
From: Emmalee Kennedy, MD <Emmalee.Kennedy@nahealth.com>
Sent: Friday, September 08, 2017 4:29 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

To whom it may concern:

Thank you for taking the time to review this document. As a palliative care physician and director of our Palliative Care Department, I see evidence daily that patients with serious illness and their caregivers are not well cared for in the current FFS payment system. In order to adequately address the effect of an illness on a patient and their caregivers, we must be able to assess and intervene on the non-physical aspects of the disease which requires an interdisciplinary team. These services are not reimbursable, yet they have been shown in numerous studies to improve quality of life and control costs.

As an active board member for a local ACO, I fully understand the need to move toward value based services and rewarding high value care through reimbursement. The PACSSI model would support Medicare beneficiaries with serious illness to ensure they get the right care, in the right place, at the right time. This model would allow reimbursement to reflect the needs of seriously ill patients and allow palliative care programs to use resources deemed necessary to provide care, including nurses, case managers, and social workers.

The quality metrics in PACSSI are indicative of the emerging standards of performance in community-based palliative care. Including patient-reported outcomes, process, and utilization measures will help capture the benefit of these programs and reflect what is important to patients and families. The phased-in approach will allow teams time to strengthen their clinical and reporting infrastructure. I also appreciate the choice of tracks, which can allow us to tailor reimbursement options to our program's ability to report on measures and accept risk.

My organization, NAH, is exploring options for more advanced APM's, and we would be very interested in participating in PACSSI if it was an option. I would encourage you to recommend it for testing by PTAC and hopefully implementation by CMS.

Thank you,

Emmalee Kennedy, MD

Medical Director, NAH Palliative Care

Cell 928-266-6070

Office 928-214-2920

Fax 928-214-2925

From: Fromme, Erik K.,M.D. <Erik_Fromme@DFCI.HARVARD.EDU>
Sent: Friday, September 08, 2017 5:00 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

Having been for many years a Director of a University Hospital's Palliative Care Program I now direct the Serious Illness Care Program at Ariadne Labs at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health.

I strongly support this 5-year demonstration. Putting payment incentives in the right places is perhaps the single most impactful way to transform our broken health care system. I think the 2 track model is a great idea.

The Serious Illness Care Program would look forward to participating in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Thank you,

Erik Fromme, MD

Erik Fromme, MD, MCR, FAAHPM | Director, Serious Illness Care Program | [Ariadne Labs](#)
Brigham and Women's Hospital | Harvard T.H. Chan School of Public Health
efromme@ariadnelabs.org | O: [617-384-8864](tel:617-384-8864)
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August 25, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Members of the Advisory Committee,

On behalf of the National Hospice and Palliative Care Organization (NHPCO), we write in support of the American Academy of Hospice and Palliative Medicine's Proposal for a Physician-Focused Payment Model – Patient and Caregiver Support for Serious Illness (PACSSI), as well as the Coalition for the Transformation of Advanced Care's proposal to provide palliative care to individuals with advanced and serious illness. As the committee reviews these proposals and refines alternative payment models, we hope you will consider the following:

1. With more than 4,000 providers nationwide, the hospice community has the expertise, experience, and capacity to provide high-quality, compassionate care to this complex patient population. If the committee moves forward with an alternative payment model for advanced illness or palliative care, we hope you will structure the payment model to be provider- and site-neutral, and to allow for wide participation by hospice providers.
2. An advanced illness or palliative care model should be developed as part of a larger continuum of care that meets the increasing needs for individuals as they progress from diagnosis through serious, advanced, and life-limiting illness. It is imperative that hospice remain available to individuals as they near the end of life.

The Medicare Hospice Benefit

As you know, for almost 35 years, the Medicare Hospice Benefit has provided high quality end-of-life care to millions of Americans. The hospice philosophy focuses on patient/family-centered care that addresses the physical, spiritual, emotional, and practical needs of the patient. Hospice patients enjoy very high quality of life. In one study, cancer patients who accessed hospice suffered less, were more physically capable, and were able to interact with others. Moreover, their family members had less persistent major depression.

One of the most significant limitations of hospice, however, is its restriction to individuals who are in their final 6 months of life, and who agree to forego curative or disease-directed therapies. Many patients who have serious illness might benefit from the range of palliative services offered in hospice, but are unable to access them because their illness is not yet advanced to the point of a six month prognosis, or they're not yet ready to forego disease modifying treatment aimed at prolonging life.

Opportunities for Palliative Care

By offering a range of palliative care services to individuals with serious and advanced illness, we could significantly improve their quality of care and quality of life. A two-year study of Aetna's Concurrent Care program found that patients who received both disease-directed care and hospice services were half as likely to visit the emergency room, two-thirds less likely to be admitted to the hospital or

intensive care unit, and almost three times as likely to forgo disease modifying treatment and elect hospice. Overall costs for caring for these patients fell by a quarter.

We believe that the PACSSI model could replicate many elements of this success for a broader population, notably, individuals who have serious illness from which they might recover, or who can reasonably expect several more years of life. We believe that this approach is the first step in developing and formalizing a more coordinated continuum of care for seriously ill individuals as they approach the final months and years of their lives. Other proposals show similar promise.

Building a Continuum of Care

As CMS reforms the health care delivery system, we encourage the development of a robust continuum of care that reflects the diversity of patient needs. For that continuum to truly meet the needs of patients, however, it is imperative that we preserve the comprehensive, all-inclusive nature of the hospice benefit, and that appropriate patients receive timely referral to and access to hospice. One of the guiding principles of this proposed new model of care should be a provider- and site-neutral framework that focuses primarily on the needs and desires of the patient and family, without adversely impacting successful care delivery models, either overtly, or as an unintended consequence.

