGs	Patients in approximately 50 MS-DRGs
Episode Length	30 days following the date of admission to home hospitalization	Length of home-based acute care plus 30 days following the date of discharge from acute care
Amount of Bundled Payment	70% of the MS-DRG payment under the IPPS	95% of the MS-DRG payment under the IPPS plus average professional fees billed during an inpatient admission
Payment for Ancillary Services During Acute Phase	Would be billed directly to Medicare for payment under existing payment systems	Would be supported through the bundled payment, not billed directly to Medicare

Key Issues Identified by the PRT

- The PRT found there were many similarities between the PRC HH-APM and the Hospital at Home Plus (HaH-Plus) proposal that PTAC recommended in September 2017. The PRT believes that most of the same strengths and weaknesses PTAC found with the HaH-Plus model also apply to the PRC HH-APM.
- The PRT felt that the broader range of eligible patients in the PRC HH-APM model compared to HaH-Plus, and the ability to have ancillary services billed directly to Medicare under the PRC HH-APM, could:
 - potentially enable smaller physician practices to participate in the PRC HH-APM model, but also
 - increase the kinds of safety risks for patients and financial risks for providers that PTAC had identified with respect to the HaH-Plus model. The PRT believes that these issues could be addressed through enhancements and modifications to the service delivery standards, patient eligibility requirements, quality measures, and payment methodology described in the PRC HH-APM proposal, while preserving the basic care model and payment model that the applicants proposed. Some of the modifications to the HaH-Plus model that were suggested by PTAC would also be applicable to the PRC HH-APM.
- In addition, the PRT felt that it could be desirable for providers participating in the PRC HH-APM to focus initially on patients in a narrower range of MS-DRGs and phase in services to a broader range of patients over time, and the PRT suggests that adjustments to the payment amounts and risk levels should be considered to allow this phased approach.
- In its review of the HaH-Plus proposal, PTAC concluded there is a need for Medicare to create a payment model to support home-based hospital-level acute care for appropriate patients. On balance, the PRT felt that with refinements to address the issues it identified, the PRC HH-APM would merit implementation.

Criterion 1. Scope (High Priority)

Criterion Description

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.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- No other CMS APMs are specifically designed to provide a home-based alternative for patients requiring inpatient-level care at the point when they are facing a hospital admission or observation stay.
- The ability to deliver ancillary services in the home using existing providers and payment systems could facilitate the ability of small providers to participate compared to the HaH-Plus APM recommended by PTAC in 2017.

Weaknesses:

- A minimum volume of patients is needed for financial viability, which could make it difficult to implement in small and rural communities. Although the wide range of patients who would be eligible would help to increase the volume of patients served, it could be difficult for small primary care or multi-specialty practices to safely deliver home hospitalization services to such a wide range of patients.
- The PRC HH-APM may be attractive to accountable care organizations (ACOs) seeking methods of paying for community-based alternatives to hospital care.

Summary of Rating:

- The proposed PFPM meets the criterion because the proposed services and eligible patients are significantly different from what is currently supported under standard Medicare payments and other APMs. Although the need to have a minimum number of patients for financial viability could limit the number of communities where the services could be implemented, the broad and flexible eligibility criteria could reduce the likelihood that the model would only be implemented in large communities. However, it could also be more difficult for smaller practices to serve patients with such a wide range of clinical needs, particularly initially.

Criterion 2. Quality and Cost (High Priority)

Criterion Description

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.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Multiple studies have shown that home hospitalization programs achieve better outcomes at lower costs than traditional hospitalization for eligible patients, although the programs evaluated previously had narrower eligibility criteria than the PRC HH-APM.
- The PRC HH-APM is specifically designed to deliver care for inpatient-eligible patients at a cost below normal Medicare payment amounts for inpatient care.
- The model discourages cost-shifting from the acute phase to the post-discharge phase and encourages coordination of care by using the same providers throughout the 30 day period.

Weaknesses:

- Although providing care to patients in the home should reduce hospital-associated morbidity (and associated costs), home care can have risks for patients if they are not carefully selected.
- The need for an adequate number of patients to cover costs could encourage admitting patients who cannot be cared for safely in the home.
- The review process for adverse events currently described in the proposal provides only limited assurances regarding the quality of care.
- The performance-based payment methodology does not adjust for the fact that eligible patients would likely have lower-than-average post-acute care costs.

Summary of Rating:

- The proposed PFPM meets the criterion. Multiple studies have demonstrated that the Hospital at Home care model improves quality and reduces costs, and the proposed PFPM seeks to improve quality of care for patients while reducing costs to Medicare. However, the PRT believes the payment model would benefit from modifications to ensure patient selection is based on clinical rather than financial considerations and to ensure patient safety.

