

Payment Reforms to Improve Care for Patients with Serious Illness

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PAYMENT REFORMS TO IMPROVE CARE FOR PATIENTS WITH SERIOUS ILLNESS

DRAFT – FOR DISCUSSION ONLY

CONTENTS

- Abstract.....3**
- I. The Need for Payment Reforms for Care of Serious Illness.....5**
 - A. Improving Care for Patients and Controlling Costs for Payers 5**
 - B. Barriers in Current Payment Systems 6**
- II. Overview of Payment Reforms for Care of Patients with Serious Illness7**
 - A. Palliative Care Support to a Medical Home (PCS) 7**
 - B. Patient and Caregiver Support for Serious Illness (PACSSI)..... 8**
 - C. How the Payment Reforms Would Support a Continuum of Care 8**
- III. Palliative Care Support to a Medical Home (PCS)11**
 - A. Entities Eligible to Receive the Payment..... 11**
 - B. Eligible Patients..... 11**
 - C. Structure of Payments and Services Covered..... 11**
 - 1. Assessment and Planning Services (PCS-AP) Payment 11
 - 2. Monthly Support Services (PCS-MS) Payment 12
 - D. Stratification of Payments Based on Patient Characteristics..... 13**
 - E. Accountability for Quality 15**
 - F. Accountability for Spending 16**
 - G. Setting and Adjusting the Payment Amounts..... 16**
- IV. Patient and Caregiver Support for Serious Illness (PACSSI)18**
 - A. Entities Eligible to Receive the Payment..... 18**
 - B. Eligible Patients 18**
 - C. Structure of Payments and Services Covered..... 19**
 - D. Stratification of Payments and Performance Measures Based on Patient Characteristics 20**
 - E. Accountability for Quality and Spending 22**
 - F. Setting and Adjusting the Payment Amounts 26**
 - G. Optional Bundled PACSSI Payment 30**
- AAHPM Alternative Payment Model Task Force.....32**

Abstract

Patients with serious, potentially life-limiting illnesses or multiple chronic conditions coupled with functional limitations are not well served by the current fragmented, intervention-oriented healthcare system. Numerous research studies and pilot projects demonstrate that high-quality, interdisciplinary palliative care services can provide significant benefits for patients, caregivers and payers, including: reducing pain and suffering related to serious illness; reducing burdens on caregivers that can worsen health and decrease employment and productivity; reducing avoidable emergency department, hospital, and intensive care unit stays; increasing days at home for patients with serious illness, thus reducing expensive post-acute care such as skilled nursing facility stays; and reducing overall healthcare costs while improving patient and caregiver quality of life.

Despite these proven benefits, many patients and caregivers do not receive palliative care because current payment systems do not provide adequate resources to enable palliative care teams to deliver those services to the right patient in the right place at the right time. Fee-for-service payments are available only to physicians and billing practitioners and are insufficient to support the other essential aspects of palliative care, including nursing, psychosocial and spiritual care services. Payment for these interdisciplinary services is available to Medicare beneficiaries through the hospice benefit; however, hospice care is only available to patients with a life expectancy of six months or less who also must give up most disease-focused treatments. New accountable payment mechanisms, based on patient need and disease severity, are required to provide palliative care services to patients in all stages of serious illness who are not yet eligible or willing to enroll in hospice care.

Data show that up to 5 percent (2.75M) of Medicare beneficiaries could benefit from palliative care services each year. These services would improve quality of care and quality of life for patients suffering with many different types of serious illness – such as cancer, COPD, heart failure, and dementia – who currently receive healthcare services in a wide range of settings, including small independent practices, larger physician groups, hospitals, post-acute care facilities, and integrated health systems. The American Academy of Hospice and Palliative Medicine (AAHPM) now proposes two new payment models to enable patients with serious illness to receive palliative care in all of these settings.

Palliative Care Support to a Medical Home (PCS) payments are designed to allow palliative care teams to provide support to medical home or accountable care organizations in addressing unmet needs of patients with serious illness who are assigned or attributed to those accountable providers. Two types of PCS services would be supported: *PCS Assessment and Planning Services (PCS-AP)*, which are one-time payments to provide comprehensive assessment and care planning services; and *PCS Monthly Support Services (PCS-MS)*, which are monthly payments to allow for co-management of patients with ongoing needs. Both PCS-AP and PCS-MS payments would be tiered based on patient complexity, functional status and intensity of interdisciplinary services required. PCS services would be subject to quality measurement, but PCS payments would not qualify as an Alternative Payment Model (APM) under MACRA because they do not require palliative care teams alone to assume “more than nominal” financial risk. Rather, they are designed to assist other quality- and cost-accountable providers in the care of their patients with serious illness.

Patient and Caregiver Support for Serious Illness (PACSSI) payments would qualify as a MACRA APM and are designed to allow palliative care teams themselves to become accountable for the care they provide to patients with serious illness and their caregivers. Monthly PACSSI payments would support interdisciplinary palliative care teams and would likewise be tiered based on patient complexity, functional status and intensity of interdisciplinary services required. In addition, payments would be adjusted up or down based upon performance on both quality and cost measures related to the services delivered. There would also be an option for palliative care teams to receive ***PACSSI Bundled Payments***, which would require greater accountability for service delivery and total cost of care.

Once implemented, these models will achieve the following goals: 1) enable accountable entities (like qualified medical homes) to access palliative care assessment, planning and/or support services for their patients; 2) enable palliative care teams themselves to take accountability as qualified APM providers for patients who are still receiving treatment but need the kind of care coordination and services that a palliative care team can offer; and 3) provide flexible payment structures to adequately support the interdisciplinary palliative care services needed by patients and their caregivers at all stages of serious illness and care needs.

We expect participation from a diverse group of palliative care teams serving urban, suburban and rural populations, and structured within small community-based practices, larger provider organizations, academic health centers, integrated health systems, and hospices.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our more than 5,000 members also include nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families and caregivers. AAHPM's APM Task Force worked to craft the models we propose, including gathering member and stakeholder input. Our Task Force represents the abovementioned diversity of palliative care teams serving Medicare beneficiaries in many communities across the country. These providers and others are interested in implementing the PCS and/or PACSSI models if they are made available. Several pilot sites would be ready to implement PCS and PACSSI payment models as early as 2018.

I. The Need for Payment Reforms for Care of Serious Illness

A. Improving Care for Patients and Controlling Costs for Payers

Patients who have serious illness or multiple chronic conditions frequently experience functional decline over time due to disease progression. All too often, the care they receive is fragmented and uncoordinated, they receive burdensome and costly interventions that are inconsistent with their values and preferences, and they are frequently admitted to the hospital because of the lack of home- and community-based services. Many of these patients and their family caregivers could benefit from palliative care and support services that can better align treatments with their individual preferences, and allow more care to be delivered where they live. Research has shown that high-quality palliative care services can provide significant benefits for patients, caregivers, and payers, including:

- Reducing pain and suffering patients experience due to their illnesses;
- Reducing stresses and physical burdens on caregivers that can create or worsen their health problems;
- Enabling caregivers to remain employed and productive;
- Reducing the number of times patients visit Emergency Departments for symptoms or exacerbations of their health conditions;
- Reducing the number of hospital admissions for exacerbations or complications of the patients' health conditions;
- Reducing the use of emergency transportation for ED visits and hospital admissions;
- Reducing the use of intensive care beds during hospital stays;
- Reducing unnecessary office visits to specialists for routine follow-up care;
- Reducing unnecessary and duplicative laboratory testing and imaging services;
- Reducing the use of low-value treatment services and medical technologies that do not extend the patient's life and may worsen the patient's quality of life;
- Avoiding the costs of maintaining medical devices that do not support or improve the patient's quality of life; and
- Reducing the use of expensive post-acute care services such as skilled nursing facilities and home health services to address post-acute care needs that can be addressed at lower cost.

