

# Physician-Focused Payment Model Technical Advisory Committee

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May 7, 2018

Alex M. Azar II, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendations to you on two proposed Physician-Focused Payment Models (PFPMs) submitted to PTAC. These comments and recommendations are required by section 1868(c) of the Social Security Act which directs PTAC to: 1) review PFPM models submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (Secretary, HHS); and 3) submit these comments and recommendations to the Secretary.

The first proposed PFPM has been developed by the American Academy of Hospice and Palliative Medicine (AAHPM) and is entitled: *Patient and Caregiver Support for Serious Illness (PACSSI)*. The second proposed model has been developed by the Coalition to Transform Advanced Care (C-TAC) and is entitled: *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*. Both models aim to address the limitations in Medicare payment policy that prevent delivery of much needed palliative care to Medicare beneficiaries with serious illnesses. The designs of both models also have much in common, combining value-based payment with similar approaches and standards for delivering comprehensive, patient-centered palliative care. For this reason PTAC is communicating with you on these two models together. We hope that this will better assist HHS to quickly move to implement a new Alternative Payment Model for palliative care.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC members carefully reviewed both proposed models, additional information pertaining to the models, and public comments on both proposals. At a public meeting held on March 26, 2018, PTAC deliberated on the extent to which these proposals meet criteria for PFPMs established in regulations at 42 CFR § 414.1465 and should be recommended.

PTAC concluded that both proposals have merit and recommend them to you for limited-scale testing. Moreover, we recommend that testing proceed with the highest possible priority. Both models require refinements, but they each have important strengths. PTAC believes that having the developers of both models collaboratively work with the Centers for Medicare & Medicaid Services (CMS) would enable development of one or more models of Medicare payment for palliative care that can accommodate a continuum of interested providers ranging from large health systems to small practices. Finally, PTAC wishes to underscore that the need for palliative care services for Medicare beneficiaries is urgent and that such care can only be effectively provided with changes to Medicare payment policy such as those proposed in these two models.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response posted on the CMS website and would be happy to assist you or your staff as you develop your response. If you need additional information, please have your staff contact me at [Jeff.Bailet@blueshieldca.com](mailto:Jeff.Bailet@blueshieldca.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey Bailet", written over a horizontal line.

Jeffrey Bailet, MD  
Chair

Attachments

# Physician-Focused Payment Model Technical Advisory Committee

## REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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Comments and Recommendations on

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

&

Patient and Caregiver Support for Serious Illness (PACSSI)

May 7, 2018

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (Secretary, HHS); and 3) submit these comments and recommendations to the Secretary. (See Appendix 1 for a list of PTAC members and their terms of appointment.) PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465. (See Appendix 2 for the Secretary's criteria.) As directed by section 1868(c) of the Social Security Act, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides operational and technical support to PTAC.

In 2017, PTAC received two proposals to improve how Medicare pays for palliative care - the *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* developed by the Coalition to Transform Advanced Care (C-TAC) and the *Patient and Caregiver Support for Serious Illness (PACSSI)* model developed by the American Academy of Hospice and Palliative Medicine (AAHPM). PTAC reviewed these proposals on March 26, 2018, found that they have much in common, and determined that both merited recommendation to the Secretary for limited scale testing.

This report includes: 1) a summary of the common, strong features of both proposals; 2) additional positive features of the individual models; 3) features of one or both models that PTAC finds in need of refinement; 4) individual summaries of both models; and 5) a record of the voting by the PTAC on each proposal. Appendices to this report include: the proposals submitted by AAHPM and additional information on this proposal (Appendix 3) and the proposal submitted by C-TAC and additional information on this proposal (Appendix 4).

## **SUMMARY STATEMENT**

Although the Medicare hospice benefit and Medicare Care Choices Demonstration provide for the provision and payment of palliative care, both are available only to individuals certified by their physicians as being in the last six months of life. The hospice benefit further requires participants to forego curative care in order to receive hospice services, and the Medicare Care Choices Demonstration is only available to beneficiaries with certain diagnoses: advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). These policies are contrary to recommendations by experts that palliative care should be offered independent of the patient's prognosis, beginning concurrently with the diagnosis of serious illness, and provided simultaneous with life-prolonging and curative therapies for persons living with serious, complex, and life-threatening illness. Evidence shows that palliative care services can improve quality of care and quality of life for patients suffering with many different types of serious illness – such as cancer, chronic obstructive pulmonary disease (COPD), heart failure, and dementia – and also reduce costs by eliminating avoidable or unnecessary care.

In 2017, PTAC received two proposals for physician-focused payment models (PFPMs) aimed at improving how Medicare pays for palliative care – the *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* developed by the Coalition to Transform Advanced Care (C-TAC) and the *Patient and Caregiver Support for Serious Illness (PACSSI)* model developed by the American Academy of Hospice and Palliative Medicine (AAHPM). PTAC reviewed these proposals on March 26, 2018, found that they have much in common, and decided to recommend both to the Secretary for limited-scale testing — with such testing to proceed with the highest possible priority. While both models require refinements, they each have important strengths. PTAC believes that having the developers of both models collaboratively work with the Centers for Medicare & Medicaid Services (CMS) would enable development of one or more models of Medicare payment for palliative care that can accommodate a continuum of interested providers ranging from large health systems to small practices. Finally, PTAC wishes to underscore that the need for palliative care services for Medicare beneficiaries is urgent and that such care can only be effectively provided with changes to Medicare payment policy such as those proposed in these two models.

## **COMMON, STRONG FEATURES OF BOTH PROPOSALS**

Both proposed models would: 1) target palliative care services to individuals with serious health conditions; 2) deliver palliative care through multidisciplinary palliative care teams; 3) provide per beneficiary per month (PBPM) care management payments as part of the payment

methodology; 4) allow different types of entities to receive palliative care payments; and 5) financially incentivize and reward the delivery of high quality care.

