



March 6, 2017

Ann Page, Designated Federal Official  
Office of Health Policy, Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services  
200 Independence Ave SW  
Washington, DC 20201

*Submitted electronically via [PTAC@hhs.gov](mailto:PTAC@hhs.gov)*

**Re: Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model**

Dear Ms. Page:

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

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our core mission is to expand access of patients and families to high-quality palliative care and advance the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research and public policy. Our more than 5,000 members include not only physicians but nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families. C-TAC’s proposal focuses on the patients and caregivers that AAHPM members serve every day.

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

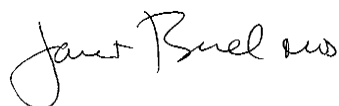
In summary, AAHPM and CAPC believe that the PFFM proposed by C-TAC to support their Advanced Care Model (ACM) is thoughtfully constructed and emphasizes many key aspects of high-quality care for patients with serious illness. C-TAC's proposed PFFM may successfully support the select palliative care providers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

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

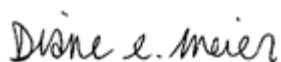
It is important to note that AAHPM's proposal also includes full-risk options that would enable successful participation by organizations implementing C-TAC's ACM model, while also providing critical opportunities for many more palliative care teams to participate in different markets and in different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

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

Sincerely,



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



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



**American Hospital  
Association®**

800 10th Street, NW  
Two CityCenter, Suite 400  
Washington, DC 20001-4956  
(202) 638-1100 Phone  
[www.aha.org](http://www.aha.org)

March 2, 2017

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

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

Dear Committee Members,

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

The ACM is designed to deliver comprehensive, person-centered care management; multidisciplinary team-based care; concurrent curative and palliative treatment; care coordination across all care providers and settings; comprehensive advance care planning; shared decision making with patient, family, and providers; and 24/7 access to clinical support. This integrative model focuses on a high-cost and high-need population, specifying care interventions that are based upon industry-recognized standards drawn from numerous evidence-based advanced illness and palliative care programs. In addition, the ACM will offer multiple pathways for organizations to incrementally add risk as existing or new APMs. This approach to alternative payment model provides needed and appropriate incentives for existing programs to broaden their reach and for new organizations to participate in value-based alternative payment programs. We applaud the model's multiple strategies for the ACM to integrate or align with other alternative payment models underway and believe the ACM offers a unique approach to dramatically improve advanced illness and end of life care in America.

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



Sincerely,

/s/

Ashley Thompson  
Senior Vice President  
Public Policy Analysis and Development

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](mailto:PTAC@ghha.gov)



55 West 125th Street  
13th Floor  
New York, NY 10027  
TEL 212-201-2670  
FAX 212-426-1369  
[capc.org](http://capc.org)

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*”<sup>i</sup> that only a small fraction – 11 % – of the costliest 5% of patients are in the last year of life.

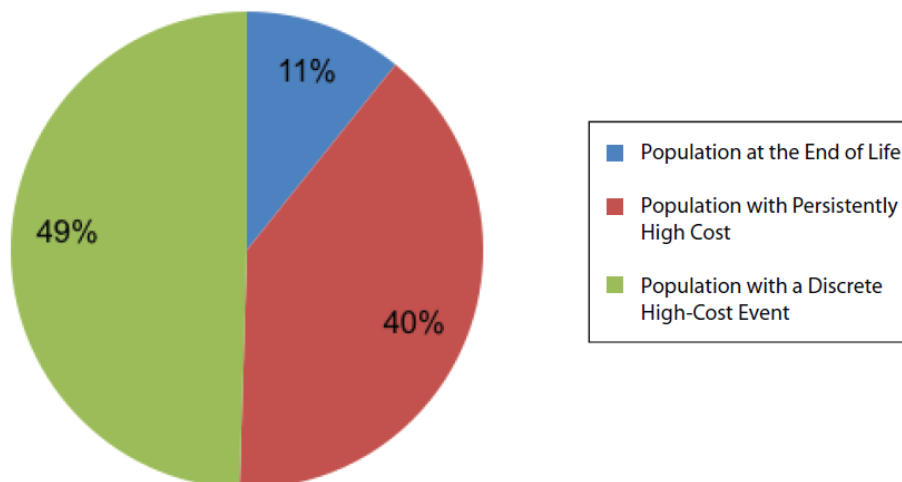


FIGURE E-18 Population with the highest health care costs (top 5 percent) by illness trajectory.

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.

