

# Physician-Focused Payment Model Technical Advisory Committee

## Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Bruce Steinwald MBA (Lead Reviewer)

Paul Casale, MD, MPH

Elizabeth Mitchell

August 14, 2017

In accordance with the Physician-Focused Payment Model Technical Advisory Committee's (PTAC's) *Processes for Reviewing and Evaluating Proposed Physician-Focused Payment Models and Making Recommendations to the Secretary of the Department of Health and Human Services*, proposals for Physician-Focused Payment Models (PFPMs) that contain the information requested by PTAC's Request for Proposals will be assigned to a Preliminary Review Team (PRT). The PRT will draft a report containing findings regarding the proposal for discussion by the full PTAC. This PRT report is preparatory work for the full PTAC and is not binding on the PTAC. This report is provided by the PRT to the full Committee for the proposal identified below.

### A. Proposal Information

- 1. Proposal Name:** *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*
- 2. Submitting Organization or Individual:** *Coalition to Transform Advanced Care*
- 3. Submitter's 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 ACM, 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 advanced 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 a 4% total risk and minimum loss rate.”

## B. Summary of the PRT Review

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

## C. PRT Process

The *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* (available on the PTAC [website](#)) was received by PTAC on February 7, 2017. The PRT conducted its work between March 13, 2017 and August 11, 2017. During this time, the PRT reviewed the proposal, all public comment letters received on the proposal, and written responses from the submitter (the Coalition to Transform Advanced Care) to questions from the PRT. After review of the submitter's written responses to the PRT's questions, the PRT held a conference call with the Coalition to Transform Advanced Care to better understand certain components of the proposal. In addition, the PRT reviewed additional, relevant information from other sources on key aspects of the proposed model.

The PRT's summary of the proposal and description of the additional, relevant information on key aspects of the proposed model reviewed by the PRT are described below. The PRT's questions to the Coalition to Transform Advanced Care, the coalition's responses, a transcript of the PRT's telephone discussion with the Coalition to Transform Advanced Care and all letters received from the public are available at the PTAC [website](#).

### 1. Proposal Summary:

The "*Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model*" submitted by the Coalition to Transform Advanced Care addresses payment for curative / treatment-oriented and palliative care of individuals in the last 12 months of their life. The payment model has two key components: 1) a \$400.00, wage-adjusted PMPM (replacing FFS payments to palliative care providers) for up to 12 months (payment stops before 12 months upon death or admission to hospice); and 2) a shared-risk component based on total cost of care in the last 12 months of life.

In the first year of an entity's participation in the model, shared "risk" is limited to shared savings; model participants progress to two-sided risk after the first year, including: 75-85% shared savings and loss rate, 30% total savings limit, 10% total loss limit; and 4% total risk and minimum loss rate. Entities that do not achieve shared savings will have a six-month correction phase; at the end of this phase, entities that are unable to perform in two-sided risk will be required to drop out. Of note, to the extent that a Medicare beneficiary lives longer than 12 months, the period of time for which the APM entity receives the \$400.00 PMPM may not be the same as the period of time for which total cost of care is calculated. For example, if a person enrolls in the program and lives 18 months, the APM entity will receive the PMPM payment for months 1 through 12, but the beneficiary's total cost of care and shared savings will be calculated based on months 7 through 18.

Payments would be made to "ACM entities," (which could be ACOs, hospitals, medical groups, home health agencies, hospices, or other health care provider types) that are composed of 1) interdisciplinary teams that deliver care management and palliative care services and 2) the network of treatment/curative care physicians who choose to participate in the model. The

ACM entity would enter into services and payment agreements with physicians, other eligible professionals, and/or other healthcare organizations involved in providing ACM services. The ACM entity would receive and distribute ACM payments (including shared savings) from Medicare in accord with their agreements with providers, and pay CMS for any losses according to the shared risk arrangements.