### **Targeting palliative care services to individuals with serious health conditions**

Both proposed models target palliative care services to individuals with serious illness as identified by multiple indicators. The eligibility criteria of both proposals require: 1) diminished functional status as measured by standard, validated instruments; and 2) increased utilization of hospital inpatient or emergency department care. PACSSI adds additional *diagnostic* eligibility criteria for palliative care; ACM adds additional *prognostic* criteria. The use of prognostic criteria is of concern to PTAC and is discussed below.

### **Requiring use of interdisciplinary palliative care teams**

Both proposed models would deliver palliative care via interdisciplinary palliative care teams (PCTs) that include a nurse, social worker, and spiritual care provider as “core” members of the team. (PACSSI additionally requires that a physician be a member of the palliative care team.) Both models provide for the addition of other types of providers as members of the PCT as determined by community needs and resources. Both models require one of the core members to hold certification in palliative care. PTAC received testimony from the National Coalition for Hospice and Palliative Care that delivery of palliative care by an interdisciplinary team is essential to address the distinct and diverse needs of people living with a serious illness and their family and other caregivers. The National Coalition for Hospice and Palliative Care further recommended that at least one team member be a prescribing clinician with board certification to avoid threats to poor-quality care, in particular poor prescribing of opioid analgesics.

PTAC members concluded that use of interdisciplinary palliative care teams will likely encourage greater integration and care coordination among practitioners, but expressed concern about potential variation in PCTs and that the degree of clinical expertise in palliative care potentially could vary depending on which provider type has certification.

### **Allowing different types of entities to receive palliative care payments**

Both proposed models would allow different types of entities to receive palliative care payments. In PACSSI, the PCTs would be Alternative Payment Model (APM) Entities and receive the payment. These teams could be independent provider organizations or associated with hospices, home health organizations, or other types of organizations. In C-TAC’s ACM, payments under the model would be made to ACM entities which also could be physician practices, hospitals, Accountable Care Organizations (ACOs), health systems, hospices, home

health agencies and other entities as long as the entity meets requirements specified in the ACM proposal. PTAC had some concerns about the involvement of hospices and the potential for financial incentives on hospices to adversely affect care. This issue is discussed below.

### **Including per beneficiary per month (PBPM) care management payments as part of the payment methodology**

Both proposed models include per beneficiary per month (PBPM) care management payments as part of the payment methodology. 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. Monthly care management payments that could be used to secure services not otherwise reimbursable would provide greater flexibility in care delivery than payments to limited types of practitioners individually under the traditional Medicare fee schedule. Provision of care management payments accompanied by financial incentives to meet certain experience of care and performance standards (see below) could better enable the delivery of high-quality palliative care. Providers receiving PBPM palliative care payments would not receive payments for Medicare chronic care management (CCM) codes or complex CCM codes.

### **Financially incentivizing the delivery of high quality care**

The payment methodologies of both proposed models would financially incentivize the delivery of high quality care. In both models, bonus payments would be awarded based on the accountable entity's performance on specified quality (and cost) metrics, although the models differ in how rewards and penalties are calculated and applied to an accountable entity. Some of the proposed methods for calculating and awarding penalties or bonuses are of concern to PTAC and are discussed below.

## **ADDITIONAL POSITIVE FEATURES OF THE PACSSI and ACM MODELS**

### **Distinguishing palliative care from hospice care**

With respect to the PACSSI model, PTAC members call attention to the model's ability to distinguish palliative care from hospice care, noting that palliative care and hospice care are "not the same thing," and that focusing on palliation may be a way to prevent some of the misuse of the Medicare hospice benefit evidenced by the large percentages of hospice enrollees in some geographic areas being discharged alive. PTAC members note that although palliative care and hospice services are interrelated and need to work together, they differ in

key perspectives; i.e., focusing on the quality of *ongoing life* (palliative care) versus focusing solely on quality of the *end of life* (hospice care).

Additionally, PTAC members stressed how palliative care models have the potential to complement other efforts to transform care in internal medicine, general medicine, and family medicine practices (such as medical home programs), because many of these practitioners also will be providing primary care to patients in need of palliative care. Because of workforce shortages of practitioners especially trained and certified in palliative care, and the need to coordinate palliative care with primary care, palliative care models have the potential for a significant spillover effect on how primary care is delivered.

### **Identifying the components of palliative care mode(s)**

The combined components of palliative care identified by the individual proposed models provide a comprehensive description of necessary and desirable components of palliative care model(s). These are:

- Education of the patient and caregiver about the patient's health conditions and the normal progression of those conditions, the types of complications that can arise, and ways to manage disease progression, minimize symptoms, and avoid complications; (PACSSI)
- Identification of areas of distress through a comprehensive physical, psychosocial, emotional, cultural, functional, and spiritual assessment; (PACSSI)
- Identification of threats to the safety of the patient or caregiver from the physical environment, medication interactions, and other sources; (PACSSI)
- Patient and family engagement defined as shared decision-making between the beneficiary/caregivers/family and the palliative care team in designing and implementing a palliative care plan; (ACM)
- Assisting the patient in establishing clear goals for care and treatment and defining their preferences for interventions and the site of care delivery if complications arise; (PACSSI)
- Development of a coordinated care plan with input from all of the patient's physicians and providers that is consistent with the patient's care goals; (PACSSI)
- Systematic and ongoing advance care planning, in which patients, their families, and their healthcare providers reflect on the patient's goals, values, and beliefs, discuss how they should inform current and future medical care, and ultimately, use this information to accurately document future health care choices, after an exploration of the patient and caregiver's knowledge, fears, hopes, and needs; (ACM)