We also applaud the Academy for including a hospice utilization measurement to gauge the effectiveness and overall quality of this care model. Studies demonstrate that the longer patients stay in hospice, the more likely they are to reap its many benefits, including pain and symptom relief, emotional and psychosocial supports, spiritual counseling, family counseling, and other benefits. Unfortunately, 35 percent of hospice patients die within 7 days of electing hospice, with a median length of stay only 17 days. One desirable outcome of this demonstration would be increasing the patient length of stay in hospice. We encourage the committee to strengthen the PACSSI proposal by measuring the percentage of patients who died in hospice, and setting the benchmark be set higher than the proposed 7 days. Further, by tying payment to this performance measure, the proposal would ensure that patients have timely access to hospice services.

In closing, we reiterate our desire to work with the committee and other stakeholders to refine our delivery system to accommodate the unmet needs of seriously ill patients and their families, and that ensures a comprehensive continuum of services, including the critically important hospice benefit.. We look forward to working with you on this project, and other efforts to improve the care and quality of life of individuals with serious, advanced and terminal illness.

Sincerely,

A handwritten signature in black ink, appearing to read "Edo Banach". The signature is fluid and cursive, with a large initial "E" and "B".

Edo Banach, JD
President and CEO

From: Tangeman, John (MD) <JTangeman@Palliativecare.org>
Sent: Wednesday, September 13, 2017 1:15 PM
To: PTAC (OS/ASPE)
Subject: Public comment-Patient and Caregiver Support for Serious illness (PACSSI)

I'm writing this note in support of the PACSSI (Patient and Caregiver Support for Serious Illness) APM model to support patients and their caregivers facing serious illness. Currently, the main pathway for funding palliative care is under the Hospice Medicare benefit. Hospice has been the gold standard for palliative care, however, there are many Medicare beneficiaries, and their caregivers, who need palliative care support but do not yet meet Hospice guidelines or delay Hospice enrollment until the "brink of death".

The PACSSI payment model closes the reimbursement gap to allow Medicare beneficiaries to get the right care at the right time in the right place.

Here, at hospice Buffalo, we have a nine-year experience with a palliative care program funded via a per member per month payment through our local Medicare Managed Care programs that is remarkably similar in structure to the proposed PACSSI program. We currently have nearly 400 adult and 83 pediatric/adolescent patients in our home based palliative programs. We have proven success in both patient, physician and caregiver satisfaction with measurable symptom reduction, reduced hospitalization and ED visits, significant cost savings to the payers and earlier appropriate referral to hospice with an enhanced hospice length of stay. We routinely struggle with the fact that we are not able to offer the program to Medicare beneficiaries who are not participating in a managed care program; there simply is no viable funding stream that can support good palliative care in the home.

Here at the Center for Hospice and Palliative care, we are well positioned to participate in a demonstration project should it be recommended by PTAC and implemented by CMS. We are already gathering outcome and performance data in order to continue to prove our worth to the Medicare managed care programs who provide our funding. We know that timely palliative care in the home is a "win" for patient's, caregivers, physicians and the payers. We're hopeful this project moves forward and would welcome the opportunity to participate.

Below are some references outlining our experience thus far. We are currently collecting data for a much larger sample of patients and will hopefully publish in the future.

Respectfully,

*John C. Tangeman MD FACP
Administrative Medical Director
The Center for Hospice and Palliative Care
225 Como Park Blvd
Cheektowaga, New York 14227*

*Office: 716.989.2040
Mobile: 716.908.1389*

Kerr CW, , Donohue K, Tangeman JC, Serehali AM, Knodel SK, Grant PC, Luczkiewicz DL, Mylotte K, Marien JS. Cost Savings Associated with a Home -Based Palliative Care Program Implemented as a Hospice-Private Payer Partnership. *Journal of Palliative Medicine*. 2014; 17: 1328-1335

Kerr CW, Tangeman JC , Rudra CB, Grant PC, Luczkiewicz DL, Mylotte KM, Riemer WD, Marien MJ, Serehali AM. Clinical Impact of a Home-Based Palliative Care Program: A Hospice-Private Payer Partnership. *Journal of Pain and Symptom Management*. 2014; 48: 883-892

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From: Caroline Hurd <churd@uw.edu>
Sent: Thursday, September 14, 2017 11:00 PM
To: PTAC (OS/ASPE)
Subject: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

Follow Up Flag: Follow up
Flag Status: Completed

Dear Physician-Focused Payment Model Technical Advisory Committee,

I want to send along my strong support for PACSSI. Creative payment models and delivery systems such as those proposed in this care delivery model are exactly what we need to transform our healthcare system and get patients and families the right care at the right time that his low cost and high quality.

Programs like this would allow the flexibility to also provide patients and families with goal-concordant health care, meaning they would have advocates in palliative care clinicians for the type of health care that matches their personal values and beliefs.

Palliative models work best when they are delivered by an interprofessional team who can address needs beyond just a medical diagnosis. Patients also need continuity and someone to help navigate our complex system, medical information and treatment decisions.

It would be a courageous and trail blazing decision should the committee support this initiative and set the change for true positive change in our health care system for our patients and families who need it most.