Beneficiaries are eligible to participate in the model if they meet two of four possible criteria, followed by a negative response from the responsible physician to “Would you be surprised if this patient died in the next 12 months?” (“The Surprise Question”). The four possible eligibility criteria are:

- **Acute Care Utilization:** i.e., 2 hospitalizations in the last 12 months **OR** one ER visit and one hospitalization in the last 6 months **OR** 2 ER visits in the last months;
- **Functional Decline:** New, irreversible dependence in at least one ADL in the last 3 months;
- **Nutritional Decline:** Involuntary lean body weight loss  $\geq 5\%$  in the last 3 months; or
- **Performance Scales:** Palliative Performance Scale Score  $\leq 60$ , Karnofsky Performance Scale Score  $\leq 60$  **OR** Eastern Cooperative Oncology Group (ECOG) Score  $\geq 3$ .

Potential beneficiary participants would be identified through referrals from physicians, hospitals or other providers or through the use of clinical algorithms. Once a potential participant is identified, the ACM entity screens participant to ensure that they meet the eligibility criteria. Patients are informed about the additional services they will receive, their team members, and how the team relates to their existing providers. Beneficiaries are informed about the payment approach -- for example, that the PMPM is only for 12 months, but that the ACM may continue to care for them after this period. The model does not require that beneficiaries be told that the program is for people in the last 12 months of their life. This information would be discussed at an appropriate time, as determine by the patient’s clinicians.

Once a beneficiary is enrolled in the model, ACM interdisciplinary teams would provide “comprehensive care management,” advanced care planning 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. At a minimum, ACM care teams would consist of a provider with palliative or hospice expertise, a registered nurse and licensed social worker who would deliver care through face-to-face and telephonic encounters. Treatment / curative care would continue to be provided by the patient’s primary and specialty care providers who agree to participate in the model, as well as those who do not agree to participate in the model. Reimbursed services continue for either 12 months or until the beneficiary dies, enters hospice, moves out of the service area, or experiences an improvement in their condition and is discharged from the program. An ACM may choose to continue to care for a beneficiary after the 12 month reimbursement period.

## 2. Additional Information Reviewed by the PRT.

### a) Environmental Scan and Literature Review

ASPE, through its contractor, conducted an abbreviated environmental scan related to this proposal. Documents comprising the environmental scan were primarily identified using Google and PubMed search engines. Key words guiding the environmental scan and literature review were directly identified from the Letter of Intent (LOI). Key words and combination of key words were utilized to identify documents and material regarding the submitting organization, the proposed model in the LOI, features of the proposed model in the LOI or subject matter identified in the LOI. Key terms used included “palliative care,” “end of life Medicare,” “advanced illness care,” “Coalition to Transform Advanced Care,” “C-TAC,” “advanced care APM,” “advanced care model,” and “population health payment model.” This search was limited to documents that met predetermined research parameters including a five-year look back period, a primary focus on U.S. based literature and documents, and relevancy to the LOI. Six documents from the grey literature and six peer-reviewed articles were identified. These documents are not intended to represent a comprehensive review. The abbreviated environmental scan is available on the PTAC [website](#).

In addition, the PRT commissioned a review of the evidence on: 1) the accuracy of physician predictions of one-year survival for patients with advanced illness and 2) factors shown to be significant predictors of survival in a non-institutionalized population. The review examined peer-reviewed literature published within the last five years, identified from PubMed. Search terms include combinations of: “end of life,” “advanced illness,” “chronic conditions,” “palliative care,” “Palliative Performance Scale,” “Karnofsky Performance Scale,” “Eastern Cooperative Oncology Group (ECOG),” “functional status,” “mortality prediction,” “survival prediction,” “prognostic confidence,” and “survival prognostication.” This literature review is available on the PTAC [website](#).

b) **Additional Information reviewed.** The PRT also talked with the following parties to better understand key aspects of (and potential effects of) the proposed model:

- A physician expert in palliative care;
- The Centers for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT)
- The CMS Center on Medicare to better understand the potential interactions of the proposed model with the Medicare hospice benefit;
- The CMS Center for Medicare and Medicaid Innovation (CMMI) to better understand the difference between the proposed model and CMMI’s Medicare Care Choices Model.

