Center to Advance Palliative Care
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April 19, 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: Requested Modification to the Advanced Care Model (ACM): Two-Tier Pricing Model

Dear Committee Members,

We have written to you previously in support of the Advanced Care Model, and more recently with additional comments on that proposal jointly submitted with our colleagues at the American Academy of Hospice and Palliative Medicine (AAHPM). Since that time, AAHPM has submitted a Letter of Intent for a payment model targeting a similar population, and CAPC would now like to propose a modification to the ACM that consolidates the best of both approaches, ensuring high-quality and cost-effective care for many more Medicare beneficiaries with serious illness.

Specifically, we would like the Committee to consider a two-tiered payment model, with a lower monthly payment for eligible beneficiaries, and a higher monthly payment to accommodate those who transition to home-based care.

A two-tiered approach is needed for two reasons. First, the ACM, as currently proposed, targets "Medicare beneficiaries with advancing chronic condition(s) associated with an expected one-year mortality" and yet we know, through the National Academy of Medicine's 2014 Report "*Dying in America*"[i] that only a small fraction –11 % – of the costliest 5% of patients are in the last year of life.

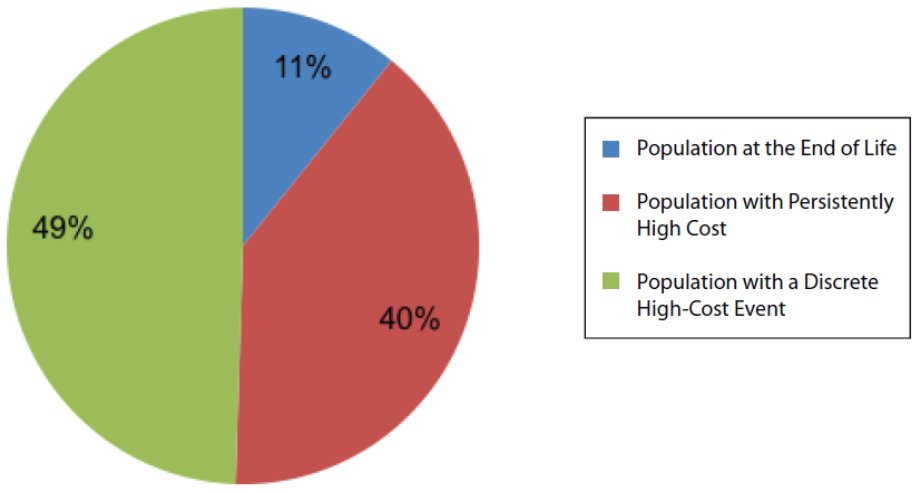


FIGURE E-18 Population with the highest health care costs (top 5 percent) by illness trajectory.

Many of the remaining high-cost individuals, especially the 40% with year-after-year of intense medical intervention, can benefit from palliative care – as many as 2.75 million Medicare beneficiaries, according to the letter of intent from the AAHPM. Yet absent an alternative payment model, access to high-quality palliative care remains a challenge for those with both a high symptom burden and multi-year survival.

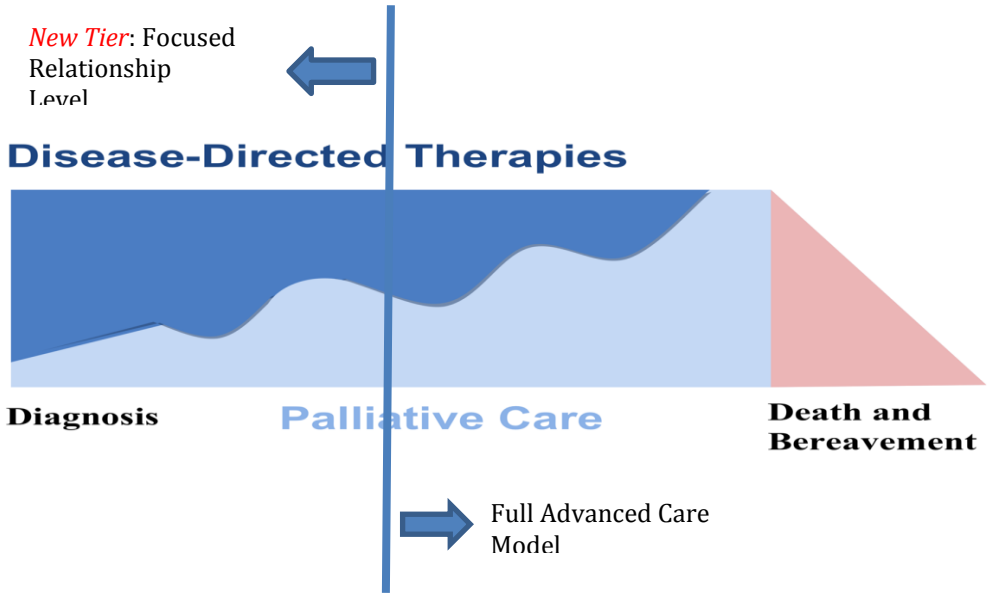
A two-tiered payment model also reflects the reality of how palliative care is provided. Like certain other specialists and reflected in CMS' recent definition of Patient Relationship Categories (section 1848(r)(3) of the Medicare and CHIP Reauthorization Act), the palliative care team's relationship to the patient can either be:

- A few consult visits
- A "continuous/focused" or "episodic/focused" relationship, where the specialty team focuses on symptoms and stressors while the treating clinicians manage the patient overall
- A "continuous/broad" relationship

The Advanced Care Model, which includes "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" falls into the "continuous/broad" category because it is that team assuming responsibility for patient care management and response. On the other end of the spectrum – those patients in need of one or several consultations from a palliative care specialty team – the current fee-for-service payment model, while not ideal, suffices.

Where the Advanced Care Model falls short is the "focused" patient relationship, which applies to many more of the high-cost/high-need population. A second payment tier is needed for this approach, where the team focuses on the palliative care services while other clinicians assume responsibility for the curative treatment and comprehensive care management; both teams can share responsibility for 24/7 clinician access and home visits are unlikely.

The new tier would apply to palliative care teams in office/clinic settings, such as embedded palliative care in Oncology or Cardiology practices.



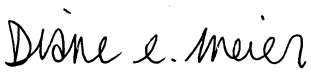
There are several ways to identify the population in the Focused Relationship Level. CAPC recommends that it be based on specified patient diagnoses combined with a prior ED or urgent care visit or hospitalization[ii] as this is all available in claims data.

We further recommend that the first tier also be paid as a per-beneficiary-per-month, although we not able to recommend a dollar amount at this time. One possibility might be to set the first tier as a percentage of the full ACM payment, say 65-75%.

In closing, we continue to support strongly an alternative payment model which enables comprehensive care of those with serious illness. Palliative care is a necessary component of serious illness care, and has been proven to improve quality-of-life and quality-of-care, and in so doing, avoid unnecessary spending. We urge the Committee to take this opportunity to facilitate the provision of palliative care to all Medicare beneficiaries who could benefit, and not just those near the end-of-life who receive a comprehensive program.

I appreciate the opportunity to propose this modification to C-TAC's Advanced Care Model and would be willing to speak to the Committee to answer any questions.

Sincerely,



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cc: Phillip Rodgers, MD, AAHPM APM Task Force
Khue Nguyen, PharmD, COO C-TAC Innovations

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[i] Institute of Medicine, Dying in America: improving quality and honoring individual preferences near the end of life: Appendix E September 17, 2014

[ii] Kelley AS, et. al., "Identifying Older Adults with Serious Illness: A Critical Step toward Improving the Value of Health Care" *Health Services Research* March 18, 2016