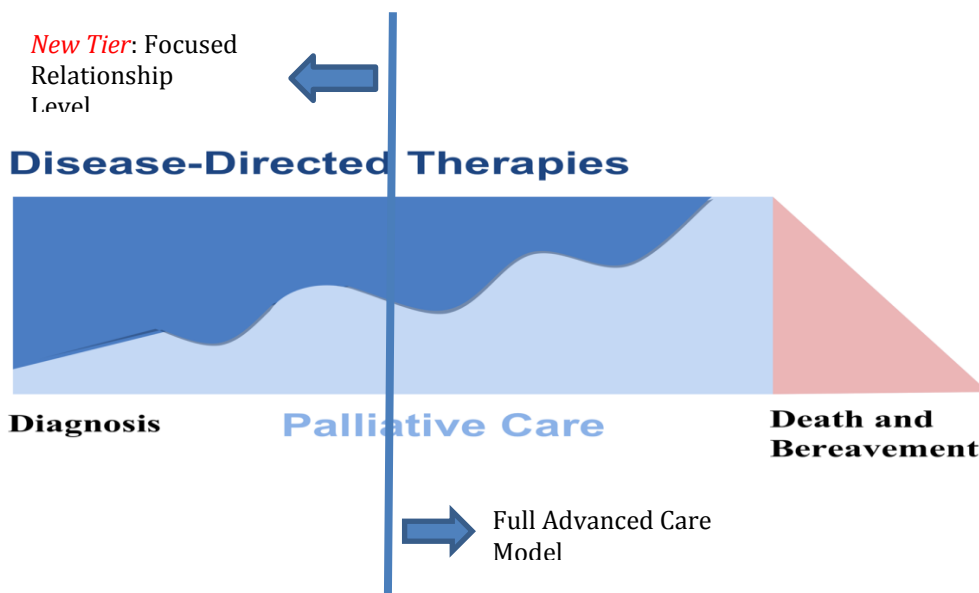
A two-tiered payment model also reflects the reality of how palliative care is provided. Like certain other specialists and reflected in CMS’ recent definition of Patient Relationship Categories (section 1848(r)(3) of the Medicare and CHIP Reauthorization Act), the palliative care team’s relationship 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<sup>ii</sup> 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,



Diane E. Meier, MD  
Director  
Center to Advance Palliative Care  
55 West 125th Street, Suite 1302  
New York, NY 10027  
[Diane.Meier@mssm.edu](mailto:Diane.Meier@mssm.edu)  
(212) 201-2675

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

---

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

<sup>ii</sup> 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



Chairman of the Board  
Alvin L. Royle, JD, CPA

President  
Steven R. Houser, PhD, FAHA

Chairman-elect  
James J. Postl

President-elect  
John J. Warner, MD

Immediate Past  
Chairman of the Board  
Bernard P. Dennis

Immediate Past President  
Mark A. Creager, MD, FAHA

Treasurer  
Raymond P. Vara, Jr.

Directors  
Mary Ann Bauman, MD  
Ivor Benjamin, MD, FAHA  
Mary Cushman, MD, MSc, FAHA  
Mitchell S. V. Elkind, MD, MS, FAHA  
Linda Gooden  
Ron W. Haddock  
Robert A. Harrington, MD, FAHA  
Marsha Jones  
Willie E. Lawrence, Jr., MD, FAHA  
Pegui Mariduena, CMC, MBA  
Stacey E. Rosen, MD  
David L. Schlatterbeck  
Bertram L. Scott  
Lee Shapiro  
David A. Spina  
Bernard J. Tyson

Chief Executive Officer  
Nancy A. Brown

Chief Operating Officer  
Suzie Upton

Chief Science & Medical Officer  
Rose Marie Robertson, MD, FAHA

Chief Marketing and Programs Officer  
Meighan Girgus

Chief of the Institute for  
Precision Cardiovascular Medicine  
Jennifer Hall, PhD

Chief Diversity Officer  
Gerald Johnson, II

Chief Administrative Officer  
Sunder D. Joshi, FCA

Chief of Mission Aligned Businesses  
John Meiners

Chief Medical Officer for Prevention  
Eduardo Sanchez, MD, MPH

Chief of Staff to the CEO  
Laura Sol

Executive Vice President,  
Corporate Secretary &  
General Counsel  
Lynne M. Darrouzet, Esq.

March 5, 2017

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

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

Dear Committee Members,

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

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

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

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

life is why™ es por la vida™ 全為生命™

Please remember the American Heart Association in your will.



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

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

Sincerely,



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



2200 River Plaza Drive  
Sacramento, CA 95833

February 2, 2017

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

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

Dear Committee Members,

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

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jeff Burnich', written over a white background.