## D. Evaluation of Proposal Against Criteria

**Criterion 1. Scope of Proposed PFPM (High Priority Criterion). Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.**

---

**PRT Qualitative Rating: Meets with priority consideration**

---

The PRT unanimously agreed that the target population of this proposal – Medicare beneficiaries with advanced, progressive illness not eligible for hospice – is a population of substantial needs that are not adequately addressed by the current payment systems. The payment model would provide for both curative and palliative care for eligible participants up to their death, entry into hospice, departure from the area, or discharge due to recovery. As described in C-TAC’s proposal, similar advanced care models offering both curative and palliative care have been fielded in the Medicare Advantage program and in the private sector.

The PRT discussed at length the eligibility requirements for Medicare beneficiary participation in the model -- i.e., that beneficiaries, based on several clinical and non-clinical measures (including the judgment of the attending physician who “would not be surprised if the patient died in the next 12 months”) would be expected to expire within 12 months.<sup>1</sup> While the PRT acknowledges the arbitrariness of the 12-month life expectancy eligibility criterion, and that there are other programs, such as the Medicare Care Choices Model targeting patients with advanced illness, the PRT concluded that the model would provide appropriate services to a population in need of coordinated care.

The Medicare Care Choices Model (MCCM) is a similar care delivery model in that it targets beneficiaries who have a terminal condition and offers both palliative and treatment care. However, the MCCM is limited to hospices as the provider entity and patients who are hospice eligible, meaning that they are expected to die within 6 months of admission to hospice. The proposed ACM would be open to a variety of providers, including hospices, and patients who are not yet eligible for hospice care.

**Criterion 2. Quality and Cost (High Priority Criterion). Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.**

---

**PRT Qualitative Rating: Does not meet**

---

<sup>1</sup> Patient eligibility is explained in greater detail than in the original proposal in C-TAC’s Response to the Preliminary Review Team Questions, Part 2, dated April 25, 2017, pages 4-6.

The PRT concluded that the model’s approach to coordinated care has the potential to reduce expensive hospitalizations and ER visits and improve the patient experience of care. However, the PRT was also concerned that the majority of quality measures in the proposal are utilization measures as opposed to explicit measures of quality of care. While the PRT did not identify specific measures that could be added, it identified quality assurance as a weakness that should be addressed. As will be discussed later, the PRT is especially concerned about the sustainability of improving quality and lowering costs for model participants who survive beyond 12 months. The PRT notes that the need to have comprehensive patient-based measures of quality of care is especially important in a population of patients nearing end-of-life.

Another quality concern of the PRT relates to the qualifications of the individual providers who would be responsible for patient management and palliative care. The physician palliative care expert consulted by the PRT stated that the responsible person should have a recognized certification in palliative care, although that person need not be a physician. The submitter stated that the team must include a provider with a hospice or palliative care certification or who has practiced more than half time in hospice or palliative care for at least 3 years. The PRT is concerned that experience without the certification might be insufficient to assure quality of care. The PRT acknowledges that a shortage of clinicians with palliative care certification may limit the model’s reach.

**Criterion 3. Payment Methodology (High Priority Criterion). Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.**

---

**PRT Qualitative Rating: Does not meet**

---

The PRT concluded that the principal elements of the payment model – a continuation of fee-for-service payments for curative services, a \$400 per-participant-per-month payment for care coordination and palliative services for up to 12 months, and a shared savings program for providers – should be sufficient to encourage both patient and provider participation and encourage coordinated care<sup>2</sup>. However, the PRT believes there are several deficiencies of the model, as noted below.

First, it is not clear that the model is equally suitable for all beneficiaries who might meet the advanced illness criteria. For example, based on published data, cancer patients appear to have a more predictable course toward hospice admission or death than other patients.

