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

Coalition to Transform Advanced Care

1299 Pennsylvania Ave NW, Suite 1175 | Washington, DC 20004

February 7, 2017

Proposal for a *Physician-Focused Payment Model: Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*

Attached, please find a submission from the Coalition to Transform Advanced Care for a Physician-Focused Payment Model entitled, *the Advanced Care Model (ACM)*.

If you have any questions related to the model, please contact:

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C-TAC
COALITION TO TRANSFORM ADVANCED CARE

February 7, 2017

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

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

Dear Committee Members,

On behalf of the Coalition to Transform Advanced Care, we would like to express our enthusiastic and strong support for the accompanying proposal, *the Advanced Care Model Service Delivery and Advanced Alternative Payment Model* for consideration for a Physician-Focused Payment Model.

The Advanced Care Model is a proven service delivery model and proposed new advanced alternative payment model (AAPM) to improve quality and cost outcomes for advanced illness beneficiaries. Today, many individuals with advanced illness receive care that is fragmented, uncoordinated, or inadequate to meet their growing needs and personal wishes. The ACM is specifically designed to meet these needs by "breaking down a range of silos between 'curative' and palliative care, between professional groups to foster interdisciplinary practice, and between traditional medical and social services" (IOM Report: *Dying in America*). The ACM AAPM payment can operate as a stand-alone APM and or in conjunction with existing APMs to ensure all Medicare FFS beneficiaries can access the needed ACM services. Furthermore, the ACM supports primary care and/or specialty provider participation. If implemented fully, the ACM would provide accountability for 25% of Medicare expenditures and engages with almost all members of the care delivery system.

Thank you for the opportunity to submit our proposal and for your consideration of its merits. We look forward to the opportunity to work with you on behalf of our members to ensure all Americans with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with the goals and values and honors their dignity.

Sincerely,

Tom Koutsoumpas, C-TAC Co-chair

Khue Nguyen, C-TAC Innovations COO

Abstract

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

The Advanced Care Model provides a population health management approach for the advanced illness population in the last year of life. The ACM goals are to improve quality, care experience, and cost outcomes for beneficiaries with advanced illness. The ACM integrates with existing APMs and contributes to their success. By creating an integrative model that is focused on a high-cost and high-need population, the ACM provides a mechanism to risk-stratify a broader Medicare population, specifies effective care interventions and creates additional financial incentives for existing APMs. In addition, the ACM will offer multiple pathways for organizations to incrementally add risk as existing or new APMs. Primary care providers and specialists can participate in the ACM APM for physician-focused payment incentives under the Quality Payment Program. Furthermore, the ACM meets the requirements for an advanced APM, with the potential to qualify participating palliative care providers and specialists.

The ACM delivers comprehensive, person-centered care management; multidisciplinary team-based care; concurrent curative and palliative treatment; care coordination across all care providers and settings; comprehensive advance care planning; shared decision making with patient, family, and providers; and 24/7 access to clinical support. ACM services end when the beneficiary enrolls in hospice or dies.

The ACM APM is designed to support provider investment in infrastructure, create an ROI opportunity, and help providers migrate from FFS to risk. The three core components of the payment model are 1) a PMPM for up to 12 months post enrollment; 2) a population and value-based payment through a phased-in two-sided risk arrangement; and 3) integration and coordination with available value-based payments. The PMPM will cover care management and ambulatory palliative care provider E&M visits. The value-based payment will be adjusted based on meeting a minimum quality performance threshold. The proposed shared-risk model will encompass total cost of care in the last year of life (including PMPM fees) and include a 75-85% shared savings and shared loss rate, 30% total savings limit, 10% total loss limit, and 4% total risk and minimum loss rate.

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I. Background and Model Overview

As Baby Boomers age, a growing number will eventually experience *advanced illness*, when one or more chronic conditions become serious enough that general health and functioning begin to decline and chances of recovery diminish, a process that continues to the end of life.[1] Although the advanced illness population contains only about 4% of Medicare beneficiaries, it accounts for 25% of annual Medicare expenditures[2]. In 2014, these patients' mean per capita utilization over the last six months of life totaled 8.4 days in the hospital, 9.4 days in SNF, 8 home health visits and 23.3 days in hospice; on average, each beneficiary saw 10.5 different physicians.[3] Of the 2.6 million people who died in the U.S. in 2014, 2.1 million, or 8 out of 10, were people on Medicare, making Medicare the largest insurer of medical care provided to those with advanced illness. [4]

This care is not just costly, but largely inconsistent with patients' values and preferences. Although most seriously ill patients would prefer to stay in the safety and comfort of their homes near the end of life, many are forced to cycle through a revolving door of repeated hospitalization.[5] Hospice, originally intended to support patients at home through their last months, today often consists of a few days of home-based care preceding death, tacked onto the end of a long siege of intensive inpatient treatment.[6] Other care models have been proposed to remedy this, but none have yet been successful. The Medicare Care Choices Model (MCCM), for example, has had challenges enrolling patients far enough upstream because it requires enrollees to already be hospice-eligible, whereas many are not clinically or emotionally ready.

The Institute of Medicine, in its landmark study, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,* calls for "breaking down a range of silos between 'curative' and palliative care, between professional groups to foster interdisciplinary practice, and between traditional medical and social services."[7] The Advanced Care Model (ACM) proposed here is designed to meet all these goals, as it bridges primary care and specialty providers, coordinates and supports a smooth progression from disease-modifying treatment toward a more palliative approach, and moves the focus of care for late-stage chronic illness out of the hospital and into the patient's home and community. In the process, it achieves the Triple Aim of better patient experience of care, improved quality and lower cost.

The ACM is based on established interventions including the Chronic Care Model, care transitions, shared decision-making and advanced care planning, palliative care, PACE, and hospice.[8] The ACM interventions have been widely tested by Medicare Advantage (MA) health plans,[9] the Center for Medicare & Medicaid Innovation (CMMI)[10], palliative care organizations,[11] and accountable care organizations (ACOs)[12].

The ACM is a population health, alternative-value-based payment model, accountable for the total health care expenditures for chronic-illness Medicare beneficiaries in the last year of life. The ACM alternative payments support team-based care provided across all major care settings, encompassing palliative care providers, other clinicians, and non-clinicians. The ACM is an APM added to usual Medicare FFS Part B professional payments. The ACM is proposed as a Physician-Focused Payment Model (PFPM) for advanced alternative payment model (AAPM), encouraging all-payer voluntary participation. The proposed ACM payment is a PMPM payment up to 12 months, with phased-in two-sided risks. The ACM may also function as a subset of a

broader APM such as the MSSP. In addition, other APMs and future PFPMs may transition eligible beneficiaries to the ACM.

The ACM target population is comprised of FFS Medicare beneficiaries with advancing chronic condition(s) associated with an expected one-year mortality. To be enrolled, these individuals must have one or more chronic conditions and show active and irreversible clinical, functional and/or nutritional decline as determined by clinical and utilization data (**Table 1)**. In addition, their clinicians must attest that the individual is likely to die in the next year.