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

February 8, 2017

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

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

Dear Committee Members,

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

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

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

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

Sincerely,

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

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



## AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
Highest Standards, Better Outcomes*

**100+years**

### Chicago Headquarters:

633 N. Saint Clair Street  
Chicago, IL 60611-3211

Voice: 312-202-5000

Fax: 312-202-5001

E-mail: [postmaster@facs.org](mailto:postmaster@facs.org)

### Washington Office:

20 F Street, NW Suite 1000  
Washington, DC 20001

Voice: 202-337-2701

Fax: 202-337-4271

E-mail: [ahp@facs.org](mailto:ahp@facs.org)

[www.facs.org](http://www.facs.org)

### OFFICERS

#### President

J. David Richardson, MD, FACS  
Louisville, KY

#### Immediate Past-President

Andrew L. Warshaw, MD, FACS, FRCSed(Hon)  
Boston, MA

#### President-Elect

Courtney M. Townsend, Jr., MD, FACS  
Galveston, TX

#### First Vice-President

Ronald V. Maier, MD, FACS  
Seattle, WA

#### First Vice-President-Elect

Hilary A. Sanfey, MD, FACS  
Springfield, IL

#### Second Vice-President

Walter J. Pories, MD, FACS  
Greenville, NC

#### Second Vice-President-Elect

Mary C. McCarthy, MD, FACS  
Dayton, OH

#### Secretary

Edward E. Cornwell III, MD, FACS, FCCM  
Washington, DC

#### Treasurer

William G. Cioffi, Jr., MD, FACS  
Providence, RI

#### Executive Director

David B. Hoyt, MD, FACS  
Chicago, IL

#### Chief Financial Officer

Gay L. Vincent, CPA  
Chicago, IL

### BOARD OF REGENTS

#### Chair

Valerie W. Rusch, MD, FACS  
New York, NY

#### Vice-Chair

Michael J. Zinner, MD, FACS  
Boston, MA

John L. D. Atkinson, MD, FACS  
Rochester, MN

James C. Denny III, MD, FACS  
Alexandria, VA

Margaret M. Dunn, MD, FACS  
Fairborn, OH

Timothy J. Eberlein, MD, FACS  
Saint Louis, MO

James K. Eelsey, MD, FACS  
Atlanta, GA

Henri R. Ford, MD, FACS  
Los Angeles, CA

Gerald M. Fried, MD, FACS, FRCS  
Montreal, QC

James W. Gigantelli, MD, FACS  
Omaha, NE

B.J. Hancock, MD, FACS, FRCS  
Winnipeg, MB

Enrique Hernandez, MD, FACS  
Philadelphia, PA

Lenworth M. Jacobs, Jr., MD, FACS  
Hartford, CT

L. Scott Levin, MD, FACS  
Philadelphia, PA

Mark A. Malangoni, MD, FACS  
Philadelphia, PA

Leigh A. Neumayer, MD, FACS  
Tucson, AZ

Linda G. Phillips, MD, FACS  
Galveston, TX

Marshall Z. Schwartz, MD, FACS  
Philadelphia, PA

Anton N. Sidawy, MD, FACS  
Washington, DC

Howard M. Snyder III, MD, FACS  
Philadelphia, PA

Beth H. Sutton, MD, FACS  
Wichita Falls, TX

Steven D. Wexner, MD, FACS  
Weston, FL

### BOARD OF GOVERNORS

#### Chair

Fabrizio Michelassi, MD, FACS  
New York, NY

#### Vice-Chair

Diana L. Farmer, MD, FACS  
Sacramento, CA

#### Secretary

Steven C. Stain, MD, FACS  
Albany, NY

August 29, 2017

Physician-Focused Payment Model Technical Advisory Committee  
C/o U.S. DHHS Asst. Sec. of Planning and Evaluation Office of Health Policy  
200 Independence Avenue S.W.  
Washington, D.C. 20201  
[PTAC@hhs.gov](mailto:PTAC@hhs.gov)

Letter of Support – Coalition to Transform Advanced Care, Advanced Care Model

Dear Committee Members,

I write to express support for the Advanced Care Model (ACM) proposed by the Coalition to Transform Advanced Care (C-TAC), which is scheduled for consideration at the upcoming September meeting of the PTAC. I would strongly encourage the PTAC to recommend this model for testing.

The ACM seeks to increase coordination of care in an area of medicine that is costly and disproportionately fragmented. The C-TAC proposal is patient-focused and recognizes the team-based nature of care necessary to efficiently and effectively meet the needs of these vulnerable patients. The model is also designed to work in cooperation with other APMs and Advanced APMs which should help to ensure that improvements in care transitions and coordination extend beyond the providers involved in the ACM.

Furthermore, the C-TAC payment model has a feasible design that can also be implemented leveraging the Episode Grouper for Medicare (EGM) to identify all open episodes for a given patient, thus using this information for risk adjustment and refining cost expectations. With future collaboration, the ACM payment model could function efficiently with the ACS-Brandeis Advanced APM proposal previously recommended by the PTAC.

Thank you for your work in helping to move meritorious models into practice. The ACM model has great potential and I again encourage you to consider recommending the model for testing.

Sincerely,

Frank Opelka, MD, FACS  
Medical Director for Quality and Health Policy  
American College of Surgeons

FOUNDED BY SURGEONS OF THE UNITED STATES AND CANADA, 1913

*The American College of Surgeons Is an Equal Opportunity/Affirmative Action Employer*