---

<sup>2</sup> The PRT decided not to include the specifics of the proposed model’s shared savings and losses and the proposed phase-in to risk sharing in its evaluation. Should the model go forward, we would expect these elements to be subject to negotiation between participating ACM entities and CMS.

The submitter suggested that organ failure patients also follow a predictable course but most of the literature supporting the ability to predict death within 12 months pertains to cancer patients. The proposer acknowledged that certain patients, such as those with dementia, are less predictable.

Second, and related to the first, is a concern for the safety of patients who survive for more than one year. The model would cease the \$400 per month payment for these patients; however they remain in the model for purposes of calculating potential savings in the last 12 months of life. Participating APM providers may choose to continue to provide both curative and palliative services. However, the model does not guarantee that these patients would continue to receive the same services that less-than-12-months participants will receive. This attribute of the model raises the possibility of skimping, as the \$400 per month payment is no longer available to finance care coordination and palliation. This could also be a disincentive to admission to hospice, as the hospice payments would count against potential savings. When asked about this potential conflict of interest, the submitter asserted that providers would have an incentive to continue to provide services after 12 months both because they would be committed to patient welfare and they would want to avoid patients from incurring high costs due to mismanagement, which would lower their chances of achieving shared savings.

Another concern relating to hospice is the overlap and potential competition with the Medicare Care Choices Model described above. The MCCM is a relatively new model involving 141 hospices – 50 percent of participants started in January 2016, and 50 percent will start in January 2018. In the initial experience, CMMI noted that participant take-up has been slower than anticipated and some hospice participants voiced concern that the \$400 per beneficiary per month (the same PMPM proposed by C-TAC) is insufficient to provide all of the additional services. While overlap with existing models is an issue that confronts many proposed PFPs, implementing the C-TAC APM in locales with existing MCCM programs might present additional difficulties.

Finally, CMS actuaries raised a concern that the shared savings amount will be difficult to calculate. Although the issue is not unique to this model, figuring out the baseline against which to compare actual costs and installing an accurate risk-adjustment system will present challenges that will be difficult to overcome. The proposal highlights the challenges in calculating the benchmark and acknowledged the need for assistance from CMS. The proposers ruled out using Hierarchical Condition Categories (HCCs) alone for risk adjustment, but the proposed alternative of using episode-based actuarial modeling is not fully specified and relies on CMS to fill in the gaps. While seeking assistance from CMS is not inappropriate, the PRT is not confident that this issue can be satisfactorily addressed.

**Criterion 4. Value over Volume. Provide incentives to practitioners to deliver high-quality health care.**

---

**PRT Qualitative Rating: Meets**

---

The model appears to rely on incentives to substitute less costly palliative services for more costly, curative services when curative services offer relatively little patient benefit. The model offers a compromise between the palliative services available under the hospice benefit and the siloed specialty services so often provided to patients with advanced illnesses and multiple comorbidities. However, the PRT remains somewhat concerned about issues already raised – particularly the dearth of patient-oriented quality measures needed to definitively measure the model’s effects on quality of care, and the compound effect of the two different types of financial incentives (i.e., loss of the \$400.00 PMPM after 12 months and shared-risk based on total cost of care in the last 12 months of life), in particular the incentive to discharge to hospice versus continuing to provide curative services, described above.

**Criterion 5. Flexibility. Provide the flexibility needed for practitioners to deliver high-quality health care.**

---

**PRT Qualitative Rating: Meets**

---

The PRT was satisfied that the availability of both curative and palliative services in a coordinated care environment provides flexibility to both patients and providers to select the range of services best designed to meet the patient’s clinical needs and preferences. However, the PRT is uncertain about the range of provider types that might be appropriate and willing to participate in the model. The proposer stated that any Medicare provider organization would be eligible to participate and rural areas could be represented through aggregation of small physician practices. In contrast, one public commenter and the physician palliative care expert consulted by the PRT noted that the resources required to implement the model and the ability to accept responsibility for the cost of care coordination and palliative care would suggest that only substantial organizations, such as health systems and large home health agencies, would be able to participate. As noted elsewhere, the PRT also was concerned that hospice organizations participating in the model might have a potential conflict of interest between keeping the patient in the model versus exiting the model through election of the hospice benefit (i.e., the monthly payment under the proposed model would be less than the per diem Medicare hospice payment).