- Symptom management; (ACM)
- Arranging for services from other providers in order to implement the care plan; (PACSSI)
- Communicating 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; (PACSSI)
- Care coordination and case management of the beneficiary’s total healthcare needs, both curative and palliative, encompassing all services including physicians and other eligible clinicians, hospital, post-acute, and social services, and coordination and promotion of evidence-based disease-modifying treatments that align with the patient’s evolving personal preferences; (ACM)
- Responding on a 24/7 basis to requests for information and assistance from the patient or caregiver or from other providers who are caring for the patient; (PACSSI) and 24/7 access to clinical support; (ACM) and
- Making visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns. (PACSSI)

#### **FEATURES OF ONE OR BOTH MODELS THAT PTAC FINDS IN NEED OF REFINEMENT**

The proposed payment methodologies of both models received the greatest attention from PTAC. The major aspects of the payment models identified by PTAC as in need of refinement are: 1) the extent to which financial incentives for cost savings should be used in palliative care models; 2) the difficulty of establishing benchmarks for performance rewards and risk adjustment; and 3) whether PBPM amounts should differ (be “tiered”) based on the clinical complexity of patients or bundled into a “blended” PBPM. PTAC had additional concerns about: 4) how quality is measured and monitored; 5) use of prognosis as an eligibility criteria; 6) the role of hospice agencies in palliative care models; 7) need for stronger use of Health Information Technology (HIT); 8) need for stronger attention to patient engagement and shared decision-making; 9) PCT coordination with the patient's primary care providers; and 10) overlapping responsibilities for provision of palliative care.

#### **The extent to which financial incentives for cost savings should be used in palliative care models**

Both proposed models provide for use of financial incentives to control spending. The PACSSI model would do this in either of two ways. Under the first option (which the PACSSI model calls “Track 1”), PCTs would be subject to positive and negative payment incentives of up to 4 percent of total PACSSI care management fees received for the year. Based on final

performance determinations for spending (and quality) in a given year, Track 1 PCTs would receive a lump sum payment amount, break even, or be required to return funds to the Medicare program. Under the second option (“Track 2”), practices would take on greater shared risk and savings based on total cost of care. In C-TAC’s ACM model, APM Entities would be accountable for the total cost of care for enrollees in their last 12 months of life.

PTAC extensively discussed whether shared financial savings / risk is a necessary component of a palliative care payment model. PTAC noted that while strong financial incentives might facilitate rapid adoption of a new model of care, the extent to which financial incentives for controlling spending should be used in palliative care models raises concerns. PTAC expressed concern that as a palliative care team interacts with the patient and their family and provides guidance around end-of-life decisions, strong financial incentives for cost savings could influence the advice given to the patient and their family. Using total cost of care measures for a patient population with a high risk of dying could create perverse incentives and unintended consequences relating to providing care.

PTAC had additional concerns about the aspect of the ACM model that would hold APM Entities accountable for the total cost of care for enrollees in their last 12 months of life, even when the enrollees are not enrolled in the model for some or even the majority of these months. For example, if a beneficiary were to enroll in the model program and disenroll in the third month in order to enroll in hospice and then die nine months later, all costs for the last 12 months of life would be included in the model’s episode costs, even though the patient disenrolled after the third month. Similarly, if an enrollee died after being enrolled in the ACM model after only one month, the ACM entity would be accountable for the costs of the month of enrollment and the preceding eleven months. PTAC has concerns about the validity and fairness of holding providers accountable for periods of time in which they are not involved in enrollees’ care.

PTAC members also discussed the extent to which “downside” financial risk is already in place for entities providing palliative care as a result of the infrastructure investments that these entities must make to provide this care. They noted that Medicare’s current fee-for-service system addresses infrastructure costs as part of the relative value units assigned to fee-for-service payments. In an alternative payment model for palliative care, understanding the cost of infrastructure development and maintenance for palliative care delivery is important and may similarly need to be built into the payment approach. This could lessen the need for financial incentives to control spending.

PTAC members discussed an alternative approach of using PBPM payments to pay for palliative and case management care along with quality incentive payments tied to clinical, patient

safety, and patient experience measures. Because cost avoidance is the anticipated result of good multidisciplinary, integrated care and not dependent upon financial incentives, cost reductions would likely be achieved and could be measured and reported on (but not financially rewarded). Alternatively, to the extent that HHS chooses to employ financial incentives for spending, any risk corridors that are established as part of a methodology of implementing financial thresholds for receipt of financial incentives should not be “one-size-fits-all” risk corridors. Rather, the risk corridor should be based on the number of patients enrolled in the program. Finally, HHS testing of palliative care models could include two payment models – one with shared savings and one without, to explore the extent to which different payment models result in differences in patient utilization of services. Qualitative evaluation of the models also could analyze the ways in which palliative care interactions are influenced by financial incentives.

### **Difficulty of establishing benchmarks for spending and performance rewards and approaches to risk adjustment**

As part of limited-scale testing PTAC also calls attention to the need to establish baseline metrics against which to compare savings and losses, and the need to develop risk adjustment methodologies for calculating performance metrics. For both proposals, PTAC points out that establishing what the baselines are in order to measure actual costs and savings is not trivial. For example, while proposing the use of spending benchmarks as part of the basis for awarding incentive payments, the PACSSI model does not describe how the spending benchmarks and risk adjustment would be calculated, but the submitters state, “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.”

The PACSSI model also did not propose any minimum savings or loss rates before risk sharing starts, which means that the model would pay more for random small gains or losses. The payment methodology also would pay more for small gains compared to benchmarks than for greater accomplishments. Specifically, the model proposes to share a higher share of savings or loss in the first five percentage points than it does after savings or losses exceed plus or minus 5%. That is inverted from how most Medicare models have been set up. PTAC also had concerns about the lack of confidence intervals around savings or loss thresholds because this provides no mechanism for accounting for random variation.