Table 1. ACM Clinical Criteria

To be considered for ACM eligibility, beneficiaries must meet 2 of the following 8 criteria			
Acute Care Utilization	**Functional Decline**	**Nutritional Decline**	**Performance Scales**
1) 2 hospitalizations in the last 12 months *or* 2) 1 ER visit & 1 hospitalization in the last 6 months *or* 3) 2 ER visits in the last months	4) New, irreversible dependence in at least1 ADL in the last 3 months	5) Involuntary lean body weight loss ≥5% in the last 3 months	6) PPS ≤60 *or* 7) KPS ≤60 *or* 8) ECOG ≥3

ACM patient identification is accomplished through a manual process based on ACM clinical criteria that are predominantly determined through clinical assessment. The ACM entity's advanced illness population will be drawn from the participating physicians' Medicare FFS population. Ultimately, the ACM entity is accountable for all identified advanced illness beneficiaries of the participating providers. The ACM may rely on referrals from participating providers or predictive modeling tools for assistance with patient identification. Notification of enrollment to beneficiary and participating physicians is required.

The ACM embodies a "team of teams" approach employing provider-directed interdisciplinary teams that can function across inpatient, outpatient and home settings. Teams are charged with providing comprehensive, person-centered care management including a personalized and evolving mix of "curative" and palliative services, systematic and continuous advance care planning, patient and family engagement, and 24/7 access to a clinician. "Comprehensive care management" is defined as care coordination and case management of the patient's *total* healthcare needs, both curative and palliative, encompassing all services including provider, hospital, post-acute, and social services.

The team composition at minimum must include a provider with palliative or hospice care expertise, registered nurse and licensed social worker, and may include other clinicians and non-clinicians practicing within their state's scope of practice licensure. Modes of service delivery

are a mixture of face-to-face and telephonic encounters. The ACM entity must employ some face-to-face visits, particularly within 48 hours of enrollment and at transitions between care settings.

ACM services continue until the beneficiary dies or moves outside the service area. Early program discharges are permissible for individuals whose clinical condition improves. However, individuals who are initially enrolled and ultimately pass away within a 12-month period will remain attributed to the program's total cost of care accountability even if they are discharged from the program. The ACM PMPM payment has a 12-month cap, although individuals may remain enrolled in the program for a longer duration. The PMPM payment also ends at transfer to the Medicare hospice benefit.

The ACM can be implemented within a wide variety of provider organizations that can fulfill the ACM requirements, including ACOs, hospitals, IAH practices, medical groups (IPAs & CINs), home health agencies, hospices and others. Ancillary organizations such as health plans, care management and telehealth providers, EMT services and social service organizations may also participate, in partnership with a qualified provider entity. Physicians and other providers who participate in the ACM will be able to access the Quality Payment Program incentives associated with participation in the advanced APM. Small physician practices may also operate the ACM by aggregating together under an ACM-proposed consortium structure.

Table 2. ACM Summary

Target Population	Advanced illness beneficiaries
Services	Team-based care across care settings; concurrent palliative care and curative treatment; advanced care planning, comprehensive care management, home and telephonic visits, and 24/7 clinician access
Payment	AAPM: PMPM + phased-in two-sided risks; integrate and coordinate with other APMs,
Entity Type	Physician groups, hospitals, home health, hospice, small practices consortium, integrated health systems and others
Outcomes	Accountability for quality and expenditures for chronic illness care in the last 12 months of life

II. Scope of Proposed PFPM

The ACM is a new advanced APM, specifically designed to improve quality and cost outcomes for advanced illness and end-of-life care. The ACM is available to a wide range of Medicare provider entities (physician practices, hospitals, health system, hospice, home health and others), providing new opportunities for organizations that have not been central to the Medicare Shared Savings Program. In addition, the ACM supports collaboration with other ancillary organizations such as health plans, care management and telehealth providers, EMT services and social service organizations.

Physicians and other eligible professionals can operate the ACM or participate as identified referring providers. The ACM will provide an opportunity for small independent practices to pool together to operate the ACM or participate as referring providers of the ACM with a qualified ACM convener. Under the Quality Payment Program (QPP), Medicare part B provider participants may qualify for AAPM incentives. AAPM participation is possible for certain

medical specialists including palliative care providers, oncologists, cardiologists, pulmonologists and nephrologists and others who traditionally have a high proportion of advanced illness patients in their Medicare patient panels. In addition, the ACM proposes a new *partial AAPM incentive payment* for providers that enroll the majority of their advanced illness eligible beneficiaries in the ACM including primary care and other medical specialties (e.g. endocrinology) who traditionally manage large populations of highly prevalent chronic illness over time. We believed this concept is consistent with and would advance the goals described in the QPP rule, and would help ensure that the ACM's focused approach on patients with advanced illness does not make it unnecessarily difficult for participants to reach their AAPM threshold. Likewise, the proposal for a partial AAPM incentive payment seeks to balance the size of any incentive payment with the proportion of the overall Medicare FFS population served—while at the same time, encourages adoption of the model particularly by clinicians practicing in smaller groups and or those that have fewer AAPM opportunities (see section IV).

Advanced illness beneficiaries on average see 10.5 different physicians.[13] The ACM therefore provides an opportunity for most medical specialties to participate in an AAPM. In C-TAC's ACM readiness survey to a representative sample of member organizations over a 3-day timeframe, 100% of respondents indicated interest in participating in the ACM, representing over 40 states and $150 B in revenues **(Table 3)**.

Table 3. Representative Organizations Interested in ACM Implementation

Organization Name	Type of Organization	Geography	Revenue	Hospitals	Physicians	Populations
Aspire Health	Physician Group	19 States and DC				20,000 Advanced Illness MA Lives
ProHEALTH Care	Physician Group	NYC Metro Area	$500M		800	
Evolent Health	MSO	National	$49M			1.2 Million Care Management Members
Community Hospice	Hospice	Northeast Florida	$100M			
Hope West	Hospice	Western Colorado (5 counties)	$37M			
Compassus	Hospice	31 states	$164M			
UPMC	Health System &	Western Pennsylvania	$10B	25	3,600	3 Million MA Lives

	Health Plan					
Sharp Health	Health System & Health Plan	San Diego	$3B	7	2,900	
Spectrum Health	Health System	Michigan	$5B	12	3,200	
Sutter Health	Health System & Health Plan	N. California	$10B	25	5,300	Yes
Texas Health	Health System	North Central Texas (16 counties)	$4B	24	5,500	
Ochsner Health	Health System	SE Louisiana	$3B	30	1,100	
Allina Health	Health System	Minnesota/ Western Wisc	$4B	12	6,000	
Trinity Health	Health System	22 states	$16B	93	5,300	
Northwell Health	Health System	New York	$9B	21	2,700	Yes
Aetna	Health Plan	National	$63B			1.2 Million MA Lives
Blue Shield CA	Health Plan	California	$13B			1.8 Million MA Lives
Priority Health	Health Plan	Michigan	$3B	115	34,000	750,000 Total Lives