**Criterion 6. Ability to be Evaluated. Have evaluable goals for quality of care, cost, and any other goals of the PFPM.**

---

**PRT Qualitative Rating: Meets**

---

The PRT concluded that the proposed model has evaluable goals concerning cost and quality but faces challenges in determining whether those goals are met. The proposal suggests using episode-base actuarial modeling to develop a matched control group evaluation strategy, but leaves the specifics of how to construct the evaluation up to CMS. The proposal also identifies a number of measurement concepts for the evaluation but, did not identify specific measures or measure specifications. Further, as noted above, most concepts to be measured would address utilization of service; e.g. hospital admissions, ED visits, ICU days, hospice LOS, visits within 48 hours of hospital discharge. The PRT would prefer more patient-oriented metrics as opposed to utilization measures to assess the effect of the model on patient quality. For example, in addition to utilization measures, the model includes level of symptom control and patient satisfaction but does not include such measures as functional status, depression management, or measures of inappropriate underutilization, premature worsening of health or death.

Evaluating the model’s effects on cost of care requires both comprehensive measurement of actual costs incurred as compared to a baseline estimate of costs that would have been incurred in the absence of the model -- the same estimates that would be used to calculate any shared savings. C-TAC would rely on CMS to conduct the necessary modeling to accomplish this, but, as noted elsewhere, the CMS actuaries have expressed concern about the accuracy of such estimates.

**Criterion 7. Integration and Care Coordination. Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.**

---

**PRT Qualitative Rating: Meets with priority consideration**

---

The PRT concluded that the proposed model warrants a “meets with priority consideration” because its principal focus is on care coordination for a population of patients whose need for care coordination is evident. In addition, apart from the reservations noted elsewhere, the model’s integration of curative and palliative services is a feature that should improve the patient experience of care and conserve resources without denying needed curative services when appropriate.

**Criterion 8. Patient Choice. Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.**

---

**PRT Qualitative Rating: Meets**

---

The PRT generally agreed that the model would promote patient choice in a fragmented delivery system. The model is designed to encourage shared decision-making between patients and families and the providers who are tasked with coordinating care. The PRT did discuss at some length the need to ensure that eligible patients, prior to enrollment, should be fully informed that: 1) they are being recruited into a program for beneficiaries thought to be in the last 12 months of life, 2) that providers will temporarily receive extra payments for coordinating their care and providing palliative services for up to 12 months, 3) that providers will share in any cost savings to the Medicare program that providers can make in the beneficiary's care in the last 12 months of life; and 4) the overall design and goals of the program.

**Criterion 9. Patient Safety. Aim to maintain or improve standards of patient safety.**

---

**PRT Qualitative Rating: Meets**

---

The PRT generally agreed that the home-based care coordination elements of the model should promote patient safety. However, the PRT, again, voiced concern for:

- 1) the need for patients to be fully informed of the nature of the program prior to their enrollment in it, so that the patient or their representative can fully participate in shared decision-making; and
- 2) the safety of patients who survive more than 12 months in view of the model's cessation of the PMPM after 12 months and use of financial incentives to control costs in the last 12 months of life. The PRT expressed a need to provide safeguards for this sub-population. The PRT also believes that the model requires more patient-based measures to track quality of care during the course of participation in the model.