Warmly
Dr. Hurd

--
Caroline J. Hurd MD
Clinical Assistant Professor
Department of Medicine
Director of Education Operations
Cambia Palliative Care Center of Excellence Harborview Medical Center University of Washington
325 9th Avenue, Box 359755
Seattle, WA 98104-2499
206-744-7078 (vm)
206-744-7052 (fax)
churd@uw.edu

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From: Dulce Cruz-Oliver <dcruzoli@jhmi.edu>
Sent: Tuesday, September 26, 2017 10:57 AM
To: PTAC (OS/ASPE)
Subject: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

TO: Physician-Focused Payment Model Technical Advisory Committee (PTAC)

U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Advisory Committee Members,

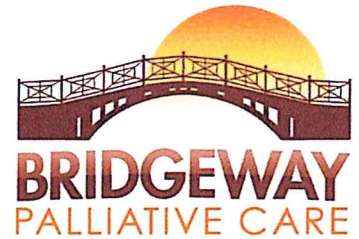
As leaders of the Palliative Medicine Program at the Johns Hopkins Hospital, we the undersigned fully endorse the initiative *Patient and Caregiver Support for Serious Illness (PACSSI)*, the American Academy of Hospice and Palliative Medicine's (AAHPM) proposed APM for palliative care. In our practice we see many patients not qualifying for hospice care yet in great need of support, especially their caregivers who are leading the care most of the time. Patients with serious illness have complex needs that require interdisciplinary care and this proposal provides a way for palliative care programs to use resources, such as nurses, case managers, chaplain and telehealth, not only for patient needs but also for family caregiver needs. This is a great opportunity in the history of healthcare that the element of informal caregiving is considered. We would look forward to participating in PACSSI, should it be recommended for testing by PTAC and implemented by Center for Medicare and Medicaid Services.

Sincerely,

Dulce Cruz-Oliver, MD, CMD, FAAHPM, AGSF and
Rab Razzak, MD

The Johns Hopkins Hospital
600 N Wolfe St., Blalock, Suite 342B
P.410-955-8305
F.410-955-2098

Dulce M. Cruz Oliver MD CMD FAAHPM AGSF
Assistant Professor of Palliative Medicine Program
The Johns Hopkins Hospital
600 N Wolfe St., Blalock, Suite 342B
P.410-955-8305
F.410-955-2098
dcruzoli@jhmi.edu



September 26, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue Southwest
Washington, D.C. 20201
PTAC@hhs.gov

RE: Letter of Support - Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Advisory Committee,

This letter is to detail our unwavering support of the American Academy of Hospice and Palliative Medicine proposal for Patient and Caregiver Support for Serious Illness (PACSSI). Bridgeway is a locally owned and operated agency offering hospice, home health, and palliative care. For years, we realized an enormous gap in care available to patients suffering from complex, chronic, advanced, and/or life limiting illnesses. Our home health is only able to provide intermittent care to home bound patients and if a patient wasn't eligible for hospice, they would simply be left without care in the home. Not all patients have a support system or have the means to pay out of pocket for care.

Last year Bridgeway decided to invest in a palliative care program. While this is a cost center and financial risk for our company, we realize it is what is best for so many patients. For more than a year, we have witnessed firsthand the incredible ability of community based palliative care. Our patient satisfaction survey taught us that our Nurse Practitioners are spending more one on one time with patients than any other provider, the education and communication with our clinicians have reduced their dependence on hospital systems as a primary care, and having care provided in home has reduced overall stress of patients and their families. Furthermore, the data collected from these patients has shown that with quality of life comes quantity of life. Our average length of stay of patients on palliative care has quadrupled; time most patients and families didn't expect to have.

While we continue to learn from serving these patients, over 600 program to date, our commitment is to furthering the continuation, education, and advancement of palliative care for years to come. The challenges we face daily with patient care and financially to support this venture could be solved with PACSSI. We look forward to the opportunity to actively participate should a pilot be recommended prior to CMS implementation. Thank you for taking the time to hear our voice.

Sincerely,

Gary Rasmussen
President

S. Kwame Fiakpornoo, MD
Palliative Care Medical Director



One Prince Street
Alexandria, VA 22314-3318
T 703.838.0033
F 703.548.1890

September 29, 2017

To: Physician-Focused Payment Model Technical Advisory Committee (PTAC)

From: AMGA

Re: Comments Concerning the American Academy of Hospice and Palliative Medicine's "Payment and Caregiver Support for Serious Illness" Payment Model Submission

On behalf of AMGA, we appreciate the opportunity to comment on the American Academy of Hospice and Palliative Medicine's (AAHPM's) "Payment and Caregiver Support for Serious Illness" (PACSSI) Payment Model Submission. AMGA, whose member medical groups provide care for approximately one in three Americans, applauds AAHPM's PTAC submission intended to improve or make more pervasive palliative care delivery for Medicare beneficiaries with serious chronic illness. We well recognize the need to provide better or timelier palliative care regardless of whether or not the beneficiary selects or qualifies for the Medicare Hospice benefit. As the PTAC is well aware, Medicare beneficiaries are forced to forgo palliative care via the Medicare Hospice benefit if they choose to continue to receive curative treatment.

We have numerous comments and questions concerning AAHPM's submission. Our comments appear under AAHPM's proposal's subtitles.

Scope of the Proposed PFPM

The proposed model, which would provide palliative care for beneficiaries with serious illness who have not chosen, or are not eligible, for Medicare hospice services, appears to be similar to the Centers for Medicare and Medicaid Services (CMS') "Medicare Care Choices Model" or demonstration. CMS has indicated that the demonstration, which is scheduled to conclude in 2020, includes 141 hospices in nearly every state and territory. How does the AAHPM model differ from the CMS demonstration relative to quality of care and patient and family satisfaction? It appears the CMS demonstration is not being evaluated for improved spending efficiency.

The AAHPM proposal notes Palliative Care Teams (PCTs) will consist of clinicians otherwise not reimbursed under the Medicare program. The proposal does not specifically indicate who these clinicians are beyond stating "nurses, social work or spiritual care professionals."

The proposal states the model "will generate significant net savings . . . in excess of any costs incurred for the PACSSI care management fees." Has the AAHPM estimated an approximate amount or percent?