According to the Dartmouth Atlas, there were over 1 million chronically ill Medicare decedents in 2014. These individuals, representing the target ACM population, account for 25% of Medicare costs, nearly the size of the entire Medicare Advantage population. If the ACM initially enrolls 20% of the target population, the initial ACM pilot would affect 5% of Medicare FFS costs. With an average annual volume of 400 per ACM entity, this would equate to 550 ACM participant organizations (entities). This estimate is conservative; in comparison, the MCCM program (available to hospices only) is open to about 150,000 beneficiaries, roughly

10% of the ACM projected volume, and attracted over 140 participating organizations. The ACM is available to the full spectrum of provider organizations, encompasses a target population 10 times larger than that of the MCCM, and incorporates a compelling shared-risk model that fully rewards performance.

The ACM includes an inherent check-and-balance system focusing on quality and flexibility in a synergistic manner. While the program can be implemented by a range of organizations (flexibility), the ACM is also comprehensive in reach, person-centered in services, and vigorous in accountability. As such, the ACM is designed to ensure high quality and care model integrity to protect beneficiaries. The internal check-and-balance system includes person-centered quality metrics tied to payment, enrollment based on predefined clinical criteria with no predefined exclusions, broad physician participation, and a benchmarking quality monitoring program. Process and outcome metrics are designed with this primary goal. For example, most of the quality metrics being proposed will be determined by advanced illness beneficiaries and their family caregivers rather than by clinicians. Remaining quality metrics are outcome-based rather than surrogate outcome-based **(Table 4).** Therefore, the ACM is positioned to be evaluated by the most vigorous quality measurement approach possible (see Section VII for a comprehensive evaluation plan).

Table 4. Examples of ACM Person-centered Quality Metrics

Domain	**Metric**	**Data Source**
Quality	1. Level of symptom control	Survey
	2. Level of decision support	Survey
	3. Hospital admissions, last 12 months of life	Claims
	4. ED visits, last 12 months of life	Claims
	5. ICU days, last 12 months of life	Claims
	6. Hospice LOS (average & median)	Claims
Access	7. Visit within 48 hours of hospital discharge	EHR/Claims
	8. Responsiveness to emergent medical issues	Survey
	9. Evidence of advanced care planning within 14 days of enrollment	EHR/Claims
Person-centeredness	10. Person-centered goals documented in routine care notes	EHR/Claims
	11. Care/treatment consistent with preferences	EHR/Claims
	12. Level of confidence in managing illness	Survey
	13. Composite patient satisfaction score	Survey

Enrollment is based on advanced illness eligibility, not limited by age, gender, diagnoses or payor type (supports voluntary all-payor participation). Given that the ACM is an added value-based payment with specified person-centered care interventions requiring broad coordination and engagement by large numbers of providers (10.5 different physicians per beneficiary), it would be virtually impossible for the ACM to inappropriately drive utilization. In order to promote broad physician support, the ACM must operate with high integrity.

The ACM has been widely tested in the Medicare Advantage Program, despite the lack of critical volume (only 3 out of 10 advanced illness Medicare beneficiaries are in the Medicare Advantage Program, divided among multiple health plans[14]). Among the top 5 national health plans, those with significant MA members have invested heavily in similar ACM services including Aetna, United, Cigna and Humana. [15] For example, Aetna's Compassionate Care Program has delivered advanced illness care management services to Aetna's members since 2004. Compassionate Care has delivered significant, consistent and sustainable outcomes for over a decade: 82% hospice election rate, 81% decrease in acute days, 86% decrease in ICU days, high member and family satisfaction, and a total cost reduction of more than $12,000 per member.[9] As another example, Aspire Health, formed to scale ACM services for health plans and other risk-bearing entities, has served more than 20,000 Medicare Advantage members through successful contracts with 20 Medicare Advantage health plans, including four of the nation's five largest health plans. Aspire Health's internally-reported outcomes include a 50% reduction in hospitalizations, 75% hospice election rate, hospice mean length of stay (LOS) of 41 days and a mean LOS of 78 days, and total cost reduction of $10,000 per member. In addition, 4.8 out of 5 patients would recommend this service to a friend.

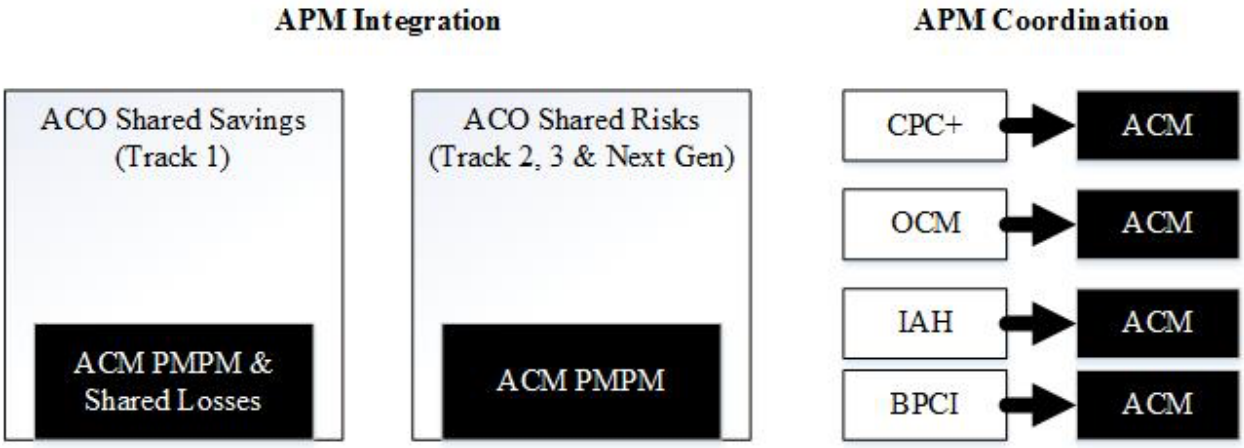
These MA successes suggest an extraordinary opportunity for the Medicare FFS Program. The ACM would provide a direct pathway for providers, creating what promises to be an effective bridge from volume to value-based care (CMMI HCIA High-Risk, High-Cost Portfolio)[16]. Given the overwhelming concentration of advanced illness in the Medicare FFS program, the ACM has the potential to create a positive spillover effect on quality and cost outcomes for the entire advanced illness population, including MA health plans, duals and private health spending.