## **Whether PBPM amounts should differ (be “tiered”) based on the clinical complexity of patients or bundled into a “blended” PBPM.**

The PACSSI model would provide different amounts of PBPM payments to APM Entities based on the clinical complexity of patients as determined by diagnosis, measures of functional status, and health care utilization. Specifically, in Year 1, Tier 1 base payment amounts would be set at \$400 per beneficiary per month, and Tier 2 base payment amounts would be set at \$650 per beneficiary per month. The higher monthly payment for more complex “Tier 2” patients could incentivize intentional or inadvertent awarding of higher scores on functional status especially as clinical consultation provided to PTAC stated that patient performance on standard measures of functional status can fluctuate from day-to-day or week-to-week. However, a number of PTAC members also observed that adverse selection can also exist under “blended rates.” For example, under a scenario of one rate, practices that take on a higher number of more severely needy patients will be penalized financially. This is especially a concern with respect to small and rural practices. While a very large organization with a higher volume of patients might be able to average out the cost, a small practice that serves a greater proportion of highest-need patients would be at inappropriate financial risk when payment amounts are based on an average population – creating an incentive to preferentially enroll less complex patients.

In its discussion with PTAC members, AAHPM acknowledged the competing benefits of blended versus tiered PBPM rates, and cited the lack of data available during this early stage of the use of palliative care as a key reason for proposing a tiered rate as opposed to a blended rate. AAHPM highlighted the need to work with CMS to better use Medicare data to inform the development of a palliative care model. To this end, PTAC recommends using and learning from all sources of data to inform the design of palliative care models – including fee-for-service Medicare data, Medicare Advantage data, and in particular CMS’ data on the use of the hospice benefit.

## **How quality is measured and monitored**

**Timing of quality measurement.** A key concern with both proposed models is about when and how frequently quality of care is proposed to be measured. In both proposed models, measurement of quality is proposed to occur at the “front” and “back” end of service; i.e., during the first month of enrollment or sooner, and after discharge or end of the episode. The PRT is concerned that these measurements would not obtain patients’ evaluation of the quality of care provided during the greatest portion of their enrollment. Patient reports of their

experience of care very soon after enrollment (when there may be more intense contact with personnel) may be different from their experiences with care several months or more after their enrollment. Further, when the second period of measurement is after discharge or the end of the episode, and the event defining discharge or end of episode is the patient's death, this means that patients would have only one opportunity to give feedback on the quality of care they experienced. PTAC members recognize that understanding the family's perspective at the end of an episode is very important, but are concerned that not seeking patients' input more frequently throughout the program is a lost opportunity. In conversations with AAHPM at PTAC's public meeting, a representative of AAHPM stated that while balance is needed in surveying patients more frequently to obtain better information and surveying less frequently to avoid undue burden on the patient and family, AAHPM would be open to obtaining patient feedback and evaluation more frequently.

**Greater measurement of outcome and experiences of care.** PTAC members also call attention to the need for strong measures of patient outcomes and experiences with care in limited-scale testing of these models – and the linking of payment to performance on measures rather than simply the reporting of measures. PTAC believes that there is a need for robust use of outcome measures given that the primary promised benefit of palliative care is the reduction of pain and suffering. However, PTAC found limited proposed use of outcome measures. For example, the PACSSI model proposed use of only two outcome measures: 1) adequacy of treatment for pain and symptoms, and 2) help with pain and trouble breathing. Neither proposal discussed the National Institutes of Health PROMIS® (Patient-Reported Outcomes Measurement Information System) measures, which include psychometrically tested and validated measures of many dimensions of patient suffering including: pain, sleep, anxiety, fatigue, social function, depression, sadness, dyspnea, nausea, vomiting, et al. Further, in the PACSSI model the “post-death” measures have a risk of confounding since the submitter states that, “The expectation is that approximately 45-50 percent 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.”

Submitters acknowledged gaps in a robust outcome measure set for people with serious illness. They also stated that quality measures proposed for use in these palliative care models come from measures used in hospice and inpatient palliative care populations, and have not necessarily been validated and tested in a community-based palliative care population. Submitters noted that new quality instruments and measures are being developed and acknowledged the need to test and validate the measures before setting benchmarks. PTAC members noted that such testing can only take place with implementation of the services that

would be made possible by the payments in palliative care models—underscoring the need to implement PTAC’s recommendation for limited scale testing of these palliative care model(s).

**Improved utilization measures.** PTAC also called attention to the need to develop strong utilization measures. In the PACSSI proposal, of the three proposed utilization measures, two address hospice utilization and one addresses Intensive Care Unit (ICU) days — and all of the measures include only enrollees who died. In C-TAC’s proposal the two proposed utilization measures also address hospice utilization of three days or more and admission to the ICU in the last 30 days of life. These also measure only the experience of enrollees who die. Further, there are no reliable benchmarks for the proposed hospice and ICU utilization measures, and as such there is a risk of unintended consequences when attempting to control and reward cost reduction using utilization measures where patient utilization can appropriately vary from an established benchmark. PTAC concluded that a broader and more meaningful set of utilization measures are needed. For example, C-TAC’s proposal calls for CMS to monitor ambulatory sensitive conditions and “All-cause unplanned admissions for ACM beneficiaries.”