B. Barriers in Current Payment Systems

A principal reason that many patients and caregivers do not receive palliative care and support services is that current payment systems do not provide adequate resources to enable palliative care providers to deliver those services. There are several barriers in the current payment system that need to be resolved in order to enable patients to receive high-quality palliative care services, including:

- Payment for palliative care and support services delivered by non-billing clinicians (e.g. nursing, social work 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 their physician determine that they have only 6 months to live. Many patients who do not qualify or are unwilling to enroll in hospice care could benefit from palliative care services. As a result, new payment mechanisms are needed to enable access to high quality palliative care for patients until eligible and willing to enroll in hospice care.
- The 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 not sufficient to support high-quality palliative care services for a patient with advanced illness, multiple chronic conditions, and/or functional limitations.
- Although a principal goal of many current Alternative Payment Models (APMs) is to improve care and reduce spending on high-cost patients, most of these APMs do not have any direct way of supporting palliative care services that would help achieve these goals.

II. Overview of Payment Reforms for Care of Patients with Serious Illness

Two new payment models are needed to overcome these barriers to providing adequate palliative care to patients with serious illnesses:

A. Palliative Care Support to a Medical Home (PCS)

PCS payments would support the delivery of palliative care services for patients with serious illnesses whose treatment is being managed by a primary care medical home, specialty medical home, accountable care organization, or other Alternative Payment or accountable entity. There would be two types of PCS payments:

- **Assessment and Planning Services (PCS-AP):** A Palliative Care Team could receive a single PCS-AP payment to provide a comprehensive set of assessment, education, and care planning services for a patient with a serious illness in order to help the patient's primary physician or care manager to develop or revise a comprehensive care plan for the patient. These services could be delivered through one or more face-to-face visits and other types of contacts with the patient and the patient's caregiver(s). There would be three levels of PCS-AP payments, with higher payment amounts for patients with more complex or advanced illnesses and/or greater functional limitations.
- **Monthly Support Services (PCS-MS):** For patients requiring ongoing palliative care support, the Palliative Care Team could receive a monthly PCS-MS payment to deliver palliative care services. There would be three different levels of PCS-MS payment based on the severity and complexity of the patient's health conditions and the patient's functional status.

PCS payments would not qualify as an Alternative Payment Model (APM) under MACRA because the Palliative Care Team would not be taking accountability for managing the patient's overall care or for the overall quality or cost of care the patient receives. Instead, PCS payments would be a "Physician-Focused Payment Model" designed to enable Palliative Care Teams to assist other physicians or providers who are taking accountability for the cost and quality of care for patients under other Alternative Payment Models. PCS would only pay for palliative care services; the costs of treatments for the patient's illness(es) and for overall care management would be paid for separately through the Alternative Payment Model that is supporting the patient's overall care. PCS payments would be considered as expenditures and added to the total cost of care of individual patients, which would encourage integration and value-based innovation between palliative care teams and accountable physicians, practices or entities.

A Palliative Care Team could only receive PCS payments if the services were explicitly ordered or authorized by the physician, practice or entity (e.g. accountable care organization) that was accountable for the patient's overall care under an Alternative Payment Model. Depending on the structure of the Alternative Payment Model, the PCS payments could either be paid directly to the Palliative Care Team by the patient's insurer, or the payments could be paid to the Palliative Care Team by the accountable provider or Alternative Payment Entity that is receiving payments under the Alternative Payment Model.

B. Patient and Caregiver Support for Serious Illness (PACSSI)

PACSSI payments would be an Alternative Payment Model designed to enable a Palliative Care Team to provide overall care coordination and palliative care services for a patient with one or more serious illnesses. The Palliative Care Team would take accountability for enabling patients to remain at home as much as possible and to help them avoid the need for stressful and expensive hospital and institutional care.

- The Palliative Care Team would receive a monthly PACSSI payment to provide both care coordination and palliative care services for patients with serious illnesses who elect to use the Palliative Care Team as their medical home. Planned medical treatments (e.g. chemotherapy or radiation for cancer, procedures for disease treatment or symptom control) for the patient's health conditions would be paid for separately.
- There would be three different levels of PACSSI payment based on the stage and complexity of the patient's health conditions and the patient's functional status.
- The Palliative Care Team would take accountability for the quality of services delivered and for helping the patient avoid emergency department visits and unplanned hospitalizations and other services. The PACSSI payment amount would be increased or decreased based on the Team's performance on quality and spending.
- An optional "bundled" version of the PACSSI payment would include the costs of ED visits and unplanned hospitalizations and other services in addition to care management and palliative care services.

C. How the Payment Reforms Would Support a Continuum of Care

As shown in Figure 1, PCS and PACSSI payments would address two major gaps in care for patients who need more than the services typically offered by primary care and specialty medical homes, but who are not eligible for or willing to receive hospice care:

- PCS payments would enable a primary care practice that is participating in a medical home APM (such as the Medicare Comprehensive Primary Care Plus APM) to provide palliative care services to its patients without the need to deliver those services directly, particularly if there were not enough eligible patients in the practice to support its own Palliative Care Team. PCS payments would also allow a medical home practice to introduce a patient to a Palliative Care Team without the patient having to transfer care management responsibilities to the Palliative Care Team.
- When a patient's conditions have progressed to a stage where palliative care needs exceed other treatment needs or where a primary care or specialty medical home does not have the capability to adequately address the patient's care management and palliative care needs, the PACSSI payment would enable a Palliative Care Team to take over responsibility for care management and coordination from the primary care physician or the specialty medical home as well as provide palliative care services to the patient, while the patient could still continue to receive treatment services for specific conditions from their primary care physician and/or specialists.

- In addition, if the physicians who are treating a patient’s health problems do not offer care management or other medical home services, the patient could designate the Palliative Care Team to deliver care management services supported by the PACSSI payment while still receiving treatment services from their physicians.
- A patient who has a very serious illness but recovers from the illness either partially or fully could receive palliative care and care management supported by PACSSI for the period of time they are seriously ill and then return to care management by a primary care practice or other provider, with or without continued palliative care supported by PCS.
- The PACSSI payment would enable a patient who is eligible for hospice, but who is not ready or willing to elect hospice services, to obtain the benefits of palliative care without the need to forego most disease-oriented services.
- The PACSSI payment would support valuable palliative care services for patients who have a serious illness and unmet needs, but who are not hospice eligible because it is not clear that their life expectancy is six months or less.
- When patients who have received hospice services experience sufficient improvement in their health and functional status that they are no longer hospice eligible, the PACSSI and PCS payments would allow them to be discharged from hospice care but still receive appropriate palliative care support.

The PCS and PACSSI payments and the services they support would complement, not replace or duplicate, the services currently available under the Medicare Physician Fee Schedule and the Medicare Hospice Benefit, and would thereby fill current gaps in the continuum of care, as shown in Table 1 on the next page.