Patient Eligibility and Assignment

The model does not provide details on how beneficiaries will be selected to participate. Is enrollment prospective or can beneficiaries enroll throughout the performance year? The proposal states there is a “pre-defined capacity limit” but does not define what that limit is. The proposal also fails to define “service area.”

Quality and Cost

The proposal lists 10 services (see page eight) that PCTs would be required to provide. However, the proposal makes no mention of the family caregivers. This is an oversight. Family caregivers should be recognized.

Under minimum standards of participation, we do not believe “at least one face-to-face visit with the patient every month” is adequate.

The proposal make mention of a PACSSI Learning Collaborative “that would allow for the dissemination of lessons learned across model participants. We believe a learning collaborative should do more. For example, “lesson's learned” should include discussions of quality improvement attained, outcomes achieved relative to spending, and methods and models that demonstration improvement in patient-provider communication.

The proposal states “PCTs' payment would be tied to risk-adjusted performance on several quality measures.” However, the proposal does not explain or provide any details on how the risk adjustment would be conducted.

Accountability for Quality

“For Years 1 and 2,” the proposal states, “PCTS will be required to report applicable measures, but payment will not be tied to performance on these measures.” We believe waiting two years for pay for performance is too long to wait to learn if “patient reported outcomes” or the patient's goals of care are being met or whether the PCT's communication skills were adequate.

Category 2 measures or “completion of care processes” measures should include “cultural” measures along with psychological (termed “emotional” in the document) and “spiritual concerns.”

Category 3 measures or “Utilization of Health Care Services,” consists entirely of three death-related measures: died receiving hospice; died receiving hospice for more than seven days; and, died but did not have any days in ICU 30 days before death. The proposal does note this category will measure “desirable services and avoidance of undesirable services.” There is no such discussion. Overall, it appears the model, unfortunately, contains no patient-reported outcome measures or patient reported experience measures. This is particularly disappointing as AAHPM proposes to “phase in accountability for performance” over two years. Effectively, payment will not be tied to performance for this period of time.

The proposal states “accountability for all measures will be based on performance relative to benchmarks.” The proposal needs to address what the benchmarks are and how they will be determined.

Payment Methodology

We do not find any discussion that explains how Year 1, Tier 1 payments would be set at \$400 Per Beneficiary Per Month (PBPM) and Tier 2 payments at \$650 PBPM.

Track 1 participants would be subject to annual positive or negative performance incentives of up to 4 percent based on performance on quality and spending. Although this presumably occurs beginning year three, the proposal is not clear.

What is the spending benchmark or how is it calculated? (The proposal hints at a definition on page 16 via the statement, risk, "would be limited to the less of 3 percent of total cost of care benchmark or 8 percent of each PCT's total Medicare A and B revenues.") The proposal also states spending will be risk adjusted but this too goes unexplained. We are well aware of how Minimum Savings and Minimum Loss rates work under the Accountable Care Organization (ACO) program. However, the statement "This +/-4 percent is intended to serve as a minimum loss rate to account for potential variation in spending due to small sample sizes and chance," is unclear.

This proposal reflects a "significant departure" from current policy because PCTs would be given the flexibility to provide services "not regularly covered under the Medicare program." However, the proposal never defines, with the exception of telehealth, what these services are or provide examples thereof.

Patient Choice

The proposal states payments would not be subject to cost-sharing requirements. Does this mean the PBPM revenue is calculated to include this spending?

Patient Safety

How "by year 3," will PCTs be held accountable for having a satisfactory rate of hospice election? What is a satisfactory rate?

In sum, AMGA, again, applauds AAHPM's effort to expand the delivery of palliative care under this PTAC submission. On balance, we believe the proposal should attempt to address many of the questions and comments we note.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,



Ryan O'Connor
Interim President and Chief Executive Officer
AMGA



September 27, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue Southwest
Washington, D.C. 20201
PTAC@hhs.gov

RE: Letter of Support - Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Advisory Committee,

This letter is to offer Guardian Homecare's support of the American Academy of Hospice and Palliative Medicine proposal for Patient and Caregiver Support for Serious Illness (PACSSI). Guardian Homecare is a part of AccentCare, a leading national home health provider for Medicare and managed care patients. As a provider of home health services we partner with palliative care programs to provide a continuum of care that is measurable in its effect on patient care. Patient satisfaction, reduced hospitalizations, transition to hospice at the appropriate time are just a few of the quantitative advantages to palliative care.

Working with nurse practitioners in the home setting also leads to more hands on care and these nurse practitioners effect care at the bedside in their ability to provide orders and oversight for our patients. Because of this partnership the dreaded conversation of when to refer to hospice has now become a part of how we care for our patients. We can rely on our partners to come along beside us as we move our patients to the next level of care. This gives us the ability to provide the "right care, at the right time in the right setting."

Financially, palliative care programs struggle to cover the cost of nurse practitioners as they are presently reimbursed. An alternate payment model would allow programs to cover existing costs and expand to other areas, such as chronic disease management, partnerships with hospital based palliative care programs to provide care after discharge, telehealth, etc. Additional resources are needed to strengthen necessary clinical and reporting infrastructure.

Palliative care is much needed. It is also greatly underutilized. We support and hope to see this payment system proposal implemented so that more patients can benefit from this type of care.

Thank you,

A handwritten signature in black ink that reads "Carlene Lee".