While the ACM will allow providers to serve new populations of Medicare FFS beneficiaries, it also supports advanced illness beneficiaries assigned to existing alternative payment models, enhancing coordination, integration and patient choice. The ACM can function as a subset of broader advanced APM models such as the MSSP. In this layered arrangement, the MSSP program can access ACM PMPM payments for their advanced illness members whereas the ACM shared-risk is rolled up to the MSSP shared risk calculations. While the layered payment for MSSP provides the practical benefit of upfront PMPM payment, the greater contribution of the ACM layering is that it commits the MSSP to delivering a set of proven interventions to generate quality and cost outcomes for the highest-risk patients. Over 90% of the MSSP are in Track 1, a one-sided risk model that does not stimulate significant care improvement investments. The ACM layered payment for the MSSP Track 1 would subject the ACO to two-sided risk for the ACM population, providing a pathway for these ACOs to take on two-side risk gradually, thereby becoming an ACO Track 1+ organization that qualifies for AAPM designation under the Quality Payment Program.

In other APMs, providers have the option to migrate from an existing APM to the ACM once beneficiaries become clinically appropriate, giving providers the option to select a targeted APM

model to match the services delivered. This migration of payment models and services reflects the changing needs of Medicare beneficiaries and provides a continuum of services and payments to match enrollees' changing needs. Such natural migration is possible for numerous models, for instance BPCI to ACM, CPC+ to ACM, OCM to ACM, and IAH to ACM.

Diagram 1. Integration and Coordination with Advanced Illness Beneficiaries in Other APMs



Given that the ACM population represents 4% of the Medicare population, ACM entities must include a diverse group of physicians to generate sufficient volume for team-based resources. Natural conveners of physicians and other providers who may operate the ACM include health systems, hospitals, hospices, home health, ACOs, CINs, and medical groups.

However, it is critical that advanced illness beneficiaries from small independent physician practices have access to the ACM. Our proposed pathway for small independent physician practices is an option to aggregate through a consortium in a simple and highly feasible manner. Minimal requirements to operate the consortium are the commitment to fulfill practices' roles in the overall success of the consortium and to distribute shared risk based on transparent principles among practices. Given that the ACM will begin with shared savings before phasing to two-sided risks, the consortium will have time to refine its operations before it is subject to shared risk. The consortium makeup could be organized to meet AAPM designation and may span across states. The consortium could invest in shared infrastructure such as staff training or telemanagement, operating within state requirements. CMS could support the consortium structure by providing aggregated as well as practice-level reports. Furthermore, the CMS' reporting registries (e.g. PQRS) could be leveraged to support ACM consortium practice-level self-reporting. We anticipate that industry leaders, including C-TAC, would commit to developing additional tools to support the consortium structure.

III. Quality and Cost

The ACM has been shown to increase quality and to reduce total cost of care by one third or more[17]. These goals are accomplished by ensuring care is truly person-centered. This is particularly important in advanced illness. Because their burden of disease is so high, most individuals progressing to advanced illness have long since become accustomed to life as a patient with the hospital as their focus of care. However, the ACM gives them another choice by

demonstrating that high-quality care and support at home can not only be as effective as repeated hospitalizations, but also safer and more comfortable; congruent with their wishes.

The ACM produces value by assuring that care is preference-based, allowing patients who wish to avoid serial hospitalizations to receive their care at home, when and where they want it. This not only reduces the total cost of care directly, but also augments efficiency and reduces operational costs in the practice itself by mitigating workforce constraints. Primary care and palliative care clinicians are in increasingly short supply, and are now learning to increase efficiency by working through clinical teams. Implementing the team-based ACM can exert a multiplier effect, allowing each clinician to leverage time and work with more patients than in traditional practice. This can be especially valuable in MSSMs, whose ongoing economic viability depends on generating shared savings.

The ACM creates an ordered delivery structure that clinicians can use to reach a much larger patient panel than they could achieve by relying exclusively on traditional face-to-face encounters. For example, physicians may initiate advance care planning discussions with a patient during an office visit, then hand off to the ACM team to continue the discussion at home, where they can elicit and document patient values and preferences. The team then ensures the patient returns to the office, where shared decision-making can yield actionable physician orders. This team-based approach is more efficient and humane than forcing seriously ill patients to make multiple trips to the office, while also reducing caregiver burden. Outcomes improve as advance directives come to reflect current patient priorities, which may change as illness progresses.

ACM prototypes have achieved significant increases in quality and reductions in total cost of care. For example, Sutter Health's Advanced Illness Management (AIM) program, a CMMI HCIA Round 1 Awardee, reduced ambulatory-care-sensitive hospitalizations by 8.6 per thousand patients per quarter and saved $6,047 per beneficiary over just the last 30 days of life compared to a control group.[18] Most of the savings resulted from beneficiaries' choosing to stay at home rather than returning to the hospital at the end of life. Another program, developed by ProHealth ACO, a medical group in New York, produced savings over the last 3 months of life of $12,000, again driven primarily by a 34% reduction in hospitalization rates in the last 30 days.[19] Both programs also significantly boosted hospice enrollment rates and lengths of stay. Section II reports on similar impact under the Medicare Advantage Program.

An ACM measurement framework is proposed to measure its impact. This framework serves two purposes: to promote continuous learning through transparent monitoring and to hold programs accountable to high quality care. A core representative set of metrics is proposed for both ongoing monitoring purposes as well as to set minimum performance threshold for shared savings payments **(Table 5).** We propose existing metrics (e.g. NQF) where applicable. In addition, new metrics have been piloted in existing ACM programs to expand quality standards. These new quality metrics are survey-based, measuring from the perspectives of the beneficiaries or their family caregivers rather than from clinicians, representing a robust and person-centered standard for quality measurement. An example survey is provided. We recommend that ACM entities have the option to pilot their own quality survey covering similar topics to generate a broader testing of new person-centered quality metrics. Quality monitoring of active enrollees is proposed on a quarterly to semiannual basis, supporting timely feedback.

Table 5. ACM Quality and Care Metrics

Domain	Metric	Data Source	Quality Monitoring
METRICS TIED TO PAYMENT			
Quality	1. Level of symptom control	Survey	X
	2. Level of decision support	Survey	X
	3. Hospital admissions, last 12 months of life	Claims	
	4. ED visits, last 12 months of life	Claims	
	5. ICU days, last 12 months of life	Claims	
	6. Hospice LOS (average & median)	Claims	
Access	7. Visit within 48 hours of hospital discharge	EHR/Claims	X
	8. Responsiveness to emergent medical issues	Survey	X
	9. Evidence of advanced care planning within 14 days of enrollment	EHR/Claims	X
Person-centeredness	10. Person-centered goals documented in routine care notes	EHR/Claims	X
	11. Care/treatment consistent with preferences	EHR/Claims	X
	12. Level of confidence in managing illness	Survey	X
	13. Composite patient satisfaction score	Survey	X
ADDITIONAL METRICS FOR THE QUALITY MONITORING PROGRAM			
Quality	14. Hospitalization per 30 days per 100 enrollees	Claims	X
	15. ER visits per 30 days per 100 enrollees	Claims	X
	16. 30-day readmission rate	Claims	X
Access	17. Visit frequency by resource type and delivery mode (home, telephonic) per 30, 60, 90 days in program	EHR/Claims	X
	18. Population characteristics, eligibility profile, LOS by discharge disposition	EHR/Claims	X

	19. Care coordination with treating provider monthly	EHR/Claims	X
	20. Care plan updated and shared with patient monthly	EHR/Claims	X

ACM BENEFICIARY & FAMILY CAREGIVER SURVEY TEMPLATE

1. In the last 3 months, how often were your health symptoms controlled to your desired level?

   A. Never B. Sometimes C. Usually D. Always

2. In the last 3 months, how often did you feel you have the support that you needed from your Advanced Care Team to help you make decisions about your care?