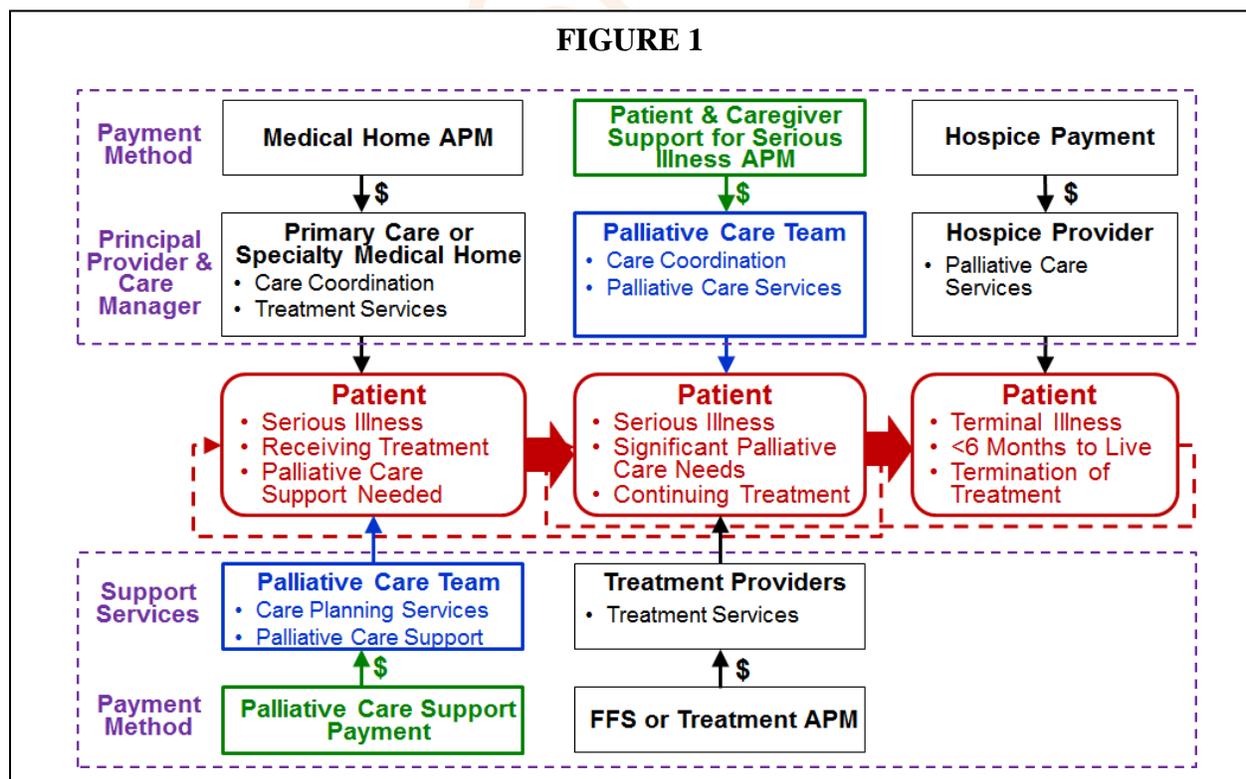


TABLE 1
Comparison of Palliative Care Payment Models to Existing Payment Systems

Type of Payment	Patient Eligibility	Services Covered by Payment	Accountability for Cost and Quality of Care
(Current) Evaluation & Management Services (E&M)	No limits on eligibility	Face-to-face visit with the physician or billing-eligible clinician	Payment amounts are adjusted based on performance on MIPS cost and quality measures
(Current) Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM)	A patient with two or more chronic conditions that place them at significant risk of death, acute exacerbation, or functional decline, if the patient agrees to receive care management services from the provider	Creation of a care plan for the patient; 24/7 access for the patient to care management services and coordination with PCP	Payment amounts are adjusted based on performance on MIPS cost and quality measures
(Current) Advance Care Planning (ACP)	No limits on eligibility	Discussion with the patient regarding advance care planning and goals of care	Payment amounts are adjusted based on performance on MIPS cost and quality measures
(New) Palliative Care Support to a Medical Home (PCS) Payments	<i>A patient with a serious illness who is receiving care management from a primary care or specialty medical home that requests palliative care support</i>	<i>Palliative care services for the patient (all treatment services can continue to be delivered and paid for separately)</i>	<i>An accountable provider is responsible for managing the quality and cost of care under an Alternative Payment Model, with assistance from the Palliative Care Team.</i>
(New) Patient and Caregiver Support for Serious Illness (PACSSI) APM	<i>A patient with a serious illness who designates the Palliative Care Team as their medical home</i>	<i>Care management and palliative care services for the patient (all planned treatment services would continue to be delivered and paid for separately)</i>	<i>The Palliative Care Team takes accountability for managing the quality of care and potentially avoidable acute care. Treatment services are managed by the treating physician.</i>
(Current) Medicare Care Choices Demonstration (MCCM)	A patient with cancer, COPD, heart failure, or HIV/AIDS who has been determined by a physician to have 6 months or less to live	Palliative care services for the patient (all treatment services can continue to be delivered and paid for separately)	The provider must report quality measures, but no adjustments in payments are made based on quality or spending.
(Current) Hospice Care	A patient who has been determined to have 6 months or less to live and who agrees to forgo treatment services for the terminal condition.	Palliative care and all services related to the patient’s terminal condition (treatment services for unrelated conditions can continue to be delivered and paid for separately)	The Hospice provider is responsible for payment of all services related to the terminal condition. The provider must report on the quality of hospice care. Treatment services unrelated to the terminal condition are managed by the treating physician.

III. Palliative Care Support to a Medical Home (PCS)

A. Entities Eligible to Receive the Payment

Palliative Care Support to a Medical Home (PCS) payments would only be made to a Palliative Care Team that has the capability to perform assessments and deliver services through an interdisciplinary team aligned with the essential elements of the *Clinical Practice Guidelines for Quality Palliative Care* published by the National Consensus Project (NCP) for Quality Palliative Care (<http://www.nationalconsensusproject.org/>). Currently published NCP guidelines set standards for palliative care teams to meet the physical, psychological, spiritual and practical needs of patients with serious illness and their caregivers. NCP periodically updates these guidelines to reflect new medical evidence and evolving models of care delivery. The current Third Edition was published in 2013, and NCP has begun work on an update to address the emergence of new models of community-based palliative care.

B. Eligible Patients

A Palliative Care Team could receive PCS payments for a patient:

- who has been assigned or attributed to a primary care practice, specialty practice, multi-specialty group, accountable care organization, or other Alternative Payment Entity that is participating in an Alternative Payment Model, providing care management services to the patient, and taking accountability for the overall cost and quality of services to the patient, and
- for whom the accountable provider has ordered a palliative care assessment or palliative care services by a Palliative Care Team.

For patients who are not part of an Alternative Payment Model, the patient's health plan could choose to contract with the Palliative Care Team to deliver palliative care assessment or support services to patients who are either referred by the health plan for the services or for patients who meet eligibility criteria established by the health plan.

C. Structure of Payments and Services Covered

1. Assessment and Planning Services (PCS-AP) Payment

The Palliative Care Team would receive a PCS-AP payment in return for delivering the following services:

- Educating the patient and caregiver about the patient's health conditions, their progression, the types of complications that can arise, and ways of managing the condition more effectively;
- Identifying areas of distress through a comprehensive physical, psychosocial, emotional, cultural, functional, and spiritual assessment;
- Identifying threats to the safety of the patient or caregiver from the physical environment, medication interactions, and other sources;

- Assisting the patient to establish clear goals for care and treatment and to define their preferences for interventions and the site of care delivery when problems arise;
- Assisting the patient's care manager to develop a coordinated care plan with input from all providers that is consistent with the patient's care goals.

A Palliative Care Team would receive one PCS-AP payment for all of the services needed to complete the assessment and planning process; the amount of payment would be designed to be sufficient to cover as many visits or other types of contacts as were necessary to complete the process. Higher payment amounts would be paid for patients who have more complex conditions and other characteristics that will generally require more time for care planning. The members of the Palliative Care Team would not bill for Evaluation & Management Services for the patients if the Team was receiving a PCS-AP payment.