Carlene Lee
Administrator/Executive Director
Guardian Homecare

11660 Alpharetta Hwy, Suite 440
Roswell, GA 30076
carlenelee@guardianhomecare.us

From: Zarrabi, Ali <ali.zarrabi@emoryhealthcare.org>
Sent: Thursday, September 28, 2017 11:00 AM
To: PTAC (OS/ASPE)
Subject: Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)

September 28, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Avenue Southwest
Washington, D.C. 20201
PTAC@hhs.gov

RE: Letter of Support - Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Advisory Committee,

This letter is to detail our support of the American Academy of Hospice and Palliative Medicine proposal for Patient and Caregiver Support for Serious Illness (PACSSI). At Emory, our palliative care clinic cares for patients with serious illness who require a great deal of support for their physical, emotional, social, and spiritual suffering. The current fee-for-service model, unfortunately, does not support many of our dedicated providers who work as part of an interdisciplinary team to improve patients' quality of life by addressing symptoms and providing care that is consistent with patients' goals.

Many of our patients have chronic and life-limiting illnesses, and for a variety of reasons, hospice is not consistent with their goals of care. For example, our patients with advanced hematologic cancers who are transfusion-dependent and our chronically ill patients who are dialysis-dependent. These patients benefit most from office and community-based palliative care programs for their care. The fee-for-service model does not work for the kind of attentive, longitudinal, and multidisciplinary care that these patients need. The PACSSI payment model would close key reimbursement gaps to help Medicare beneficiaries with serious illness get the care that they need.

The gravity of our patients' illnesses requires critical time and resources from nursing, case managers, spiritual health counselors, social workers, and telehealth. The quality metrics and the payment incentives in the PACSSI proposal would best reflect the work that our teams in office and community-based palliative care provide.

The Palliative and Supportive Care Clinic at Emory University looks forward to participating in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Sincerely,

Ali John Zarrabi, MD
Assistant Professor of Medicine
Division of Hospital Medicine
Palliative and Supportive Care
Emory University School of Medicine

Stephanie Choate, LCSW
Supportive Care Clinic
Emory Palliative Care Center

Bassel El-Rayes, MD
Professor of Medicine
Vice Chair for Clinical Research, Department of Hematology and Oncology
John Kauffman Family Professor for Pancreatic Cancer Research
Emory University School of Medicine

Ali John Zarrabi, MD
Assistant Professor of Medicine
Division of Hospital Medicine
Palliative and Supportive Care
Emory University School of Medicine
(c) 631-897-1617



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JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

September 29, 2017

Jeffrey Bailet, MD
Committee Chairperson
Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide our strong support for the American Academy of Hospice and Palliative Medicine's Patient and Care Giver Support for Serious Illness (PACSSI) proposal currently being reviewed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Studies have shown that high-quality, interdisciplinary palliative care services can provide significant benefits for patients with serious illness or multiple chronic conditions, functional limitations, and high health care utilization. However, many patients who meet these criteria do not receive palliative care, or receive limited palliative care services, due to the structure of current payment systems. The PACSSI care model would provide tiered monthly care management payments to interdisciplinary palliative care teams (PCTs) for delivery of community-based palliative care to patients. PACSSI care management payments would replace payment for evaluation and management services, including office visits, home visits, hospital visits, as well as Chronic Care Management, Complex Chronic Care Management, Transitional Care Management, and Advance Care Planning services.

The AMA strongly supports improving the availability of palliative care for patients with serious illnesses or multiple chronic conditions, and functional limitations. AMA policy supports continued study and testing by the Centers for Medicare & Medicaid Services (CMS) for models providing and paying for concurrent hospice and palliative care. In addition, AMA policy supports encouraging CMS to identify ways to optimize patient access to palliative care, and to provide appropriate coverage and payment for these services. We believe the PACSSI model includes several features that will help providers improve palliative care for a highly complex set of patients, while also reducing Medicare spending.

Stakeholder Engagement

The AMA supports the PACSSI model development process, which included input from a wide variety of stakeholder organizations, including medical specialty societies and national associations representing other disciplines involved in providing palliative care. As illustrated in the attachments to the PACSSI

proposal, many of these stakeholders submitted letters of strong support for the model, and several of these stakeholders represent sites that would be willing to pilot this model in the future.

Widespread Application

The two-track structure of the PACSSI model will allow a diverse group of palliative care teams from urban, suburban, and rural locations to participate. In addition, the model can be structured within small community-based practices, larger provider organizations, academic health centers, integrated health systems, and hospices. The AMA supports the flexibility of the PACSSI model and its potential for widespread applicability and expansion.

Interdisciplinary PCTs

The inclusion of interdisciplinary PCTs in the PACSSI payment model will help ensure coordination of care across all providers with input into the patient care plan, as well as coordination across care settings. PCTs can include currently non-billing clinicians such as social workers or spiritual professionals, who are not otherwise reimbursed under the Medicare program. In addition, the AMA supports the requirement that participating PCTs must have the capability to respond appropriately on a 24/7 basis to patient and caregiver requests for advice and assistance. This requirement will help ensure issues associated with the patient's health conditions and functional limitations are managed in the most efficient way in alignment with the patient's wishes. We also support the use of both in-person and video conference services to provide face-to-face services in all care settings when needed.

Risk Adjustment

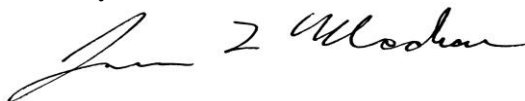
The AMA supports the PACSSI model's use of the Palliative Performance Scale to develop two levels of payment depending on the severity of the patient's condition. In year one, Tier 1 base payment amounts would be set at \$400 per beneficiary per month, and Tier 2 base payment amounts would be set at \$650 per beneficiary per month. The use of the Palliative Performance Scale is an innovative approach to clinical risk adjustment that offers advantages over existing Medicare risk adjustment methodology.

Quality Metrics

The AMA supports the quality metric framework included in the PACSSI model. In addition, the AMA supports the proposal to phase in accountability for the quality measures to ensure there is sufficient time to test the measures and develop accurate benchmarks.