**Stronger quality assurance standards.** PTAC also calls attention to the need for stronger minimum quality assurance standards than are found in both proposals. The requirement of both proposals to mandate that one of the core members of the PCT hold a certification in palliative care is a good example of the types of quality assurance standards that palliative care models should have in place, but PTAC noted the need for improvement in this standard and in other areas. For example, although the PACSSI proposal also states that, “At a minimum, one of the core interdisciplinary team members must have certification in palliative care to support specialty level practice,” because the core team members consist of a physician, nurse, social worker, and a spiritual care provider, the degree of clinical expertise in palliative care can vary depending upon which of the provider types has certification in palliative care; e.g., chaplain, social worker or physician. There also may need to be stronger minimum standards for contact with beneficiaries. The PACSSI proposal states that 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 were not adequately defined. The C-TAC proposal proposes use of a provider’s “YES” / “NO” attestation that a patient’s care plan is consistent with preferences as a “Minimum Quality Standard Measure,” but PTAC is concerned that this may be too minimal.

## Use of prognosis as an eligibility criterion

PTAC has several concerns about using prognosis (i.e., expected months of remaining life) as an eligibility criterion for palliative care. First, PTAC notes the position of multiple palliative care experts that palliative care should not be tied to prognosis. See, for example, Meier, D., et al. (2017). A National Strategy For Palliative Care. *Health Affairs*, 36(7) at: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0164>). This concern was echoed in public comments made by the President of the National Coalition for Hospice and Palliative Care at PTAC's March 26 meeting:

“ . . . our fourth point is who is in the eligible beneficiary population, and I want to underscore that it should be based on patient and caregiver need and not prognosis, not only because needs should be the reason for receiving services but also because it is almost impossible to predict prognosis until the last few days or weeks of life.”

Consistent with this, a PTAC review of evidence showed that the accuracy of predicting prognosis is limited. Further, a review of literature on the process of communicating prognosis to patients (available on the ASPE PTAC [website](#)) identified a number of additional concerns:

- Although a majority of patients would prefer to know their prognosis, a substantial minority prefer not to be told this information. Patients who do not desire prognostic information most commonly cited the emotional burden associated with that knowledge as the reason for not wanting to have that conversation.
- Little is known about the impact of learning prognosis on patients' well-being.
- Patients have a high degree of variability in terms of *how much* they want to know about their prognosis, *how* they want it communicated, and *when* they want this information, with a general theme of flexibility and highly individualized processes for communicating prognostic information to patients.
- Although studies of *how* prognostic information should be communicated are limited, there is some evidence that patients would prefer more 'qualitative' information in this regard, such as whether they will live a 'long' time, as opposed to a more quantitative presentation ("you have x months or years to live"). Similarly, a number of studies have documented patient preference for a positive framing that focuses more on survival than mortality.

The PRT is concerned that using prognosis as an eligibility criterion in a palliative care model may impose a more specific and structured framework than current evidence supports. It further may not be sufficiently patient-centered and could have unintended adverse consequences for the patient.

## **Role of hospice agencies in a palliative care model**

PTAC has concern about the role of hospice providers in a palliative care model that would provide financial incentives for cost savings (see above) and allow the hospice providers to play a dual role. For example, in C-TAC's model, hospice agencies could be both the APM Entity providing palliative care under the model and participating in shared savings, and a hospice to which the APM Entities' enrollees are discharged. This dual role of hospice agencies raises concern about the possibility of triple financial incentives affecting care; i.e., a financial incentive to encourage discharge to hospice when the PBPM 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 months of life because of the effects on the hospice agency's potential for shared savings as a palliative care APM Entity. PTAC is concerned that the interactive effects of these financial incentives could pose a potential conflict of interest and harm patients.

## **Need for stronger use of health information technology**

PTAC members noted that palliative care fundamentally requires that information be shared across multiple providers and practice settings, including allowing patients access to their clinical health information and enabling patients and caregivers to track and share information with providers. Use of health information technology (HIT) offers more robust data-sharing opportunities with both the patients and with providers across the community, and because of this, HIT should be a key component of any palliative care model by:

1. 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.
2. Enabling patients and caregivers (through patient portals or other patient-facing applications) to track and share information with providers in real time;
3. Allowing response on a 24/7 basis to requests for information and assistance from the patient or caregiver or from providers who are caring for the patient (including but not limited to telephone calls, secure emails, patient portal messages, electronic alerts).

PTAC calls attention to the ACM proposal's anticipation that telehealth technology, secured texting, videoconferencing and use of registry and/or health information exchange solutions will be used.



## **Stronger attention to patient engagement and shared decision-making**

PTAC agrees with comments submitted by the National Partnership for Women & Families about the need to ensure that palliative care models contain strong requirements to ensure patient and family engagement and shared decision-making. Such requirements should:

1. Require greater involvement of patients and caregivers in developing and executing care plans by: adopting standards for developing care plans *with* patients and their families rather than *for* patients; reinforcing the role of patients and caregivers in tracking progress and updating the care plan as part of required services; and requiring patient/caregiver verification that a care plan is consistent with their values and preferences, as well as the ability to provide updates to the plan, as a required care process.
2. Incorporate shared decision-making into the proposed palliative care services and quality metrics (including surveys). Public commenters noted that shared decision-making goes significantly beyond “allowing” patients and families to ask questions. Rather, it facilitates bidirectional communication between providers and patients in which risks, benefits, and alternatives of proposed treatment are discussed and the provider and patient/caregiver share in the process of deciding what is best for the patient based on his or her individual goals, preferences, and values.
3. Require use of HIT to facilitate patient and caregiver communication, such as through providing electronic access to the patient’s clinical health information (e.g., medications, lab results, care plans, clinical notes) and use of e-messaging, secure e-mails, electronic alerts, patient portal messages.

## **Assuring PCT coordination with the patient's primary care providers**

PTAC notes the need for palliative care models to have explicit standards and requirements for how the PCTs will work with the patients’ primary care providers. Model components such as those contained in the PACSSI model can address this:

- “• 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 . . .”