The Palliative Care Team could only bill for a PCS-AP payment if the service was specifically ordered by a physician or Alternative Payment Entity that is participating in an alternative payment model in which the physician or entity is responsible for managing the quality and cost of care for the patient. The Team could provide PCS-AP services multiple times to the same patient if they were ordered by the physician who is managing the patient's care.

Depending on the way the patient's care management provider is being paid, the Palliative Care Team would either bill the patient's health plan for the PCS-AP payment or it would bill the care management provider that ordered the service. For example, a primary care medical home practice that is receiving monthly care management payments for its patients could contract directly with the Palliative Care Team to deliver PCS-AP services to individual patients who would benefit. If the primary care medical home practice is participating in a shared savings payment model, the Palliative Care Team would bill the patient's health plan for the PCS-AP payment, and that payment would be included in the calculation of the total cost of care for the patient that the medical home is responsible for managing.

2. Monthly Support Services (PCS-MS) Payment

The Palliative Care Team would receive a PCS-MS payment to deliver the following services:

- Responding on a 24/7 basis to requests for information and assistance from the patient or caregiver or from other providers who are caring for the patient;
- Making visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns;
- Providing other services that the Palliative Care Team believes would assist the patient in more effectively managing their health condition.

A Palliative Care Team would receive one PCS-MS payment each month to provide all of the palliative care services identified in the patient's care plan. Higher monthly payment amounts would be paid for patients with more complex conditions and other characteristics that will generally require more time and resources. The members of the Palliative Care Team would not bill for Evaluation & Management Services during a month in which the Team was receiving a PCS-MS payment (i.e., no E/M payments for face-to-face visits to the patients, no Chronic Care Management or Complex Chronic Care Management services, etc.).

The Palliative Care Team could only bill for a PCS-MS payment if the service was specifically ordered by a physician or Alternative Payment Entity that is participating in an alternative payment model in which the physician or entity is responsible for managing the quality and cost of care for the patient.

D. Stratification of Payments Based on Patient Characteristics

There would be three different payment amounts for both PCS-AP and PCS-MS payments to reflect the fact that more time for care planning and for support services would be needed for patients who have more complex needs. The Palliative Care Team would consult with the accountable provider in determining the appropriate category for an individual patient based on the Team's assessment of the patient's characteristics and needs. The Team would document the basis for those findings in the electronic medical record. The Palliative Care Team would then use the billing codes in Table 2 to indicate the category to which the patient was assigned.

Because there has been very little funding support for community-based palliative care services to date, there is only limited information available to use in defining the stratification categories. Consequently, the categories will need to be refined after the initial 2-3 years of experience in implementing PCS payments.

Table 2
Categories of Palliative Care Support Payments

Category	Billing Code	Patient Characteristics
Level 1 PCS-AP Level 1 PCS-MS	xxx11 xxx21	<p>Low Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of 70; OR • PPS score of 80 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 30 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity
Level 2 PCS-AP Level 2 PCS-MS	xxx12 xxx22	<p>Moderate Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of 50-60; OR • PPS score of 70 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ multiple serious or complex illnesses; or ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 90 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity
Level 3 PCS-AP Level 3 PCS-MS	xxx13 xxx23	<p>High Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of ≤ 40 • PPS score of 50-60 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ multiple serious or complex illnesses; or ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 90 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity

E. Accountability for Quality

The Palliative Care Team would share accountability for delivering high-quality care to patients and for achieving a good care experience for the patient and their caregivers, family, and significant others. Although it would be desirable to base accountability on outcomes (e.g., management of pain and other symptoms), outcome-based performance measures have not been tested and are not commonly used by palliative care programs in the United States. If sufficient resources are provided through the PCS payments, the Palliative Care Team will collect information on patient-reported outcomes to enable development of outcome-based measures and performance standards. In the meantime, the Palliative Care Team's performance on quality and patient experience would be assessed using a composite of process measures and a measure of the care experience:

- **Quality of Care Measure.** The percentage of patients for whom all of the following activities were performed within 15 days of the start of palliative care services and then regularly during the ongoing delivery of services, unless the activity is inapplicable or inappropriate and the exceptions are documented.
 - Completion of a comprehensive assessment (physical, psychological, social, and spiritual);
 - Screening for symptoms (including pain, dyspnea, nausea, and constipation);
 - Documented discussion regarding emotional needs, or screening for anxiety or depression;
 - Documented discussion of spiritual concerns, documentation of preference not to discuss spiritual concerns, or screening with the question “Are you at peace?”; and
 - Documentation of advance directives, which may include preferences for surrogate decision-maker(s) and life-sustaining treatment.

(These measures were selected or adapted from the *Measuring What Matters*¹ list based on their clinical importance, evidence of feasibility, demonstration of important gaps in care, and variance across diverse settings.²)

- **Consumer Assessment of Palliative Care Experience.** A Palliative Care Experience score would be determined using a survey that each Palliative Care Team would administer 15 days after the start of palliative care services that were delivered for at least two days, every three months during ongoing care, and 15 days after any care crisis, discharge from palliative care services, or death. The score for a patient for a month would be based on the score on the most recent survey taken. Since cognitive and functional impairments are prevalent in palliative care populations, knowledgeable surrogates would be permitted to respond on behalf of patients who could not complete the survey for themselves.

Performance on each measure would be determined by comparing the Palliative Care Team's score on the measure to the median score on that measure for all Teams receiving the PCS

¹ Dy AM, Kiley KB, Casarett DJ, et al. *J Pain Symptom Manage* 2015;49:773-81.
<http://dx.doi.org/10.1016/j.jpainsymman.2015.01.012>

² Kamal AH, Bull J, Taylor DH. *J Pain Symptom Manage* 2016;51:497-503.
<http://dx.doi.org/10.1016/j.jpainsymman.2015.12.313>

payments during the prior year. The comparisons would be made separately for patients in each of the three categories defined in Table 2 and also separately for patients receiving palliative care in a private home versus a care facility. (The comparison would be based on the location in which the patients received palliative care at the time the measure was calculated.) As long as the Team's performance was within two standard deviations around the median for both measures, the Team's performance would be deemed "good performance." If performance was significantly better than the median on both measures, it would be deemed "excellent performance" and if it was significantly worse on either measure, it would be deemed "poor performance."

There would not be any measures of performance on cost because the services would only be delivered as part of an Alternative Payment Model in which another physician or Alternative Payment Entity is taking accountability for the cost of services. That other provider would be responsible for controlling utilization of the PCS payments through the referrals/orders it makes for the PCS services.

F. Accountability for Spending

PCS-AP and PCS-MS services will be accountable for spending in one of two ways, depending on how the Palliative Care Team is paid for them. First, an accountable provider (e.g. Medical Home or ACO) participating in an Alternative Payment Model may pay the Palliative Care Team for the type and level of services described in Table 2. In this model, the Palliative Care Team would be expected to help reduce spending at least enough to offset the cost of their services to the accountable entity in their APMs specific payment model (e.g. bundled payments, shared savings, global payments, etc.).

Alternatively, a health plan could pay the Palliative Care Team directly. In this case, the cost of the team's services would be added to overall spending, against which performance would be measured via relevant methodology specific to the Alternative Payment Model (e.g. bundled payments, shared savings, global payments, etc.).

In either case, accountable providers are incentivized to collaborate closely with Palliative Care Teams to ensure performance on spending measurement, and Palliative Care Teams are incentivized to add value to the accountable provider's care management processes.