Patients with a serious illness or multiple chronic conditions often receive fragmented and uncoordinated care, which can include burdensome and costly interventions, such as hospitalizations. The AMA supports further testing and adoption of the PACSSI care model proposal, and believes this model shows promise in promoting care coordination and delivering palliative care and support services which better align with patient preferences. The AMA believes the PACSSI model will improve the quality of care for Medicare beneficiaries with serious illness, while reducing costs for the Medicare program. The AMA urges the PTAC to recommend the PACSSI model for testing. We thank the Committee for the opportunity to comment.

Sincerely,



James L. Madara, MD



HOSPARUS HEALTH®

September 26, 2017

Physician-Focused Payment Model Technical Advisory Committee

c/o Angela Tejada

U.S. DHHS Asst. Secretary for Planning and Evaluation Office of Health Policy

200 Independence Avenue S.W.

Washington, D.C. 20201

Public Comment - Patient and Caregiver Support for Serious Illness (PACSSI)™

Emailed to: PTAC@hhs.gov

Dear Ms. Tejada,

Hosparus Health appreciates the opportunity to provide comments regarding the proposed American Academy of Hospice and Palliative Medicine's (AAHPM) [Patient and Caregiver support for Serious Illness \(PACSSI\)](#) Alternative Payment Model (APM) currently under review by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). PTAC is the body established under the Medicare Access and CHIP Reauthorization Act (MACRA) to consider proposed models and make recommendations to the Secretary of Health & Human Services for testing and implementation of APMs.

Hosparus Health is one of the nation's largest **non-profit** hospice organizations with a current daily census of over 1050 patients. Our 37 county footprint spans over 11,000 square miles in Kentucky and Indiana including 9 Urban, 17 Mostly Rural and 11 Completely Rural counties as described by the US Census Bureau. Our interdisciplinary teams have garnered national acclaim for innovative and compassionate end of life care, including Kourageous Kids, our long standing pediatric palliative and hospice program. In 2015 we began piloting an innovative adult advanced illness care program in 22 Kentucky counties. Our explosive and continued growth spanning 40 years qualifies us as a credible voice to provide suggestions to improve access to care while providing cost savings to our healthcare system.

Patients who have serious, potentially life-limiting illnesses or multiple chronic conditions coupled with functional limitations are not well-served by the current fragmented, intervention-oriented health care system. The approval of demonstration projects like the PACSSI model is an opportunity to disrupt the healthcare system by launching innovative, sound programs that bend the cost curve and provide increased value to both providers and users of the system. . Health care systems worldwide are facing macro-scale changes involving advanced illness and end-of-life care that could affect both the quality of care and quality of life for patients and their caregivers. We believe the PACSSI model holds great promise for both improving quality of care for Medicare beneficiaries with serious illness and reducing costs for the Medicare program. The five year PACSSI demonstration model will drive the triple aim:



- improving the patient experience of care,
- enhancing population health through caregiver and patient quality of life
- reducing the per capita costs of care

by addressing the key gaps that currently exist under the Medicare program to provide high-quality palliative care services.

Payment for palliative care and support services delivered by non-billing clinicians (e.g. nursing, social work, pharmacists, or spiritual care professionals) is generally only available to patients through the hospice benefit, which requires a patient to forgo many treatment services and to have two physicians determine that their life expectancy is six months or less.

Many patients who do not qualify for or are unwilling to enroll in hospice care could benefit from palliative care services, estimated at 2.75 million current Medicare beneficiaries, as referenced on page 2 of the AAHPM proposal. New payment mechanisms are clearly needed to enable access to high-quality palliative care for patients until they are eligible and willing to enroll in hospice care.

In addition, fee-for-service payments that are currently available to physicians for chronic care management, complex chronic care management, and non-face-to-face services are insufficient to support high-quality palliative care services for patients with advanced illness, multiple chronic conditions, and/or functional limitations. The PACSSI model fills in the gaps in care that other payments and models fail to sufficiently address. The PACSSI model includes opportunities for new APM entities and palliative care teams (PCT) to collaborate to provide high-quality care management and palliative care services to eligible beneficiaries. Of particular importance to Hosparus Health is that this model is transferrable to other payers, including private payers and publicly funded programs like Medicaid and TRICARE/VA, for patients who meet the eligibility criteria.

Hosparus Health applauds the AAHPM task force for the comprehensive approach to the PACSSI plan, using a patient centered focus on the complexities and needs of the patient and not their life expectancy. The quality metrics in the proposal reflect an emerging framework for quality performance in community-based palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of our organization, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure. We applaud AAHPM for creating tiers of moderate and high complexity to reflect the fact that some patients will require more intensive care than others and tie this intensity to different (per member per month) PMPM payment options. The combination of payment and delivery reforms included in the PACSSI model provides strong incentives and accountability for PCTs to deliver high-quality care.

The AAHPM model focuses on the complexities and needs of the patient without placing a time limit on the length of care. Hosparus Health agrees with the PACSSI model approach. The opportunity to take care of patients with complex chronic conditions longer will provide more opportunity to bend the cost curve of healthcare for people living with serious illness. We believe that supportive care should be piloted upstream from hospice care by nonprofit organizations like Hosparus Health. This will contribute



to the documentation that longer term care improves quality of life and erodes the barrier of prognostication-based eligibility that is currently present in the hospice Medicare benefit. Additionally, we agree that the length of stay in hospice should still be a key quality measure of any serious illness care program.