In addition, PTAC notes that including strong measures of care coordination in the proposed quality measure set will help achieve coordination across the PCT and patient's primary care providers.

### **Overlapping responsibilities for provision of palliative care**

PTAC also notes that implementation of palliative care models could have substantial implications for integrated delivery systems and ACOs that are implementing similar approaches to palliative care. Palliative care programs can be key mechanisms for ACOs to deliver better care to this population and achieve targeted savings. PTAC members noted that some Medicare ACOs are already implementing many of the practices found in these palliative care models. PTAC calls attention to the need to clarify issues that will arise when the overlapping payment models will be implemented in the same geographic area, particularly if shared savings models are used for palliative care and for ACOs.

## SUMMARIES OF ACM and PACSSI MODELS

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

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

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

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

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

Services covered by the proposed payment include:

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

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

1. An ACM care team that includes a registered nurse, a licensed social worker, and a provider with board-certified palliative care expertise. ACM teams may also include other clinicians practicing within their scope of licensure and non-clinicians.

AND

2. Participating physicians and other eligible clinicians who may include primary care and specialty providers involved in patients' care. Participating physician providers:
  - a. commit to identifying patients for enrollment in the ACM and ACM quality goals;
  - b. agree that their enrolled patient population will be attributed to the ACM;
  - c. may participate in additional payment of shared risk from the ACM, by establishing arrangements with the ACM entity; and
  - d. may clinically integrate with the ACM entity.

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

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

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

Payment would consist of:

1. Wage-adjusted \$400 Per Member Per Month (PMPM) payments of indefinite duration. The “episode” is defined as the total cost of care for the last 12 months of life, as long as a PMPM was paid for at least one of these months. Total costs of care for the last 12 months of life are included in the episode cost regardless of how many months the beneficiary was enrolled in the ACM program; and all PMPM payments (including those in excess of 12 months) are included in the episode costs regardless of whether those ACM payments are received in the last 12 months of life. The proposal states, “The ACM entity . . . remains accountable for a beneficiary’s last 12 months of life cost if the ACM beneficiary is served by the ACM entity at any point during the ACM beneficiary's last 12 months of life.” For example, if a beneficiary is enrolled and disenrolls in the third month in order to enroll in hospice and then dies nine months later, all costs for the last 12 months of life will be included in the model’s episode costs even though the patient disenrolled after the third month. Similarly, if an enrollee dies after being enrolled in the ACM model after only one month, the ACM entity is accountable for the costs of the month of enrollment and the preceding eleven months.
2. Quality bonus payments or shared losses based on the total cost of care for the last 12 months of life with a 4 percent minimum shared savings/loss rate. A bonus payment would be triggered only if savings is at least 4 percent of a risk-adjusted, total-cost of care spending target. Similarly, a shared loss rate would be triggered only if the excess spending is at least 4 percent of the spending target. However, the bonus payment would be based on the full savings amount and the shared loss rate would be based on the full loss amount.

3. Quality bonus payments (funded by savings) would be subject to a maximum bonus of \$250 PMPM; CMS would keep a proportion of savings when the quality bonus payment rate is less than 100% and would keep all savings in excess of \$250 PMPM.
4. A 40-60 percent shared loss rate would be based on quality performance and compliance with a minimum quality standard (the ACM provider's attestation that the patient's care plan is consistent with his/her preferences), up to a maximum loss rate of \$100 PMPM. CMS will partially share the loss up to \$100 PMPM and cover all losses in excess of this amount.
5. Upside quality bonus payments would be operational in Years 1-2; shared loss would begin in Year 3.
6. There would be a remediation period when quality performance is low or when expenditures are significantly higher than expected. An ACM entity will be required to leave the program if corrective actions do not show positive trends within six months and significant improvement within a year.
7. Payment would replace the ACM entity's palliative care provider evaluation and management (E&M), Chronic Care Management, Complex Chronic Care Management, Transitional Care Management, and Advance Care Planning payments.

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

In addition, the model proposes an additional quality monitoring program to be operated by CMS that would analyze for outliers in such areas as: all-cause unplanned admissions, ambulatory sensitive conditions, hospice enrollment, and proportion of ACM enrollees with more than 12 months of enrollment. Additionally, each ACM entity would be required to submit a yearly operational plan that delineates participating providers and contractors, how ACM services will be provided including care guidelines, staffing plan including training, patient identification and notification process, performance management plan, physician engagement plan, risks and barriers mitigation plan, and financial risk management plan. ACM entities that are outliers in one or more areas and exhibit below average performance under the ACM pay-for-quality structure would trigger an audit. A remediation period would ensue for any

identified issue and the ACM entity would be required to leave the program if a positive trend is not achieved within six months and significant improvement within a year.

**Patient and Caregiver Support for Serious Illness (PACSSI)**

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

**PACSSI Eligibility and Tiering Criteria**

Tier	Diagnosis of Serious Illness	Functional Status	Health Care Utilization
Tier 1: Moderate Complexity	<p><b>EITHER:</b> One of the following diseases, disorders, or health conditions:</p> <ol style="list-style-type: none"> <li>1. Metastatic Cancer</li> <li>2. Pancreatic, Gastrointestinal, Lung, Brain, or Hematologic cancers</li> <li>3. Heart Failure with Class III or IV level function under the New York Heart Association Functional Classification</li> <li>4. Heart Failure with Left Ventricular Assist Device</li> <li>5. Advanced Pulmonary Disease (Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis)</li> <li>6. Advanced Dementia with stage 6 or 7 using the Functional Assessment Staging Tool or <math>\geq 2</math> Activities of Daily Living (ADL) limitations</li> <li>7. Progressive Neurologic Disorder (e.g. Cerebrovascular</li> </ol>	<p><b>Criteria for Individuals with a Non-Cancer Diagnosis:</b></p> <p><b>EITHER:</b> <i>Palliative Performance Scale (PPS)</i> score of <math>\leq 60\%</math> <b>Or:</b> <math>\geq 1</math> Activities of Daily Living (ADL) limitation <b>Or:</b> <math>\geq 1</math> Durable Medical Equipment (DME) order (oxygen, wheelchair, hospital bed)</p>	<p><b>One significant health care utilization in the past 12 months, which may include:</b></p> <ul style="list-style-type: none"> <li>- Emergency Department (ED) visit</li> <li>- Observation stay</li> <li>- Inpatient hospitalization</li> </ul> <p><i>Note: This criterion may be waived under certain circumstances.</i></p>