G. Setting and Adjusting the Payment Amounts

Standard payment amounts would be established, with the amounts differing based on (1) the category in Table 1, (2) the site of care (home vs. facility), and (3) for patients residing at home, the population density of the county in which the patient resides. The payment amount would be designed to adequately support the average amount of time and resources that the Palliative Care Team would need to spend delivering services to patients who have the characteristics defined in the category and who receive care in a particular site of care and county. The amount of payment for an individual patient may be higher or lower than the costs the Palliative Care Team incurs for services to that patient, but on average, the total amount of payments for all patients in a particular category, site of care, and county should be greater than or equal to the total costs the Team incurs in delivering services to those patients.

Payment amounts would be reduced by 8% for Palliative Care Teams with a poor performance rating, and physicians, care managers, and ACOs could decide to no longer refer patients to Teams with poor performance ratings. Teams with an excellent performance rating would receive 8% higher payments.

The initial payment amounts would need to be established using data on the costs of the personnel involved and the estimated time they would spend with patients in each category. Palliative Care Teams in rural communities will likely require higher PCS-MS payment amounts because of the lower caseloads and longer travel times that are necessary in areas with low population densities. After the initial year of the program, the participating Palliative Care Teams would calculate their actual costs of services in order to calculate more accurate rates for subsequent years. This process would be repeated again within 1-2 years. In subsequent years, the payment rates would be increased each year based on the Medicare Economic Index.

IV. Patient and Caregiver Support for Serious Illness (PACSSI)

A. Entities Eligible to Receive the Payment

Patient and Caregiver Support for Serious Illness (PACSSI) payments would only be made to a Palliative Care Team (PCT) that has both:

- the capability to perform assessments and deliver services through an interdisciplinary team structured in accordance with the essential elements of the National Consensus Project for Quality Palliative Care (<http://www.nationalconsensusproject.org/>) ; and
- the capability to respond appropriately on a 24/7 basis to patient and caregiver requests for advice and assistance in managing issues associated with the patient's health conditions and functional limitations. Appropriate response includes the ability to provide face-to-face services in all care settings when needed (either in person or through videoconference services) as well as telephonic responses.

B. Eligible Patients

A Palliative Care Team could receive a PACSSI payment for an adult who:

- has one or more serious diseases, disorders, or health conditions that have progressed to a stage where patients frequently experience avoidable complications that are typically treated using expensive acute care services; or
- has multiple progressive chronic conditions and significant functional limitations.

The following types of patients would be *ineligible* to receive services supported by PACSSI payments:

- Patients with serious mental illness without another serious, life-threatening condition
- Patients who have elected to receive hospice care
- Patients who do not consent to receive PACSSI services

In order for the Palliative Care Team to receive the PACSSI payment for an eligible patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would need to:

- explicitly designate the Palliative Care Team as the patient's sole provider of care management services and palliative care services;
- agree to work with the Palliative Care Team to develop a care plan;
- agree to adhere to the care plan to the best of the patient's and caregiver's ability as long as the Palliative Care Team met its commitments to deliver quality care and support to the patient and caregiver; and
- authorize the Palliative Care Team to contact the patient's other physicians and providers to:

- notify other physicians that the patient has designated the Palliative Care Team to serve as the patient's care manager and that no other physician will be eligible to bill for care management, transitional care management, or advance care planning services, and
- request on behalf of the patient that those other physicians and providers contact the Palliative Care Team before ordering any new tests or treatments for the patient.

The submission of a bill for PACSSI services to a patient during a month would represent a certification by the Palliative Care Team that the patient met the eligibility requirements.

In order to receive PACSSI payments, a Palliative Care Team would be required to accept any patient living in the service area who met the eligibility criteria, unless the Team had reached a pre-defined capacity limit. If the Team was unable to serve a patient due to the capacity limit, it would be required to establish a waiting list. If changes in the existing patients under the Team's care enabled the Team to accept additional patients, it would be required to accept patients from the waiting list before accepting new patients. *[NOTE: This provision is intended to address concerns about cherry-picking patients and to avoid having CMS or other payers "attribute" patients to the Team in order to avoid cherry-picking.]*

C. Structure of Payments and Services Covered

For each eligible patient who designates the Palliative Care Team to provide care management and palliative care services, the PCT would bill for and receive a monthly Patient and Caregiver Support for Serious Illness (PACSSI) payment from the patient or the patient's insurer. This payment would be used to support the following services:

- Educating the patient and caregiver about the patient's health conditions and the typical progression of those conditions, the types of complications that can arise, and about ways to manage disease progression, minimize symptoms, and avoid complications;
- Identifying areas of distress through a comprehensive physical, psychosocial, emotional, cultural, functional, and spiritual assessment;
- Identifying threats to the safety of the patient or caregiver from the physical environment, medication interactions, and other sources;
- Assisting the patient to establish clear goals for care and treatment and to define their preferences for interventions and the site of care delivery if complications arise;
- Developing a coordinated care plan with input from all of the patient's physicians and providers that is consistent with the patient's care goals.
- Arranging for services from other providers in order to implement the care plan;
- Communicating with 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;
- Responding on a 24/7 basis to requests for information and assistance from the patient or caregiver or from other providers who are caring for the patient;

- Making visits to the patient in all sites of care (home, hospital, nursing home, etc.) as needed to respond appropriately to problems and concerns; and
- Providing other services that the Palliative Care Team believes would assist the patient in more effectively managing their illnesses.

The submission of a bill for PACSSI services to a patient during a month would represent a certification by the Palliative Care Team that it had provided all of the appropriate services listed above to the patient during that month. During a month in which the Palliative Care Team billed for the PACSSI payment, the members of the PCT would not bill for any Evaluation & Management services under the Physician Fee Schedule, including office visits, home visits, hospital visits, Chronic Care Management, Complex Chronic Care Management, Transitional Care Management, or Advance Care Planning. Claims from any other physician for Chronic Care Management, Transitional Care Management, or Advance Care Planning services would be denied for payment.

In addition to the PACSSI payment, the Palliative Care Team could bill and be paid for any other medically necessary procedures or treatments that are administered to the patient, are otherwise eligible for payment, and are not included in the services covered by the PACSSI payment.

Physicians and other providers who are not part of the Palliative Care Team could continue to bill for and be paid for their Evaluation & Management services and for any procedures or treatments they deliver for the patient's health conditions.

D. Stratification of Payments and Performance Measures Based on Patient Characteristics

The patients who could benefit from Patient and Caregiver Support for Serious Illness payments vary in the frequency and nature of problems they experience and in the amount of support they need to avoid those problems and to address them effectively when they occur. As a result, a payment amount that would be adequate to address the needs of one set of patients would be inadequate for patients with greater needs, and rates of problems and service utilization might be higher for one group of patients because of differences in the patients' characteristics rather than the effectiveness of the services delivered by the Palliative Care Team.

To address this, three different categories of patients would be defined based on patient characteristics that are associated with higher care needs and higher risk of problems. The initial set of category definitions are shown in Table 3. The Palliative Care Team would receive a higher PACSSI payment for a patient in a higher-need/higher-risk category. Utilization and quality measures would be calculated separately for patients in each category.