Further, the proposed model seeks a waiver of conditions of participation requirements for hospice and home health for parties that seek to provide these services. In response to a question from the PRT regarding this, the submitter responded:

“Both home health agencies and hospices may serve as the ACM entity and/or provide resources to deliver the ACM services. While these organizations can furnish ACM services and meet all home health or hospice conditions of participation, it would be helpful if CMS can provide clarifications or waivers that are consistent with other CMS APM waivers to facilitate the efficient delivery of ACM services by home health agencies or hospices. ACM services are not home health or hospice, therefore, tying these

services within a home health or hospice conditions of participation could be unnecessary. We also propose that these are distinct programs even if they are being provided under the same organizational structure.”

## **Criterion 10. Health Information Technology. Encourage use of health information technology to inform care.**

---

### **PRT Qualitative Rating: Meets**

---

The PRT concluded that the proposal meets this criterion but observed that, like other PFPM proposals received by PTAC, there was little attention given in the proposal on how the exchange of information among providers would be optimized in a way to enhance the model’s care coordination and integration goals. The model would require participating entities to utilize an EHR and would propose that CMS expand its claims data collection to enhance participating providers’ ability to assess eligibility and care process activities. The PRT believes that, especially for a declining population at risk of iatrogenic problems such as adverse medication reactions, timely and effective information sharing among multiple providers is essential.

## **E. PRT Comments**

The PRT’s most positive observations regarding the C-TAC proposal derive from the needs of the target population, Medicare beneficiaries with advanced progressive illness who are not eligible for hospice care. The proposal asserts that integrating curative services paid for by traditional fee for service with patient-centered palliative services covered by a per-beneficiary-per-month payment can both improve the patient experience of care and conserve resources. While the PRT has serious concerns as noted below, we generally found that the incentives of the payment methodology specified in the proposal, including a shared savings and risk sharing incentive for providers, are congruent with the model’s coordinated-care objectives.

The PRT’s reservations about the model follow several themes. The first is the broadness of the patient and provider populations who could participate in the model. The model relies on a predictable course of decline and eventual death of patient participants, but we observed that patients with differing underlying illnesses might exhibit varying predictability. As noted above, the literature on end-of-life predictions indicates that cancer tends to be more predictable than other diseases, and the PRT is concerned that patients with some illnesses that exhibit substantial variability in life expectancy might be inappropriate participants, even if they meet the selection criteria.

Second, the model, as proposed, would be open to almost any type of provider organization to participate, but the PRT is not convinced that all organization types would

be able to provide the resources and assume the risk to be a successful implementer of the model. The PRT is especially concerned about both potential conflict of interest and overlap with the Medicare Care Choices Model if hospices were to implement the model.

Third, because the model would significantly alter care patterns for a vulnerable population, the PRT believes there would need to be greater assurances concerning patient engagement and shared decision-making than was evident in the proposal. This includes both decisions about palliative versus curative care during the participation period, as well as information provided to the patient and family prior to electing to participate.

Also, the PRT believes that patients need to be fully informed about the model design, such as the fact that additional, palliative services will be provided to them and that providers would be compensated an extra payment for providing these services with the expectation there would be savings from providing fewer curative services (such as fewer hospitalizations). However, we were uncertain about how prescriptive to be about other elements of the design, such as the expectation that the patient has 12 months or less to live. We decided to highlight the issue for discussion at the PTAC public meeting, if the PTAC otherwise believes the model is worthy of consideration for recommendation.

Fourth, the PRT has reservations about the nature of the metrics to be used to evaluate quality of care. We would like to see more patient experience of care measures than were included in the proposal. We are especially concerned that there should be safeguards to ensure that beneficiaries who participate for more than 12 months are not disadvantaged in any way.

Finally, the PRT observed that determining the effect of the model, including calculating the savings that will be included in the shared savings program and the losses that might be incurred by some provider organizations, will be challenging. A related challenge is that the introduction of the C-TAC model, and its patient recruitment, might affect the evaluation of other models, including ACOs, operating in the same locale. While such challenges are not unique to the C-TAC model, the PRT believes that they need to be addressed.

**END OF DOCUMENT**