We also agree with the measures of quality found in Table 3 starting on page 11 of the PACSSI model and understand the incentives under the pay for performance tiers outlined; however, as the proposed PMPM fees are an improvement, but may not cover the expected full cost of care in this pilot, we applaud the proposals inclusion of quality scores as an over-riding measure of success before distribution of any cost savings. The pilot phase should also include an assessment of whether the recommended PMPM fees are adequate to cover the costs of a program intensive enough to achieve the intended quality and cost savings.

As mentioned in our opening paragraphs, Hosparus Health has taken the lead in Kentucky by expanding our service delivery model to include an adult advanced illness / palliative care pilot program to reach patients earlier and longer. From 2015-2016 Hosparus Health led an advanced illness care pilot program involving twenty-two (N=22) patient participants. The pilot was conducted in collaboration with, and partially funded by, a commercial health insurance provider. The outcomes below are telling.

AIC 2015-2016 Results

Hosparus Health has piloted the 2015-2016 Advanced Illness Care initiative with a local commercial insurance provider and achieved the following outcomes (N=22):

Measure	Hosparus Health AIC	National Average/Benchmark
% patients with completed Advance Directive	78%	< age 60= 30% > age 60= 50%
ER Visits Avoided	30	--
Estimated ER Cost Avoidance	\$36,000	\$1200/visit average in 2015
Estimated Inpatient Cost Avoidance	\$180,000- (6) stays of 3 days at cost per stay of \$30,000 *Likely to be higher in this population	1 in 5 ER visits results in hospitalization (CDC), \$30,000/stay per Healthcare.gov
Patient/Family Satisfaction	Overall 4.9 (Very satisfied)	1-5 scale

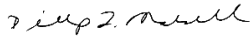
This small pilot inspired Hosparus Health to allocate significant financial resources to expand the pilot in 2017 as a private pay model in 22 Kentucky counties. We continue to work with commercial insurance companies to pilot our program with their costliest and most needy patients, and plan to expand the program to Indiana in early 2018.



This APM Model would give us the ability to expand our PC program further. We are well positioned to participate in a large-scale demonstration project spanning two states with significant populations who could benefit from a coordinated and supported serious illness care program. The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. We appreciate the option for smaller or less risk-ready practices to participate and grow in Track 1, where PACSSI payments are adjusted based on quality and spending measures. We also believe that Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality. As a true pioneer in piloting a program like this in both rural and urban settings, Hosparus Health is poised and willing to take on the risk of the Track 2 model.

In conclusion, the AAHPM's *Patient and Caregiver Support for Serious Illness (PACSSI)* payment model closes key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time, while also bending the cost curve in our healthcare system. Hosparus Health would be honored to participate in PACSSI, should it be recommended for testing by PTAC and implemented by CMS.

Respectfully submitted by:



Phil Marshall, MBA
President & CEO

Dr. Jim Gaffney, MD, MBA
SVP / Chief Medical Officer

Gwen Cooper, MPA
SVP / Chief External Affairs Officer

Link to full model proposal <https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf>

Enclosure: Proposal abstract and background



From: Hoff, Robert (Todd) <Hoff.Robert@scrippshealth.org>
Sent: Friday, September 29, 2017 10:48 AM
To: PTAC (OS/ASPE)
Subject: Please support PACSSI

The payment incentives in PACSSI are well-structured to drive improvements in both quality and cost performance. I appreciate the option for smaller or less risk-ready practices to participate and grow in Track 1, where PACSSI payments are adjusted based on quality and spending measures. I also believe that Track 2 will provide larger, more risk-experienced programs the opportunity to drive greater shared savings while also being accountable for quality .

Regards,

Todd

Todd Hoff, MBA, CRA, FACHE
Corporate VP of Operations - Clinical Ancillaries
Scripps Health
10010 Campus Point Drive, AN102
San Diego, CA 92121-1513

Office: (858)-678-6237
Cell: (619)-823-3418

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September 29, 2017

Physician-Focused Payment Model Technical Advisory Committee
c/o Angela Tejada
Assistant Secretary for Planning and Evaluation Office of Health Policy
200 Independence Ave. SW, Washington, DC 2020

RE: Patient and Caregiver Support for Serious Illness (PACSSI)

Dear Committee members:

The National Partnership for Women & Families appreciates the opportunity to comment on the Patient and Caregiver Support for Serious Illness (PACSSI) payment model submitted by the American Academy of Hospice and Palliative Medicine (AAHPM). The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

In general, we support efforts to provide palliative care to patients (and their caregivers) in all stages of serious illness. We applaud AAHPM for crafting a thoughtful proposal to support interdisciplinary palliative care teams (PCTs) to deliver community-based palliative care to patients who meet certain eligibility criteria. We support AAHPM's goal to develop a model that enables more patients to benefit from high-quality palliative care services, specifically care aligned with their values, needs, preferences and goals.

Additionally, the explicit focus on family and other caregivers is a significant strength of the proposed model, and long overdue. As the primary care coordinators for their families, women shoulder a disproportionate share of caregiving responsibilities,¹ often to the detriment of their own health and economic security. Caregivers play an integral role in the coordination and management of care for their loved ones, and their inclusion in the PACSSI model reinforces and facilitates their role as vital members of the care team. Moreover, proactively and explicitly engaging an individual's family and other caregivers better allows the individual's abilities, culture, values and faith to be respected, and care instructions are more likely to be understood and followed.

We also appreciate the inclusion in the proposed PCTs of social workers, spiritual care professionals and other community service providers not reimbursed under the Medicare

¹ Bott NT, Sheckter CC, Milstein AS. Dementia Care, Women's Health, and Gender Equity: The Value of Well-Timed Caregiver Support. *JAMA Neurol.* 2017;74(7):757–758. doi:10.1001/jamaneurol.2017.0403

program. Non-medical services and supports have a significant affect on a patient's quality of life and are often critical to achieving the care plan goals. We applaud AAHPM for promoting these interdisciplinary partnerships through the PACSSI model.