	<p>Accident, Parkinson’s Disease, Amyotrophic Lateral Sclerosis, Progressive Supranuclear Palsy)</p> <ol style="list-style-type: none"> <li>8. Hepatic Failure (Cirrhosis)</li> <li>9. End Stage (V) Renal Disease (excluding patients on dialysis)</li> <li>10. Protein-Calorie Malnutrition</li> <li>11. Cachexia</li> <li>12. Hip Fracture (with functional decline)</li> </ol> <p><b>OR:</b> Diagnosis of three or more chronic conditions defined in the Dartmouth Atlas:</p> <ol style="list-style-type: none"> <li>1. Malignant Cancer, Leukemia</li> <li>2. Chronic Pulmonary Disease</li> <li>3. Coronary Artery Disease</li> <li>4. Congestive Heart Failure</li> <li>5. Peripheral Vascular Disease</li> <li>6. Severe Chronic Liver Disease</li> <li>7. Diabetes with end organ damage</li> <li>8. Renal Failure</li> <li>9. Dementia</li> </ol>	<p><b>Criteria for Individuals with a Cancer Diagnosis:</b></p> <p><b>EITHER:</b> PPS of <math>\leq 70\%</math> or Eastern Cooperative Oncology Group (ECOG) scale of performance score <math>\geq 2</math></p> <p><b>Or:</b> <math>\geq 1</math> ADL limitation</p> <p><b>Or:</b> DME order (oxygen, wheelchair, hospital bed)</p>	
Tier 2: High Complexity	Same as Tier 1, excluding dementia as the primary illness	<p><b>Criteria for Non-Cancer Diagnosis:</b> PPS of <math>\leq 50\%</math> or <math>\geq 2</math> ADL limitations</p> <p><b>Criteria for Cancer Diagnosis:</b> PPS of <math>\leq 60\%</math></p> <p><b>OR:</b> ECOG <math>\geq 3</math></p> <p><b>OR:</b> <math>\geq 2</math> ADL limitations</p>	<p>Inpatient hospitalization in past 12 months <b>AND</b> one of the following:</p> <ul style="list-style-type: none"> <li>- ED visit</li> <li>- Observation stay</li> <li>- Second hospitalization</li> </ul> <p><i>Note: This criterion may be waived under certain circumstances.</i></p>



Palliative care services covered by the proposed payment methodology include:

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

These services would be delivered by Palliative Care Teams (PCTs) consisting of varying types of providers. The proposal states that, "PCTs would be able to organize themselves and determine the appropriate level of representation across multiple disciplines, including physicians, nurses (including advanced practice nurses), social workers, spiritual care providers, physician assistants, pharmacists, counselors and others, as necessary and appropriate to address the needs of the local patient community." In response to a question from the PRT, the submitter clarified that, "A physician must be part of the team, along with a nurse, a social worker, and a spiritual care provider. . . At a minimum, one of the core interdisciplinary team members must have certification in palliative care to support specialty level practice."

PCTs would serve as the Alternative Payment Model (APM) entities and receive the Medicare payment for the palliative care services. APM entities could include PCTs working as independent provider organizations or PCTs associated with hospices, home health organizations, hospitals, businesses focused on palliative care delivery, or integrated health systems through direct employment or contracting.

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

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

Under both tracks, based on the patient’s eligibility and categorization into one of the two eligibility tiers described above, PCTs would receive monthly PACSSI care management payments as follows:

- In Year 1, Tier 1 base payment amounts would be set at \$400 per beneficiary per month, and Tier 2 base payment amounts would be set at \$650 per beneficiary per month.
- Base payment amounts would be adjusted upward or downward based on the existing Geographic Practice Cost Indices used to adjust the Work Relative Value Units component of the current Medicare Physician Fee Schedule (PFS).
- Payments for facility-based patients would be reduced by 20 percent to reflect lower costs of providing palliative care in a facility due to the existence of supportive care services otherwise provided by facilities.
- Base payment amounts would be increased annually based on the annual increase in the PFS conversion factor.

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

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

Track 2 is a voluntary track available to PCTs in Year 3. Under this track, practices would take on shared risk and savings based on total cost of care. Risk would be based on spending above a risk-adjusted benchmark, but would be limited to the lesser of 3 percent of the total cost of care benchmark or 8 percent of each PCT's total Medicare A and B revenues. Shared savings would be based on spending below the benchmark and would be capped at 20 percent of the total cost of care benchmark. Mechanisms such as outlier provisions and risk corridors would provide protections for PCTs against catastrophic losses. The monthly PACSSI care management payments would be included in total spending, and PCTs' eligibility for and extent of savings or risk would be dependent on quality performance.

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

1. Have a written care plan developed for each patient and approved by the patient by the end of the first month of services;
2. Document that the patient had been assessed and determined to have the characteristics required for eligibility for payment and for the assigned payment category;
3. Have at least one face-to-face visit with the patient every month. "Face-to-face visits may be conducted by non-physician members of the PCTs and/or may be provided virtually;"
4. Maintain documentation that it had responded to all telephone calls from patients; and
5. Participate in a PACSSI Learning Collaborative.