   A. Never B. Sometimes C. Usually D. Always

3. In the last 3 months, how often did you receive the support or care that you needed for your urgent concerns?

   A. Never B. Sometimes C. Usually D. Always

4. In the last 3 months, how often did you feel confident about how to manage your health conditions?

   A. Never B. Sometimes C. Usually D. Always

5. On a scale of 1-10, please rate your overall satisfaction with the care that you received from your Advanced Care Team.

The ACM provides an opportunity to deepen our understanding of advanced illness. To promote this understanding, we propose that any metrics other than those applied through patient survey be reported electronically via EHR or claims. We further propose that CMS create an ACM encounter code for ACM entities to support future in-depth analysis of the advanced illness population over time, and to enable CMS to report on all proposed non-survey-based measures. This would promote efficiency, support timely reporting and reduce the ACM implementation burden.

IV. Payment Methodology

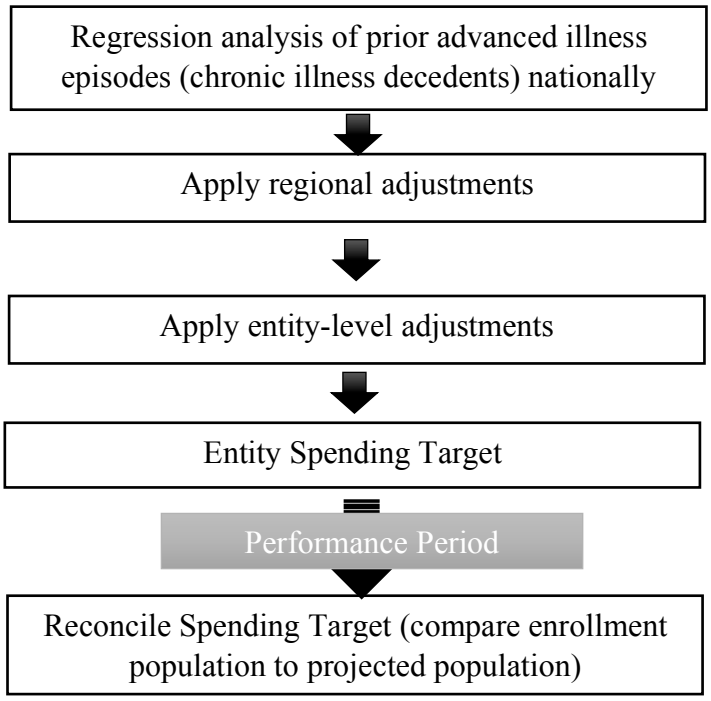
The ACM consists of PMPM payment and phased-in two-sided risk. The alternative payment replaces FFS payments for palliative care providers and broadens coverage to include additional team-based ACM services. The proposed PMPM base rate is $400, wage-adjusted, up to 12 months. Different payment schedules should be considered to support upfront investment such as an option to receive a lump sum payment for the first 3 months, subject to actual enrollment reconciliation at the end of a performance period. The PMPM ends when the beneficiary elects hospice, leaves the service area, dies without hospice, or is discharged due to significant clinical improvement. While the ACM PMPM is capped at 12 months, the ACM entity may follow

enrollees for a longer duration. The rationale is that clinical criteria are inherently imperfect and a small subset of beneficiaries may indeed outlive their 12 months prognosis. The ACM would begin with shared savings in the first year and transition to two-sided risk thereafter. The ACM shared-risk model will encompass total cost of care in the last year of life (including PMPM fees) and include a 75-85% shared savings and shared loss rate, 30% total savings limit, 10% total loss limit, and 4% total risk and minimum loss rate. ACM entities that do not achieve shared savings will have a six-month correction phase. At the end of this phase, ACM entities that are unable to perform in two-sided risk will be required to drop out.

In determining the shared-savings methodology, we reviewed existing approaches including those reliant on prospective HCC-risk adjustment to align historical benchmark and performance-year population, matched-control, and episode-based actuarial modeling. We ruled out HCC-risk adjustment as a primary component of financial modeling for this population as the cost of care dramatically shifts during the intervention year, especially in the last six months of life. Use of HCC-risk adjustment based on prior year's experience to predict intervention year cost based on a historical benchmark population is therefore challenging. Although a matched-control method might be more feasible, the spending target cannot be determined until the end of the performance year and the method requires more effort to set up, including matching analysis for each ACM entity.

Episode-based actuarial modeling is a more compelling method. Under this method, we recommend that CMS determines the advanced illness episode cost from prior years and applies additional adjustments to project the ACM entity's spending target. The advanced illness episode is defined as the last 12 months of life for chronically ill beneficiaries. Regression analyses can be used to determine appropriate categories of advanced illness episode types (e.g. HF, cancer, multiple advanced conditions) and variations in cost based on population size and episode mix. To determine the ACM entity-spending target, we propose regional adjustment followed by entity-level adjustments. Regional adjustments would factor in differences in medical culture and practice patterns as well as social-economic trends. Entity-level adjustments would factor in entity-level population size and episode mix. Adjustment would ensure that the projected population for the entity matches on key variables **(Diagram 2)**. Outlier cases above the 95th percentile would be further adjusted or excluded from the shared savings analysis.

Diagram 2. Advanced Illness Episode Modeling



Adjustment Variables

Status prior to intervention: utilization & demographic during year 2 (mos 12-24) prior to death:

- Age, sex, total cost of care, number of hospitalizations, SNF days & home health episodes

Clinical status at intervention: last year prior to death:

- HCC Score, Primary Advanced Illness CC, Duals status

The ACM entity is accountable for all identified advanced illness beneficiaries of the participating providers. The shared savings analysis is applied to enrollees that have died by the end of the performance year, including enrollees who were prematurely discharged. Shared savings or losses are determined by comparing the total cost of care of the intervention group with the entity's spending target. A reconciliation step is proposed to correct for significant discrepancies in the spending target price based on significant changes in the actual enrollment population vs. the projected population. Given that the ACM entity is being compared to the regional price, with further adjustment to reflect the volume size and episode mix associated with the entity, the ACM will continue to reward any ACM entity that can outperform their regional market. Over time, the ACM participation rate may become saturated, at which point the ACM becomes a standard of care. At such successful phase, the ACM payment can convert to an updated PMPM and pay-for-performance payment.