Table 3
Payment and Performance Categories for
Patient and Caregiver Support for Serious Illness Payments

Category	Billing Code	Patient Characteristics
Level 1 PACSSI	xxx31	<p>Low Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of 70; OR • PPS score of 80 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 30 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity
Level 2 PACSSI	xxx32	<p>Moderate Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of 50-60; OR • PPS score of 70 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ multiple serious or complex illnesses; or ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 90 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity
Level 3 PACSSI	xxx33	<p>High Complexity Patients One or more serious, potentially life-limiting illnesses AND either:</p> <ul style="list-style-type: none"> • Palliative Performance Scale score of ≤ 40 • PPS score of 50-60 AND one or more other high-need indications: <ul style="list-style-type: none"> ➤ multiple serious illnesses; or ➤ significant symptom distress; or ➤ discharge from inpatient facility within previous 90 days; or ➤ remote location; or ➤ sudden or persistent nutritional, functional, or cognitive decline; or ➤ caregiver with limited capacity

Because there has been very little funding support for community-based palliative care services to date, there is only limited information available to use in defining the stratification categories. Consequently, the categories will need to be refined after the initial 2-3 years of experience in implementing the PACSSI payment model.

The Palliative Care Team would determine the appropriate category for an individual patient based on the Team's assessment of the patient's characteristics. The Team would document the basis for those findings in the electronic medical record. The Palliative Care Team would then use the billing code in Table 3 to indicate the category to which the patient was assigned. If a patient's characteristics changed sufficiently to warrant a change in category from one month to the next, that change would be indicated by using a different billing code for the month during which the characteristics had changed. Patients could move to a higher level and then move back to a lower level if they experience a medical event that worsens their condition temporarily or if there are changes in the availability of caregiving support in their home.

The Palliative Care Team would not have to re-document each month that characteristics documented previously still existed. If a different billing code were submitted, only the reasons for the change would need to be documented. The Palliative Care Team would be expected to do a full assessment of the patient's condition and needs no less frequently than once per year and to make any changes in the patient's care plan and billing category on that basis.

E. Accountability for Quality and Spending

A Palliative Care Team billing for PACSSI payments would accept accountability for delivering high quality care to the patient and for helping the patient avoid emergency department visits and unplanned hospitalizations and other services.

1. Minimum Quality Standards

The Palliative Care Team would be required to meet the following standards in order to bill for a PACSSI payment for a particular patient:

- The Team would need to have a written care plan developed for each patient and approved by the patient by the end of the first month of services;
- The Team would need to maintain documentation in the Electronic Health Record that the patient had been assessed and determined to have the characteristics required for eligibility for payment and for the assigned payment category;
- For Level 1 patients, the Team would need to have at least one face-to-face visit with the patient every three months;
- For Level 2 and 3 patients, the Team would need to have at least one face-to-face visit with the patient every month; and
- The Team would need to maintain documentation that it had responded to all telephone calls from patients.

The submission of a bill to a payer for PACSSI services delivered to a patient during a month would represent a certification by the Palliative Care Team that it had met the minimum quality standards.

2. *Performance on Care Quality and Outcomes*

The Palliative Care Team would share accountability for delivering high-quality care to patients and for achieving a good care experience for the patient and their caregivers, family, and significant others. Although it would be desirable to base accountability on outcomes (e.g., management of pain and other symptoms), outcome-based performance measures have not been tested and are not commonly used by palliative care programs in the United States. If sufficient resources are provided through the PACSSI payments, the Palliative Care Team will collect information on patient-reported outcomes to enable development of outcome-based measures and performance standards. In the meantime, the Palliative Care Team's performance on quality and patient experience would be assessed using a composite of process measures and a measure of the care experience:

- **Quality of Care Measure.** The percentage of patients for whom all of the following activities were performed within 15 days of the start of palliative care services and then regularly during the ongoing delivery of services, unless the activity is inapplicable or inappropriate and the exceptions are documented.
 - Completion of a comprehensive assessment (physical, psychological, social, and spiritual);
 - Screening for symptoms (including pain, dyspnea, nausea, and constipation);
 - Documented discussion regarding emotional needs, or screening for anxiety or depression;
 - Documented discussion of spiritual concerns, documentation of preference not to discuss spiritual concerns, or screening with the question “Are you at peace?”; and
 - Documentation of advance directives, which may include preferences for surrogate decision-maker(s) and life-sustaining treatment.

(These measures were selected or adapted from the *Measuring What Matters* list based on their clinical importance, evidence of feasibility, demonstration of important gaps in care, and variance across diverse settings.)

- **Consumer Assessment of Palliative Care Experience.** A Palliative Care Experience score would be determined using a survey that each Palliative Care Team would administer 15 days after the start of palliative care services that were delivered for at least two days, every three months during ongoing care, and 15 days after any care crisis, discharge from palliative care services, or death. The score for a patient for a month would be based on the score on the most recent survey taken. Since cognitive and functional impairments are prevalent in palliative care populations, knowledgeable surrogates would be permitted to respond on behalf of patients who could not complete the survey for themselves.

Performance on each measure would be determined by comparing the Palliative Care Team's score on the measure to the median score on that measure for all Teams receiving the PCS payments during the prior year. The comparisons would be made separately for patients in each of the three categories defined in Table 3 and also separately for patients receiving palliative care in a private home or a care facility. (The comparison would be based on the location in which the patients received palliative care at the time the measure was calculated.) As long as the Team's performance was within two standard deviations around the median for both measures,

the Team's performance would be deemed "good performance." If performance was significantly better than the median on both measures, it would be deemed "excellent performance" and if it was significantly worse on either measure, it would be deemed "poor performance."

During the initial year of implementation of the PACSSI payments, there will be no data available in the relevant categories to serve as a baseline, so the payer and the Palliative Care Team would agree on initial target levels for each measure, and the Palliative Care Team would be deemed to have "good performance" for each measure if it was at or above the target level for that measure, and the Team would be deemed to have "poor performance" if it was below the target level. If there is insufficient basis for setting a target performance level in the initial year for a particular measure, the Palliative Care Team would automatically receive a "good performance" rating and the data collected on the measure for all Teams would be used to assess performance during the second and subsequent years.

3. *Performance on Avoidable Utilization and Spending*

The Palliative Care Team's performance in managing utilization and spending would be assessed based on the standardized monthly spending per patient on all services received by the patients other than medications and any planned procedures to treat the patient's illnesses and health problems.

Calculation of Standardized Spending Measure

Spending for the following services would be *included* in the performance measure:

- E&M services from physicians and other healthcare providers;
- Laboratory tests and imaging studies;
- Emergency Department visits and urgent care center visits;
- Hospital admissions and outpatient procedures other than planned treatments and procedures for the patient's conditions; and
- Post-acute care services, including skilled nursing facilities and home health services

Spending for the following services would be *excluded* from the performance measure:

- Medications for curative treatment rather than palliation, whether covered under a medical benefit or pharmacy benefit; and
- Hospital admissions and outpatient procedures that (a) were planned as part of the patient's treatment for their condition when the patient began to receive PACSSI services and (b) are specifically identified in the patient's plan of care (including services identified as appropriate when specific types of complications occur). This would include services such as chemotherapy and radiation therapy for cancer or placement of a pacemaker.

Spending would be “standardized” by establishing a “standard” price for each type of service, multiplying that price by the number of each service that the patient received, and then summing the products. The standard price would be established by:

- Calculating the average amount paid by the payer during the most recent 12-month period for which data are available in the local market for each type of service; and then
- Increasing these amounts by an estimate of the increase in prices from the previous period to the current year.

Use of this price-standardized spending measure avoids putting the Palliative Care Team at risk for changes in the prices charged by hospitals and other providers, while still holding the Team accountable for avoiding unnecessary services and unnecessarily expensive services. Basing standardized prices on a prior period enables a performance target to be established prior to the beginning of the year.