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

Quality measures upon which PCT performance would be measured and payments would be based would be of three types: 1) patient or proxy-reported experiences about several aspects of their palliative care; 2) PCT completion of certain care processes; and 3) utilization of hospice and ICU services by patients at the end of life. Because several of the measures are new measures that require additional testing and do not have sufficient evidence to establish benchmarks, PACSSI phases in accountability for performance on this subset of measures. For Years 1 and 2, PCTs would be required to report 15 applicable measures addressing: satisfaction with care, communication, timeliness of care, adequacy of treatment for pain and symptoms, certain care processes, percentage of patient who died receiving hospice care, and percentage who died without any ICU days during the 30 days before death, but payment will not be tied to performance on these measures. For Year 3, when all measures have established benchmarks,

PCTs' accountability for quality performance and payment would be based on a composite score that equally weights performance across each of the three categories.

## EVALUATION OF EACH PROPOSED MODEL USING THE SECRETARY’S CRITERIA

### The Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model\*

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Does not meet		Meets		Priority consideration		Rating
	1	2	3	4	5	6	
1. Scope of Proposed PFPM (High Priority) <sup>1</sup>	0	0	0	1	4	5	Meets criterion and deserves priority consideration
2. Quality and Cost (High Priority)	0	0	1	7	2	0	Meets criterion
3. Payment Methodology (High Priority)	0	0	5	5	0	0	Meets criterion
4. Value over Volume	0	0	0	9	1	0	Meets criterion
5. Flexibility	0	0	0	9	1	0	Meets criterion
6. Ability to be Evaluated	0	0	3	7	0	0	Meets criterion
7. Integration and Care Coordination	0	0	0	5	3	2	Meets criterion
8. Patient Choice	0	0	1	6	2	1	Meets criterion
9. Patient Safety	0	0	3	7	0	0	Meets criterion
10. Health Information Technology	0	0	4	5	1	0	Meets criterion

\* Mr. Harold Miller abstained from voting

### PTAC’s Overall Recommendation to the Secretary\*

Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
0	5	5	0	Recommend for limited-scale testing

\* Mr. Harold Miller abstained from voting

<sup>1</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

**Patient and Caregiver Support for Serious Illness (PACSSI)\***

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Does not meet		Meets		Priority consideration		Rating
	1	2	3	4	5	6	
1. Scope of Proposed PFPM (High Priority) <sup>1</sup>	0	0	2	1	0	7	Meets criterion and deserves priority consideration
2. Quality and Cost (High Priority)	0	6	1	0	2	1	Does not meet criterion
3. Payment Methodology (High Priority)	1	6	1	2	0	0	Does not meet criterion
4. Value over Volume	0	1	4	3	1	1	Meets criterion
5. Flexibility	0	0	1	6	1	2	Meets criterion
6. Ability to be Evaluated	0	0	6	2	1	1	Meets criterion
7. Integration and Care Coordination	0	0	2	4	3	1	Meets criterion
8. Patient Choice	0	1	0	3	5	1	Meets criterion and deserves priority consideration
9. Patient Safety	0	1	5	3	1	0	Meets criterion
10. Health Information Technology	0	2	8	0	0	0	Meets criterion

\* Mr. Harold Miller abstained from voting

**PTAC's Overall Recommendation to the Secretary\***

Do not recommend	Recommend for limited-scale testing	Recommend for implementation	Recommend for implementation as a high priority	Recommendation
2	7	1	0	Recommend for limited-scale testing

\* Mr. Harold Miller abstained from voting

<sup>1</sup>Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

## APPENDIX 1. COMMITTEE MEMBERS AND TERMS

**Jeffrey Bailet, MD, Chair**

**Elizabeth Mitchell, Vice-Chair**

Term Expires October 2018

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**Jeffrey Bailet, MD**  
*Blue Shield of California*  
San Francisco, CA

**Elizabeth Mitchell**  
*Blue Shield of California<sup>1</sup>*  
San Francisco, CA

**Robert Berenson, MD**  
*Urban Institute*  
Washington, DC

**Kavita Patel, MD, MSHS**  
*Brookings Institution*  
Washington, DC

Term Expires October 2019

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**Paul N. Casale, MD, MPH**  
*NewYork Quality Care*  
*NewYork-Presbyterian, Columbia*  
*University College of Physicians and*  
*Surgeons, Weill Cornell Medicine*  
New York, NY

**Bruce Steinwald, MBA**  
*Independent Consultant*  
Washington, DC

**Tim Ferris, MD, MPH**  
*Massachusetts General Physicians*  
*Organization*  
Boston, MA

Term Expires October 2020

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**Rhonda M. Medows, MD**  
*Providence Health & Services*  
Seattle, WA

**Len M. Nichols, PhD**  
*Center for Health Policy Research and Ethics*  
*George Mason University*  
Fairfax, VA

**Harold D. Miller**  
*Center for Healthcare Quality and*  
*Payment Reform*  
Pittsburgh, PA

**Grace Terrell, MD, MMM**  
*Envision Genomics*  
Huntsville, AL

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<sup>1</sup>Ms. Mitchell was President and CEO, Network for Regional Healthcare Improvement, when PTAC deliberated and voted on this proposal.

## APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

### PFPM CRITERIA ESTABLISHED BY THE SECRETARY

- 1. Scope.** 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.
- 2. Quality and Cost.** Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
- 3. Payment Methodology.** 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.
- 4. Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
- 5. Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
- 6. Ability to be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- 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.
- 8. Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- 9. Patient Safety.** Aim to maintain or improve standards of patient safety.
- 10. Health Information Technology.** Encourage use of health information technology to inform care.