The ACM patient identification process identifies patients based on ACM clinical criteria determined through clinical assessment. These clinical criteria cannot be identified in the claims database. To date, state-of-the-art predictive algorithms are capable of identifying under half of the eligible population, while clinical criteria can yield 80-90% accuracy. Follow-up assessments can ultimately fine-tune the initial estimate.

The spending target reconciliation step proposed above accounts for the imperfect science of advanced illness identification. Furthermore, it allows CMS to monitor for discrepancies in the manual enrollment process. Patient selection bias would be detected and differentiated from general inexperience with ACM implementation. These discrepancies would be detected earlier in the performance period through the proposed quality monitoring program, which will track the intervention population characteristics. The reconciliation step provides an enhanced analysis.

ACM entities who underperform on their enrollment process will be required to develop a corrective action plan. ACM entities exhibiting a skewed enrollment pattern will be required to conduct a more vigorous review and corrective action plan and/or may face disqualification.

The ACM is the only APM to fully address the unique needs and opportunities in advanced illness care. The ACM target population, which represents a significant proportion of Medicare's highest-need population, can be found in all current Medicare APM programs. Significant population overlaps exists with CPC+, IAH, and MCCM. The level of population overlap between CPC+ and IAH with ACM could range between 10-30%, whereas the MCCM population is a complete subset of a much broader ACM population. In other models, the ACM is a natural payment and service program to fill gaps once a model ends; for example in the chronic illness (HF, COPD) BCPI and OCM programs. Despite the population overlap, the ACM is unique in that it specifies a set of services, metrics, monitoring program and fuller payment model with two-side risks.

A primary goal of the ACM is to promote participation in value-based payments and to capture new FFS beneficiaries for this high-need population. Another equally important goal is for the ACM to enhance existing APMs. A layered payment approach is available to MSSP programs and may help 90% of them migrate gradually to two-sided risk. For other models, migration to the ACM for the overlapping population may fill a gap and/or provide greater incentives.

By participating in the ACM, providers may access incentives associated with an AAPM under the Quality Payment Program. Provider participation is predetermined at the start of a performance period. The ACM draws its advanced illness population from the participating provider's FFS Medicare population. By choosing to participate in the ACM, providers are committing to the ACM's model of care and the collaboration with the ACM care team to maximize quality for their advanced illness patients. Through participation in the ACM, providers can qualify for Advanced APM status if they meet the population threshold requirements and earn enhanced incentives under the Quality Payment Program.

Alternatively, we propose a partial AAPM incentive for remaining providers. Under the partial Advanced APM incentive, providers with a high advanced illness enrollment (75%) would have access to the 5% bonus payment for their advanced illness professional fees. This arrangement would provide the appropriate incentives to primary care providers who are active in the ACM care, but have a very small proportion of advanced illness in their overall Medicare population. In this regard, we believe this concept is consistent with and would advance the goals described in the QPP rule, and would help ensure that the ACM's focused approach on patients with advanced illness does not make it unnecessarily difficult for participants to reach their AAPM thresholds. Likewise, the proposal for a partial AAPM incentive payment seeks to balance the size of any incentive payment with the proportion of the Medicare FFS population being cared for in the ACM—while at the same time, encourages adoption of the model particularly by clinicians practicing in smaller groups and or those that may have fewer AAPM opportunities.

Table 6. Quality Payment Program for ACM Participating Providers

Advanced APM	Meet AAPM threshold
Partial AAPM Incentive	Advanced illness enrollment rate of 75% or greater, Apply AAPM financial incentive (5% bonus payment) for *advanced illness Part B professional fees*

To support the ACM care delivery and payment model, we propose that CMS applies regulatory waivers from Next Gen ACO to the ACM model. Furthermore, we recommend waivers including the removal of beneficiary's coinsurance requirement for ACM services and conditions-of-participation requirements for hospice and home health for the provision of ACM services.

V. Value over Volume

The ACM incentivizes clinicians to provide more home-based care for their sickest and most vulnerable patients, and disincentivizes recurring hospitalizations for these patients. This reduces overall healthcare costs because it moves the focus of care from the hospital, the most expensive care setting, to the patient's home, where care delivery is more cost-effective and person-centered.

The ACM AAPM provides both financial and nonfinancial incentives to providers to change the way they practice. Financial incentives include reimbursement and shared savings associated with the ACM APM and additional incentives for participation in an AAPM under the Quality Payment Program. The upfront payment supports the finance of the ACM operation of interdisciplinary care team. The shared savings is a trade-off for higher quality person-centered care from forgone revenue associated with hospitalization and ICU care. The most potent driver of treatment volume and costs in the care of advanced illness is hospitalization, particularly over the 3 months prior to death as admissions become longer and more frequent. Many of these hospital stays can be prevented through education, advance care planning and shared decision making that allow fully informed patients to stay at home through the end of life. The high probability of savings encourages providers to accept the alternative payment model and promotes the success of ACOs and other existing APMs.

The ACM can also reduce costs at the practice level. Providers must find new ways to care for the large and growing number of patients with late-stage chronic illness. Using home-based teams enables existing providers to manage their sickest and most vulnerable patients at home, allowing the group to avoid the cost of augmenting clinical and office staff and disrupting practice workflow.

Nonfinancial incentives provided by the ACM center on the multidisciplinary team, which enables participating physicians and other providers to participate in care at home without having to do multiple house calls themselves. ACM team members act as the physician's eyes, ears and hands through face-to-face and virtual visits at the patient's residence. Team members are also trained to manage pain and other symptoms, and actively collaborate, within limits of their license, with recommendations to physicians who may lack training and experience in palliative care. Team input to physicians provides invaluable information about the patient's home environment, family and caregiver stressors and other non-medical determinants of health. A survey of physicians using the ACM showed that over ¾ reported that the intervention reduced their workload.[20]

The C-TAC team has had extensive experience in the use of these incentives through their prior work at health system and health plan and through their current involvement in guiding organizations through ACM implementation. For example, the AIM program is a broad-scale

implementation of a 24-hospital integrated system in Northern California over a 20-county footprint, which includes both metropolitan and rural areas. Aetna's Compassionate Care® program is nationally scaled for Aetna members for over a decade. Respecting Choices® (RC), is an internationally recognized, evidence-based system of advance care planning facilitated by trained staff and community volunteers which has succeeded in changing the medical culture of hospitals and practices nationally and internally for over two decades.

