Response to Preliminary Review Team (PRT) Questions on: the *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* – revised proposal submitted by the Coalition to Transform Advanced Care (C-TAC)

Question about discussions on prognosis with potential enrollees and actual enrollees:

Page 4 of proposal states:

> "After identification, discussion of advanced illness, and referral by a clinician involved in the beneficiary's health care, the beneficiary would receive a face-to-face visit by an ACM clinician to assess eligibility and provide notification of ACM services. The notification provides transparency about the ACM to beneficiaries. **The beneficiary notification would include an explanation of the ACM services and payment structure, a description of advanced illness and ACM eligibility criteria (<u>including prognosis</u>),** . . .
>
> Within 14 days of enrollment, the beneficiary will have received advance care planning services by the ACM team that would include exploration of goals, values and preferences and continued discussions of disease process **and prognosis**."

1. What exactly will patients will be told both about their prognosis and the target population for the program at these two different times? In particular, will patients be told that the program is targeted to individuals in the last year of their life?

   <u>Response</u>: First, following referral and prior to enrollment, the ACM clinician will make a face-to-face visit to assess eligibility and discuss the ACM program with the patient. During this discussion, the clinician will explain that the ACM is designed to provide services to those who need and are eligible for these services. Specifically, the patient will be told the ACM program is for people with declining health as shown by multiple visits to the hospital or ER, decline in daily activities or functioning, or weight loss, and where the provider would not be surprised if they were to pass away in the next year. Accordingly, during this pre-enrollment face-to-face visit, patients will be told the ACM program is targeted to individuals in the last year of their life.

   Second, within 14 days of enrollment, an ACM team member will have ongoing advance care planning discussions about disease progression, goals, values and treatment options and preferences with the patient, their family, and providers. Discussion of prognosis is also a component of these advance care planning discussions.

Questions about payment methodology:

Please help us understand the payment model by working through an example of a "typical" patient participating in the program. Assume an example patient is enrolled in the program and expires 8 1/2 months later. Explain how the payment model would work with respect to that patient. In particular,

please include the following information and ensure that you include the time periods for all of the comparisons and payments that will be made:

2. When and how many pmpm payments would be made for that patient?

   Response: Nine PMPM payments would be made, at the beginning of each month, as the PMPM is designed to provide an upfront payment for patient care services.

   (This response assumes the patient is enrolled prior to the enrollment cut-off date for that month, as would be established by CMS. For example, CMS may set the cut-off date at the 15th (or mid-point) of the month, and enrollments after this cutoff point would not receive a PMPM for that month.)

3. How would costs for that patient be calculated?

   Response: The cost for that patient would be the total Medicare cost of care in the last 12 months of life, plus all PMPM payments.

4. What would those costs be compared to?

   Response: Those costs would be compared to the spending target for last 12 months of life of similar patients. The spending target would be based on the national average spend of similar patients, plus trend, novel therapy and geographic adjustments, as described in Appendix E of our Proposal, "ACM Spending Target Determination."

5. How would bonus payments or penalties be calculated and made; and when would they be paid?

   Response: Bonus payments or penalties would be determined by calculating the difference between the spending target and the actual enrollee cost. The analysis would be completed for decedents that were enrolled in the ACM at any given point during their last 12 months of life. The payment would be made as soon as possible after the completion of each 12-month evaluation period.

6. Are all costs and payments calculated and made for individual patients or are some aggregated over a group of patients?

   Response: Costs and payments would be calculated in aggregate rather than for individual patients. The spending target would be based on the regression analysis of similar patients with adjustments, as described in Appendix E of our Proposal, "ACM Spending Target Determination.

7. How would costs and payments calculations change in the example if instead of expiring after 8 ½ months, the patient was admitted to hospice and expired 2 months later?

Response: The PMPM payments would remain the same, at 9 PMPM payments, if the patient instead were admitted to hospice after 8 ½ months and expired 2 months later. The total Medicare cost in the last year of life for the patient in this case would increase by the amount of Medicare hospice spending for the two months the patient received hospice services.