This standardized spending measure would be calculated separately for patients in each of the three subcategories defined in Table 3, in order to compare spending levels across Palliative Care Teams for patients with similar characteristics. If there are fewer than ten patients in a category, the current year average would not be used for comparison purposes; however, if performance information from the prior year were available and the combined number of patients was sufficient to calculate a reliable estimate, the multi-year average would be used.

Performance Targets During the Initial Years of the Payment System

During the initial two years of the program, a Palliative Care Team’s performance on the spending measure would be determined as follows:

- Data would be obtained on current average rates of standardized spending for the types of patients who would be eligible for the PACSSI payment but who are not receiving PACSSI services. Ideally, these data would be specific to the region and payer that is implementing the PACSSI payment, but otherwise, national data or data from other regions would be used.
- A target performance level for the measure would be established by reducing the current average spending by an amount estimated to be sufficient to offset the expected spending on PACSSI payments.
- The actual spending for the Palliative Care Team’s patients would be compared to the target performance level. If the measure is within 4% of the target level, the Palliative Care Team would be deemed to have “good performance.” If the measure is more than 4% below the target level, the Palliative Care Team would be deemed to have “excellent performance,” and if the measure is more than 4% above the target level, the Palliative Care Team would be deemed to have “poor performance.”

Performance Targets During Later Years of the Payment System

In subsequent years, the performance target for the spending measure would be determined as follows:

- Data from the prior year for all Palliative Care Teams receiving the PACSSI payments would be used to determine the average proportion of patients in each category and the average spending measure in each category across all Teams.
- The value of the measure in each patient category for a Palliative Care Team would be multiplied by the average proportion of patients in that category across all Teams to compute the target spending level for the Palliative Care Team’s patients.

4. *Adjustment of Payments Based on Performance*

The Palliative Care Team would receive the default payment level in each category during the current year if the Team’s performance was “good” on both the quality and spending measures during the prior year. Otherwise, the payment levels would be adjusted up or down based on the Team’s balance of excellent, good, and poor performance on the various measures.

Payment adjustments would be made according to the schedule in Table 4:

Table 4
Performance-Based Adjustments to PACSSI Payment

Performance on Quality:	Performance on Spending:		
	Poor	Good	Excellent
Poor	-8%	-8%	-8%
Good	-8%	0%	+4%
Excellent	-4%	+4%	+8%

These adjustments would meet the standards for “more than nominal risk” under MACRA during 2018.

F. Setting and Adjusting the Payment Amounts

Standard payment amounts would be established, with the amounts differing based on (1) the category in Table 3, (2) the site of care (home vs. facility), and (3) for patients residing at home, the population density of the county in which the patient resides. The payment amounts would be designed to achieve two goals:

- **Provide adequate resources to support the services patients need for high-quality care.** The amount of payment for each category of patients should be adequate to support the average amount of time and resources that the Palliative Care Team would need to spend delivering services to patients who have the characteristics defined in the category and who receive care in a particular site of care and county during a month. The amount of payment for an individual patient may be higher or lower than the costs the Palliative Care Team incurs for services to that patient but, on average, the total amount of payments for all patients in a particular category, site of care, and county should be greater than or equal to the costs the Team incurs in delivering services to those patients.

- **Budget neutrality/savings for payers.** The total spending by the payer on all healthcare services to the participating patients should be no greater than what it had been for similar patients prior to the creation of the new payment system, and ideally the spending would be lower. In situations in which a palliative care provider has already been delivering the types of services that would be supported through the PACSSI payments using other temporary sources of funds, the payer would need to account for the savings that had already been achieved in calculating the net savings that could be achieved through the PACSSI payments and in setting the appropriate target spending level.

The initial payment amounts would need to be established using data on the costs of the personnel involved, the caseloads they could manage, and the expected savings from reduced acute care use. For example, Table 5 shows an initial estimate of the costs of providing PACSSI services to patients in each category and the reductions in ED visits/hospitalizations and/or spending that would be needed to offset these costs.

Based on these analyses, initial payment amounts would be established for each billing code, similar to what is shown in Table 6. After the initial year of the program, the participating Palliative Care Teams would calculate their actual costs of services in order to calculate more accurate rates for subsequent years. This process would be repeated again within 1-2 years. Palliative Care Teams in rural communities will likely require higher payment amounts because of the lower caseloads and longer travel times that are necessary in areas with low population densities. In subsequent years, the payment rates would be increased each year based on the Medicare Economic Index.

TABLE 5
Projected Costs and Savings from Palliative Care Services

Projected Costs and Savings from Palliative Care Services							
Personnel	Annual Cost	Low Risk Patients		Medium Risk Patients		High Risk Patients	
		Caseload	PMPM	Caseload	PMPM	Caseload	PMPM
Physician	\$200,000	750	\$ 22.22	500	\$ 33.33	300	\$ 55.56
Advance Practice Practitioner	\$100,000	500	\$ 16.67	240	\$ 34.72	150	\$ 55.56
RN	\$60,000	170	\$ 29.41	80	\$ 62.50	50	\$100.00
Social Services	\$45,000	320	\$ 11.72	120	\$ 31.25	75	\$ 50.00
Home Aide	\$25,000	0		0		65	\$ 32.05
Spiritual Care Provider	\$50,000	1000	\$ 4.17	500	\$ 8.33	300	\$ 13.89
Benefits	30%		\$ 20.26		\$ 40.63		\$ 75.45
Supplies, Travel, Admin.	50%		\$ 43.89		\$ 88.02		\$163.47
Total Cost			\$ 148.33		\$298.78		\$545.97
Avoidable Utilization	Cost/Unit	Rate/Pt	PMPM	Rate/Pt	PMPM	Rate/Pt	PMPM
ED Visits	\$1,000	4	\$333	6	\$500	10	\$833
Hospital Admissions	\$10,000	2	\$1,667	3	\$2,500	5	\$4,167
			\$2,000		\$3,000		\$5,000
Reduction Needed for Budget Neutrality		-7%		-10%		-11%	
Total Spending	Average	Ratio	PMPM	Ratio	PMPM	Ratio	PMPM
Total Spending	\$10,000	2	\$1,667	3	\$2,500	5	\$4,167
Reduction Needed for Budget Neutrality		-9%		-12%		-13%	

TABLE 6
Initial Payment Amounts for PACSSI Services

Category	Billing Code	Patient Characteristics	Initial Payment Amount
Level 1	xxx31	Low-Medium Need & Risk	\$150 per patient per month
Level 2	xxx32	Medium Need & Risk	\$300 per patient per month
Level 3	xxx33	High Need & Risk	\$550 per patient per month