VI. Flexibility

The ACM is flexible in several ways. Eligibility requirements are broad and can include any Medicare provider organization. Examples of ACM-eligible entities include physician groups, CINs, ACOs, hospital, hospice, home health and health agencies. Furthermore, the ACM proposes a consortium structure to support simple aggregation of small physician practices that can span state borders. From a care delivery aspect, ACM entities have flexibility over how they organize team-based services, subject to core service requirements. At a population level, the ACM accepts patients of all diagnoses, including cancer and non-cancer disease as well as geriatric frailty. The ACM therefore can be applied to multispecialty practices or specific specialties such as primary care or cardiology. The ACM payment is also dynamic. The ACM entity can choose to apply the ACM payment to new populations and/or existing APM attribution.

VII. Ability to be Evaluated

The ACM evaluation can be structured from the measurement plan and shared savings analysis framework. Key outcome measures can be compared between the intervention group and usual care **(Table 7)** for advanced illness decedents.

Table 7. Evaluable Metrics for the ACM Program and Usual Care

Domain	Metric	Data Source
Quality	1. Hospital admissions, last 12 months of life	Claims
	2. ED visits, last 12 months of life	Claims
	3. ICU days, last 12 months of life	Claims
	4. Hospice LOS (average & median)	Claims
Shared Savings Metric	5. Total cost of care, last 12 months of life	Claims

The adjustment variables in the financial modeling framework proposed in Section IV (episode-based actuarial modeling) can be used to develop a matched-control group. This includes conducting the evaluation at the regional level and matching a control group to entity-level advanced illness episode mix.

CMS could also conduct additional prospective evaluations to enhance the claims-based analysis and/or analyze additional quality measures. A prospective control group could be constructed by applying the patient identification criteria and measuring on all metrics associated with payment

(**Table 8**). This additional analysis could also measure the survival time of those in the intervention group compared to the control group. C-TAC would be committed to working with partners to conduct this additional evaluation if the ACM is approved.

Table 8. ACM Metrics Tied to Payment

Domain	Metric	Data Source
Quality	1. Level of symptom control	Survey
	2. Level of decision support	Survey
	3. Hospital admissions, last 12 months of life	Claims
	4. ED visits, last 12 months of life	Claims
	5. ICU days, last 12 months of life	Claims
	6. Hospice LOS (average & median)	Claims
Access	7. Visit within 48 hours of hospital discharge	EHR/Claims
	8. Responsiveness to emergent medical issues	Survey
	9. Evidence of advanced care planning within 14 days of enrollment	EHR/Claims
Person-centeredness	10. Person-centered goals documented in routine care notes	EHR/Claims
	11. Care/treatment consistent with preferences	EHR/Claims
	12. Level of confidence in managing illness	Survey
	13. Composite patient satisfaction score	Survey

VIII. Integration and Care Coordination

ACM implementation creates a fully integrated delivery structure that provides seamless care to beneficiaries with advanced illness across major clinical dimensions:

- Space: from inpatient through ambulatory to home settings
- Time: from onset of advanced illness through disease progression to the end of life
- Treatment: from intensive disease-modifying treatment through palliation to hospice

Comprehensive care coordination is accomplished through the following processes:

- Furnishing high-impact interdisciplinary team visits in hospital, office/clinic and home

- Providing comprehensive transitional and post-acute care
- Establishing efficient and reliable handoff processes among teams and settings
- Facilitating advance care planning over time, at the patient's own pace, in all settings
- Eliminating unwanted or duplicative visits and interventions
- Employing standardized, proactive telemanagement procedures
- Ensuring effective and timely communication across all clinical settings
- Engaging principal primary and specialty physicians as core members of the clinical team
- Helping patient and family navigate among disparate providers
- Educating and supporting patients, family members and caregivers in self-management
- Assuring adequate family and caregiver support to minimize hospital and SNF transfers
- Extending the reach of palliative care from hospitals into home and community
- Optimizing EHR to serve as a reliable communications channel among clinical settings
- Integrating facility and community social services into the clinical workflow

A core function of the ACM is to ensure that explicit and well-documented care plans are in place for all providers, and to reconcile all input from PCPs, specialists and hospitalists so that orders, medications, appointments and other critical elements are unified into a single plan of care that is easily understood by patients, family members and caregivers so that they can understand how best to navigate their own complex and unique systems of care. This unified care plan is documented in the medical record and transmitted to all involved clinicians to ensure all needed services are delivered in a coordinated manner across inpatient, ambulatory, home and long-term care settings. The ACM team may perform all these tasks, or form co-management partnerships with other providers and teams in the existing care structure. Participating provider participation is supported through enhanced incentives available under the Quality Payment Program. APM coordination and integration is also a distinguishing feature of the ACM (see Payment Methodology).

IX. Patient Choice

The ACM enhances patient choices for Medicare FFS beneficiaries. The ACM care delivery model is designed to promote patient choice in a fragmented care delivery system. Core ACM services include care coordination across care settings and services, comprehensive advanced care planning and symptom management support. These interventions are designed to help beneficiaries receive the care that they want and need. When these interventions are implemented, population health outcomes of reduced hospitalizations and appropriate increased hospice use are achieved. This does not imply that uniform outcomes are expected, and some patients may continue to have repeated hospitalizations and may never utilize hospice care. Nevertheless, regardless of socio-economic, clinical or geographic differences, beneficiaries can expect to receive services that target their unique needs and preferences. To ensure that individualized care needs are addressed, ACM quality metrics are designed for the beneficiary or their family caregiver representative rather than ACM clinicians (see Section II).

X. Patient Safety

The ACM prevents harm and promotes patient safety in several ways. For example, because home-based care allows the team to assess and manage both clinical and social determinants of health in real time, changes in patient status can be monitored closely, avoiding crises that often lead to ER visits and hospital admissions. In addition, medical errors are avoided as the ACM

team coordinates visits with the primary physician and multiple specialists, tracking their recommendations so that orders, medications and other critical elements may be reconciled and understood by patients, families and caregivers.

However, because the ACM supports a natural transition from disease-modifying treatment toward care based on comfort, it promotes patient safety in a more fundamental way. Although prevailing wisdom and community standards of practice tend to support increasingly aggressive treatment as disease advances, evidence is accumulating that this approach harms patients. Meta-analyses of controlled trials show that once patients reach the advanced stage of chronic illness, most disease-modifying treatments (with rare exceptions, such as beta blockers in advanced systolic heart failure) do not prolong survival, and death occurs rapidly and predictably in most cases.[21,22] In contrast, early palliative care or hospice enrollment has been shown to prolong life by months on average compared to standard treatment in advanced illness.[23,24] The ACM may therefore prevent harm and promote patient safety to a greater degree compared to persistent pursuit of traditional treatment.