Criterion 3. Payment Methodology (High Priority)

Criterion Description

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.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- The payment methodology would provide payments for several types of home-based services that are not paid for, or not paid for adequately, under current Medicare payment systems.
- The payment methodology encourages reducing unnecessary and avoidable post-acute care.
- By allowing continued billing for ancillary services under current payment systems, the PRC HH-APM could be simpler for both CMS and small providers to implement.

Weaknesses:

- The Home Hospitalization Payment is not adjusted based on quality.
- Although the submitter suggested that at least twelve different quality measures be tracked, only 5 of the measures would be used to affect payment.
- The amount of the payment does not depend on the amount of home care needed by the patients, which could encourage participants to focus patient selection on those that would qualify for higher-paying MS-DRGs.
- Small providers could face financial challenges if the cost of home nursing services is higher than the Home Hospitalization Payment (based on 70% of the MS-DRG payment) for the patients they serve, even though the cost is lower than what the full MS-DRG payment to a hospital would have been had the patient been admitted to the hospital.

Summary of Rating:

- The proposed PFPM meets this criterion. The proposed payment methodology would fill the gaps in current Medicare payment systems that preclude delivering Hospital at Home services, and it is designed to achieve the goals of the PFPM criteria.

Criterion 4. Value over Volume

Criterion Description

Provide incentives to practitioners to deliver high-quality health care.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Since patient participation is voluntary, and since patients generally require a referral from a physician, the program would likely have difficulty attracting sufficient participation to remain operational if it did not deliver high-quality care.
- Shared savings payments are reduced if quality performance is low.

Weaknesses:

- There is no direct financial penalty for poor performance on quality measures; poor performance would only reduce the amount of shared savings payments.
- If a patient had to be admitted to an inpatient unit before the end of the acute phase of care, the APM Entity would experience a financial penalty (because the payment to the hospital for the inpatient stay would be counted towards the episode spending), which could discourage or delay admitting a patient to the hospital even if they could no longer be safely cared for at home.

Summary of Rating:

- The proposed PFPM meets the criterion. The proposed PFPM includes incentives to providers to deliver high value care to patients participating in the model. However, because the financial viability of the services depends upon having sufficient patient volume, there are still risks that physicians would be incentivized to admit patients inappropriately. Modifications to the payment methodology to encourage quality of care and additional monitoring of patient safety would mitigate this concern.

Criterion 5. Flexibility

Criterion Description

Provide the flexibility needed for practitioners to deliver high quality health care.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- The bundled payment based on 70% of the MS-DRG payment would give the APM Entity significant flexibility to deliver different types of services to patients.
- The APM Entity would also have the flexibility to order ancillary services and specialist visits to be paid through existing payment systems, as long as the overall spending on the patients served was less than the target prices established for those patients.

Weaknesses:

- Since ancillary services would be paid for through standard payment systems, the provider's flexibility to deliver different services in different ways would be more limited than with a single bundled payment for all services.
- The challenges in gaining an adequate number of patients to generate the revenues needed to cover the financial costs of the program could make APM Entities less willing or able to deliver or order all of the services that patients need.
- Although the APM Entity would be accountable for coordinating post-acute care and would have the flexibility to deliver different services than are available today, it would not be able to control all aspects of post-acute care services.

Summary of Rating:

- The proposed PFPM meets the criterion. The proposed payments offer flexibility to redesign the delivery of care to achieve reduced spending and maintain or improve quality.

Criterion 6. Ability to be Evaluated

Criterion Description

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- The proposal specifies goals for quality of care and costs that can be evaluated.
- Because a number of other similar Hospital at Home programs have previously been evaluated, the results of those evaluations could be combined with the evaluation of this PFPM to allow more robust conclusions about the impact of the care model.
- The Mount Sinai Health Care Innovation Award (HCIA) program is currently being evaluated, and the methods for drawing valid comparison groups in that evaluation should be helpful in designing an evaluation of the PRC HH-APM.

Weaknesses:

- Because of the diversity of patients eligible for the PRC HH-APM (especially in relation to the Mount Sinai HCIA program), it may be difficult to accurately compare costs and quality other than for the most common types of participating patients.
- Because the patient's home environment will be a major factor in determining the patient's eligibility for home hospitalization, and information about the home environment is not available in claims data or standard clinical data, it will be difficult to establish a comparison group of patients who have similar characteristics.

Summary of Rating:

- The proposed PFPM meets the criterion, but special efforts will be needed to develop a comparison group of patients that are similar on the characteristics affecting eligibility for home hospitalization.