Lastly, we strongly support including patient- or proxy-reported experiences of palliative care services as part of the composite quality score proposed for the PACSSI model. Employing patient-reported outcome (PRO) tools and collecting PRO data are of the highest value to consumers and patients, and are fundamental to patient-centered care, shared decision-making and care planning.

We recommend a few ways that AAHPM could strengthen the PACSSI proposal to be even more patient- and family centered. Our suggestions focus on the following dimensions of person-centered care:

- **Care Planning:** Developing care plans *with* patients and families
- **Shared Decision-Making:** Utilizing shared decision-making as a standard for education and communication
- **Person-Centered Health Information Technology (IT):** Adopting a broader, more expansive role for health IT

Involving Patients and Caregivers in Developing and Executing Care Plans

We appreciate the proposal's focus on engaging patients and caregivers to establish clear goals and preferences for treatment and interventions. We encourage AAHPM to go a step further and more explicitly involve patients and caregivers in translating goals into a coordinated care plan. Creating plans *with* patients and families will result in plans that are more effective in achieving individual goals and slowing functional decline. We strongly urge AAHPM to reflect this vision of partnership in revised language by changing references to developing care plans *for* patients to developing these plans *with* patients and their families. For example:

- Develop a coordinated care plan with input from the patient, their caregivers, and all of the patient's physicians and providers that is consistent with the patient's care goals. (p. 8, proposed PACSSI required services)
- Have a written care plan developed ~~for~~ with each patient and approved by the patient by the end of the first month of services. (p. 9, proposed PCT requirements)

Furthermore, the proposal should reinforce the role of patients and caregivers in tracking progress and updating the care plan as part of required services. Who better than the patient or their caregiver to know whether the plan is working and what needs to be changed? Patient-facing health IT offers new opportunities for patients and caregivers to contribute to this process (see comments below).

- Communicate with the patient, caregiver, and the patient's other physicians and providers on an ongoing basis to ensure care is being delivered consistent with the care plan and to update the care plan as conditions warrant. (p. 8, PACSSI required services)

The PACSSI model should also include patient/caregiver verification of a care plan that is consistent with their values and preferences, as well as the ability to provide updates to the plan, as a required care process.

Shared Decision-Making

Another crucial aspect of high-quality patient- and family-centered care is shared decision-making. We encourage AAPHM to strengthen the PACSSI model by incorporating the idea of shared decision-making into the proposed palliative care services and quality metrics.

Shared decision-making goes significantly beyond “allowing” patients and families to ask questions. Meaningful shared decision-making facilitates bidirectional communication between providers and patients in which risks, benefits and alternatives of proposed treatment are discussed. It means the provider and patient/caregiver share in the process of deciding what is best for the patient based on her individual goals, preferences and values.

We recommend that any surveys developed to measure the experience of palliative care in the PACSSI model also capture information about these key elements of a shared decision-making process. For example:

- Whether the patient/caregiver was informed about all the reasonable options, including doing nothing, and told what is known about the potential risks, benefits and alternatives to those options.
- Whether the patient/caregiver was meaningfully involved in the decision making process, which includes the opportunity to discuss the options, ask questions and express her or his preferences about which path to follow.
- Whether the patient/caregiver had enough support and advice to make a choice about a treatment recommendation/care plan.

The PACSSI model should also conduct retrospective comparisons of how closely care received aligned with the care plan and established goals, using patient-reported data when possible. For example:

- Was the care the patient received over the last 12 months consistent with the patient/caregiver’s stated values/goals/preferences?

Role of Health IT

We encourage AAHPM to take a more expansive view of the role that health IT can play in the PACSSI model, particularly in supporting patients and their caregivers to achieve the goals of a care plan. A 2014 National Partnership survey clearly shows that patients’ online access to health information has a positive impact on a wide range of activities that are essential to better care and improved health outcomes, including knowledge of health and ability to communicate with providers.²

Health IT should facilitate the safe and secure sharing of information, not just between providers or for quality reporting purposes as the proposal notes, but among patients, families and other designated caregivers, as well as with community-based services and supports. Giving consumers the tools to electronically access and manage their own health

² National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>, pg. 29.

information is foundational to patient engagement and ensuring that patients receive high-quality care.

PCTs should allow patients (and caregivers, as appropriate) to electronically access their clinical health information (lab results, medication lists, care plans, clinical notes, etc.), as well as any relevant educational resources. Moreover, digital tools like secure messaging (often enabled through patient portals or other patient-facing applications) help patients and caregivers easily track and share information with providers in real time. The PACSSI proposal can incorporate a more robust, person-centered approach to health IT by broadening its approach to patient and caregiver communication. For example:

- Respond on a 24/7 basis to requests for information and assistance from the patient or caregiver or from any other providers who are caring for the patient (including but not limited to telephone calls, secure emails, patient portal messages, electronic alerts). (p. 4, scope of proposed PFPM)
- Maintain documentation that it had responded to all ~~telephone calls~~ official (or agreed upon) forms of communication from patients and caregivers (i.e., telephone calls, secure email messages). (p. 9, PCT requirements)

Thank you again for the opportunity to provide input on the proposed PACSSI payment model. We appreciate and support AAHPM's efforts to develop a model that improves care for seriously ill patients and their caregivers. We look forward to working with the PTAC, providers, and patients and families across the nation to develop physician-focused payment models that deliver high-quality health care.

If you have any questions about our comments and recommendations, please contact Katie Martin, vice president for health policy and programs, at kmartin@nationalpartnership.org or (202) 986-2600.

Sincerely,



Debra L. Ness, President