XI. Health Information Technology

The ACM requires participating entities to utilize an EHR. Care coordination and care management are central interventions of the ACM. The communication and sharing of care plans between the ACM and the beneficiary's usual care team can be optimized through the electronic platform. Furthermore, we propose that CMS provide an ACM encounter code. This code would allow ACM entities to submit their electronic care encounters, including ACM care plans, to the CMS claims system. The electronic care encounter would contain clinical information that can be used to calculate new metrics for the ACM program. These include clinical eligibility information for each enrollee and care process activities such as advanced care planning and ACM patient encounter within 48 hours of hospital discharge. Given that the ACM can be operated by provider entities other than physician practices, we ask that CMS consider the use of non-certified EHR to be qualified for Advanced APM designation. We anticipate that telehealth technology, secured texting; videoconferencing and use for registry and/or health information exchange solutions will be leveraged to maximize efficiency of the ACM. Finally, the ACM entity must follow patient privacy laws and requirements.

XII. Supplemental Information

The ACM was designed with the invaluable input of innovators and health care leaders. We would like to acknowledge the planning committee for their dedications to ensure the ACM represents our collective knowledge of advanced care models across the U.S. These members include: Aetna: Alena Baquet-Simpson; Aspire Health: Brad Smith; Northwell Health: Kristofer Smith; Priority Health: Greg Gadbois; Sutter Health: Monique Reese and Beth Mahler; and C-TAC: Khue Nguyen, Brad Stuart, Tom Koutsoumpas, Randy Krakauer, Gary Bacher, Mark Sterling, and Marian Grant.

Furthermore, letter of supports are presented in Appendix A.

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Appendix A

- Aetna
- Aspire Health
- Center to Advance Palliative Care Letter of Support
- Ochsner Health
- Spectrum Health
- UPMC

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Senior Director, Medical Health Services
axsimpson@aetna.com

February 7, 2017

Physician-Focused Payment Model Technical Advisory Committee
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Washington, D.C. 20201
PTAC@hhs.gov

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

Dear Committee Members,

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

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

Aetna has been a leader in management of Advanced Illness for more than 10 years, and our Compassionate Care program is an industry leader. We believe the ACM is a natural and yet critical breakthrough to dramatically improve advanced illness and end of life care in America.

As Senior Director Medical Health Services, Aetna Medicare, I greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

Alena M. Baquet-Simpson, MD
Senior Director, Medical Health Services

Aetna

Aspire Health

February 6, 2017

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

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

Dear Committee Members,

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

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

As background, Aspire Health is the nation's largest provider of home-based advanced illness services, serving patients in 19 states and 42 cities. To date, we have served over 20,000 patients with a serious illness through our partnerships with Aetna, Anthem, BlueCross BlueShield of Alabama, BlueCross BlueShield of Tennessee, Cigna-HealthSpring, Health Care Services Corporation, Highmark, Humana, Priority Health, Universal American and many others. We have seen strong outcomes for our patients including:

- Patient and family satisfaction scores of 4.8 on a 5.0 scale when patients are asked if they would recommend our services to a loved one
- 50%+ reductions in hospitalizations
- 70%+ of our patients who pass away end up passing away in a hospice with a median length of stay in hospice of 41 days and a mean length of stay in hospice of 78 days
- $10,000+ in savings per patient we serve who passes away

In the case of advances illness services, Medicare Advantage plans have played the role we believe the government intended, driving innovative and creative solutions that benefit patients, families and the overall healthcare system. Unfortunately, because of the lack of reimbursement for advance illness services for traditional Medicare fee-for-service patients, we are currently not able to see Medicare fee-for-service patients today in most of the 19 states and 42 cities where we operate. A model like C-TAC's Advanced Care Model would allow us to begin serving Medicare fee-for-service patients immediately.

We would also be open to an ACM that included lower cost to the federal government, specifically shared savings that are only half of those proposed in the C-TAC Advanced Care Model (e.g., providers receiving 30% to 40% of shared savings vs. 70% to 80% of shared savings). We believe this change would allow programs like ours to provide high-quality services to patients facing an advanced illness while lowering overall cost to the federal government.

I greatly appreciate the opportunity to endorse C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

Brad Smith
Co-Founder and Chief Executive Officer
Aspire Health

February 3, 2017

Physician-Focused Payment Model Technical Advisory Committee
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RE: Letter of Support-- Advanced Care Model (ACM)

Dear Committee Members,

I am writing on behalf of the Center to Advance Palliative Care (CAPC) to express our support for an advanced alternative payment model targeted to Medicare beneficiaries with serious illness. The Advanced Care Model submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) provides an example of an opportunity to improve quality, care experience and cost outcomes, focused on a subset of Medicare beneficiaries with serious illness who are expected to die within 12 months.

The Advanced Care Model (ACM) relies on many of the standards and evidence-basis in the palliative care field, and with the payment structure and incentives proposed, it will broaden the reach of home-based palliative care to those in need. We appreciate the model's flexibility, its inclusion of patient-reported outcomes, and the opportunity for independent small practices to participate in advanced alternative payment models. We also appreciate the option for the ACM to integrate or dovetail with other alternative payment models, such as the MSSP, IAH or CPC+ programs, which will enable other at-risk provider groups to improve the care they deliver to their most seriously ill patients. That being said, we strongly advocate that all participating entities continue to meet the Medicare conditions of participation.

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

As the Director of CAPC, I appreciate the opportunity to comment on C-TAC's Advanced Care Model and would be willing to speak to the Committee to answer any questions.

Sincerely,

Diane E. Meier

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Ochsner Health System

February 2, 2017

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

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

Dear Committee Members,

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

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

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

I greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model and will fully support the implementation of the model going forward.

Sincerely,

Philip M. Oravetz
Medical Director, Accountable Care
Ochsner Health System

SPECTRUM HEALTH

February 7, 2017

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

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

Dear Committee Members,

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

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

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

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

Sincerely,

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

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

UPMC *Insurance Services Division*

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February 7, 2017

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

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

Dear Committee Members,

On behalf of the UPMC Insurance Services Division and the UPMC Center for High-Value Health Care (the Center), I am delighted to offer this letter of support for the Advanced Care Model submitted by The Coalition to Transform Advanced Care (C-TAC) to the Physician Focused Payment Model Technical Advisory Committee (PTAC) for review and approval. It is our strong belief that implementation of this model will substantially improve quality, care experience and cost outcomes for Medicare beneficiaries with advanced illness.

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

As a health care payer within one of the nation's largest integrated delivery and financing system, the UPMC Insurance Services Division believes the ACM is a natural and yet critical breakthrough to dramatically improve advanced illness and end of life care in America. A fully owned subsidiary of UPMC and a global enterprise, the UPMC Insurance Services Division offers a full range of group health insurance, Medicare, Medicaid, Special Needs Plan, Children's Health Insurance Program, behavioral health, employee assistance, and workers' compensation products and services to over 3 million members. The Center, a non-profit health services research organization, translates the work of UPMC's unique payer-provider laboratory into evidence-based practice and policy change for improving health care quality and efficiency. As the Associate Vice President of the Center, I greatly appreciate the opportunity to endorse the approval of the C-TAC's Advanced Care Model.

Sincerely,

Donna J. Keyser

Donna Keyser, PhD, MBA
Associate Vice President
UPMC Center for High-Value Health Care