Criterion 7. Integration and Care Coordination

Criterion Description

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.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Participants' financial responsibility for inpatient costs for patients who need to be admitted to the hospital after beginning home hospitalization care will require the participating entity to develop relationships with hospitals and post-acute care providers.
- A patient's primary care provider would be involved in the patient's admission to home hospitalization under the PRC HH-APM, either through a direct referral from the PCP to the program or as a consultation during the admission to the program from the ED.
- During the post-acute phase, providers would begin transitioning care to the patient's primary care provider, providing critical information about the patient's home situation to inform the care plan.

Weaknesses:

- The proposal assumes PCP participation but does not directly require that collaboration.
- The quality measure for PCP follow-up is based on only scheduling an appointment with the PCP, not an actual visit.
- The program creates three new situations in which coordination, communication, and transition would be needed – the initial transfer from the ED to the home, a transfer to the hospital from home (if escalation is required), and a possible transfer back to home following an escalation.

Summary of Rating:

- The proposed PFPM meets the criterion. The proposal has several mechanisms in place to ensure that the patient's usual providers are aware of the patient's participation in the PRC HH-APM, are involved in care planning as appropriate, and can incorporate insights on the patient's home environment into ongoing care plans.

Criterion 8. Patient Choice

Criterion Description

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- The program would provide a significant new home care option for eligible patients, which evaluations have shown is preferred by many patients and their families.
- Admission to the program would be voluntary on the part of the patient.
- The payment model would provide flexibility to the care team to deliver non-traditional services to patients.

Weaknesses:

- The discretion involved in determining patient appropriateness could result in providers encouraging participation of patients who would be better served in an inpatient setting in order to meet financial goals.
- The higher payments for more complex patients could cause APM Entities to admit patients in higher-weight DRGs inappropriately.

Summary of Rating:

- The proposed PFPM meets the criterion. Eligible patients may decide to participate in the PRC HH-APM or to receive traditional inpatient admission. Serving patients in their home affords patients and their families more control over the environment in which care is delivered.

Criterion 9. Patient Safety

Criterion Description

Aim to maintain or improve standards of patient safety.

PRT Conclusion

Does not meet criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Participation in the program is limited to patients with diagnoses and other characteristics that can be cared for safely in the home, and patients can be admitted to an inpatient unit at any time.
- The minimum number of daily telehealth visits and in-home visits ensures proactive monitoring.
- The same team provides care during the acute and post-acute phases, which may help to reduce complications during the post-discharge period.

Weaknesses:

- The model does not include a method for measuring, reporting, and monitoring to ensure visits are completed, that timely responses are made to calls, or that training has been provided.
- The payment model is not intended to support in-person home visits by a physician/clinician.
- Financial pressures may encourage enrolling patients who really need inpatient care.
- There is a financial disincentive to escalate care to an inpatient unit or to provide initial care in a hospital or skilled nursing facility if needed for patient safety.
- Measures of hospital admissions and mortality would be tracked but would not affect payment.
- The model lacks both a clear mechanism for patients and their families to report adverse events and an independent entity designated to review adverse events and the response to them.
- It could be difficult for providers to provide appropriate care for so many eligible diagnoses.

Summary of Rating:

- The proposed PFPM does not meet the criterion. Although the PRC HH-APM would likely improve patient safety by reducing complications associated with hospitalization, the PRT believes that the proposed PFPM does not have adequate safeguards to assure patient safety in the home.

Criterion 10. Health Information Technology

Criterion Description

Encourage use of health information technology to inform care.

PRT Conclusion

Meets criterion

Unanimous or Majority Conclusion

Unanimous

Strengths:

- Participants in the PRC HH-APM will be required to use Electronic Health Record (EHR) systems.
- The use of multiple types of personnel and potentially multiple organizations to deliver care would serve as an incentive to record and share information electronically.
- APM Entities would be expected to use telehealth capabilities for remote patient visits and monitoring of vital signs.

Weaknesses:

- Current EHR systems do not support inpatient-level services in an ambulatory care environment.
- The lack of effective interoperability of current EHR systems will make it difficult to share information if separate organizations are providing services to patients.
- The costs of the modifications to EHRs required for optimal functioning of the proposed PFPM may limit its attractiveness to potential APM Entities.
- There is no mechanism for ensuring that APM Entities implement telehealth services in a way that successfully identifies and addresses patient problems.

Summary of Rating:

- The proposed PFPM meets the criterion. While current EHR capabilities pose challenges to implementation of home hospitalization services, the proposed model encourages use of HIT. Implementation of home hospitalization programs supported by the PRC HH-APM could encourage EHR vendors to develop better cross-setting and interoperability capabilities.