FIGURE 2
Stratification and Performance-Based Adjustment of Payments

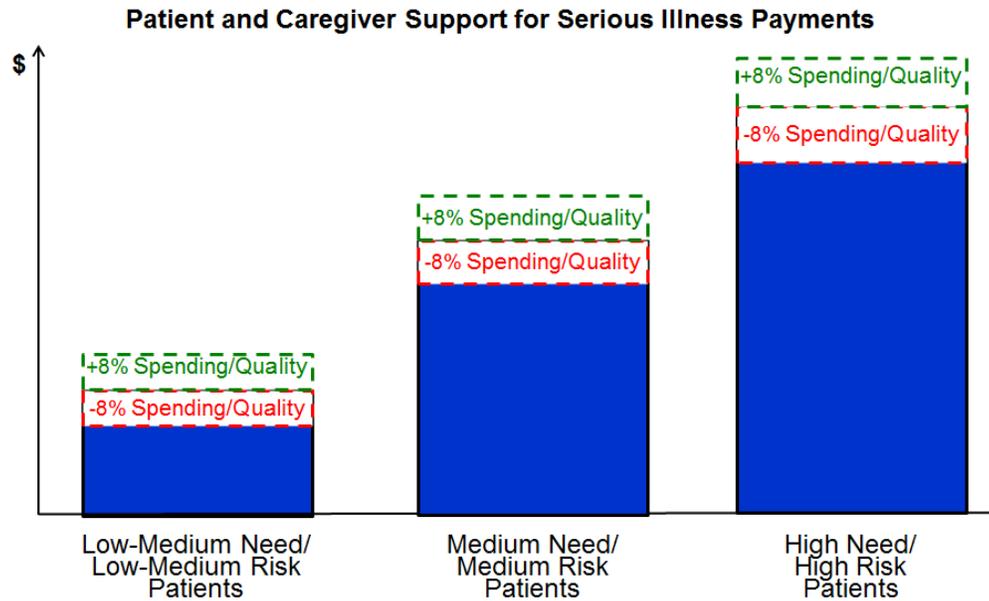
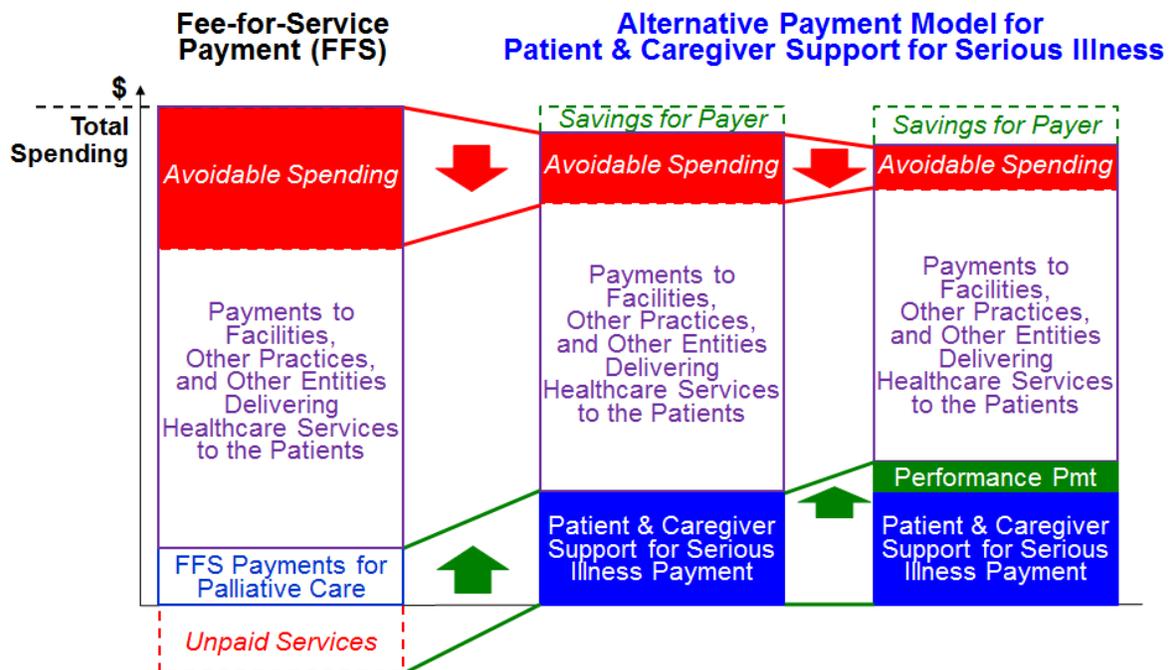


FIGURE 3
Lower Total Spending Through Alternative Payment Model



G. Optional Bundled PACSSI Payment

Palliative Care Teams with two years or more of experience in successfully delivering PACSSI services and managing utilization and spending for their patients could choose to accept a “bundled” PACSSI payment instead of the standard PACSSI payments. PACSSI Bundled Payments would be designed to cover not only the costs of the services that the Palliative Care Team delivers, but also to cover the costs of all or most of the other services the patients receive other than planned treatment services.

Advantages of a PACSSI Bundled Payment

Compared to the payment structure described in the previous section, a PACSSI Bundled Payment would have the following advantages:

- Palliative Care Teams would have greater flexibility to deliver or purchase different kinds of services for patients if they felt those services would address patient needs at lower overall costs. For example, if the Palliative Care Team felt that modifications to a patient’s home or occasional services from home care aides could help avoid the kinds of problems and complications that would result in hospitalizations, the Team would have the flexibility to use the PACSSI Bundled Payment to pay for those alternative services.
- Payers would have greater predictability in their spending on patients, since most of the costs associated with higher rates of hospitalizations or higher rates of utilization of other services would come out of the PACSSI Bundled Payment they had already committed to make, rather than increasing the total amount the payer would have to spend.

Services Included in the PACSSI Bundled Payment

The PACSSI Bundled Payment would be intended to cover the costs of all the services delivered or ordered directly by the Palliative Care Team and also any services or aspects of services that could reasonably be affected by the care delivered by the Palliative Care Team. Services and aspects of services that could not be controlled by the Palliative Care Team would either be excluded from the bundle or the amount of the bundle would be adjusted based on aspects of services that the Palliative Care Team could not control, such as increases in the prices of medications for which there are no effective, lower-cost alternatives.

Setting the Amount of a PACSSI Bundled Payment

The amount of the bundled payment would be based on the average per-patient spending on included services for patients in each payment category during the year prior to initiation of the bundled payment, with an adjustment to reflect cost inflation since that year. Because the Palliative Care Teams would have already been using the services supported by the PACSSI payments to reduce these spending levels over what they would otherwise have been, the bundled payment would be designed to control future spending growth rather than to achieve additional savings. However, if the Palliative Care Team felt that additional savings were possible through the enhanced flexibility in the bundled payment, it could agree to accept a lower bundled payment amount.

Paying Providers for Services Under the PACSSI Bundled Payment

Many of the services covered by the bundled payment would not be delivered directly by the Palliative Care Team, so rather than trying to require other providers who deliver services to bill the Team rather than the patient's insurer, the bundled payment would be treated as a budget for spending rather than an actual payment to the Team. This budget would be implemented in the following way, in order to achieve the benefits of a true bundled payment without requiring Palliative Care Teams to serve as payers of claims:

- The Palliative Care Team would continue to be paid a monthly PACSSI payment for its services. The amount of this payment could be higher than the amounts paid under the standard PACSSI payment system if a Team wanted to deliver more services to patients directly.
- The patient's health plan would pay other providers if they delivered services covered by the bundle to the Palliative Care Team's patients. These payments would be based on current fee-for-service rates.
- The health plan would tabulate the total amount paid on all services to the Palliative Care Team's patients during the month and compare that total to the bundled payment amount. If the total payments were less than the bundled payment amount, the balance would be paid to the Palliative Care Team; if the total payments were larger than the bundled payment amount, the Palliative Care Team would be responsible for paying the balance to the health plan. In order to avoid the need for repayments, the health plan could "withhold" a portion of the Palliative Care Team's payments, and then if the payments for all services exceeded the bundled payment amount, the health plan would only repay a portion of the withhold to the Palliative Care Team.

Protecting Palliative Care Teams Against Excessive Risk Under PACSSI Bundled Payments

In order to protect the Palliative Care Team against excessive financial risk, the PACSSI Bundled Payment budget would be adjusted as follows:

- **Additional Payment for Outlier Patients.** If total spending on services for a particular patient exceeded a pre-defined threshold (the outlier limit), the patient's health plan would pay for the spending beyond the threshold and the Palliative Care Team would only be responsible for paying for the spending below the threshold from the PACSSI Bundled Payment. Lower outlier limits would be established for smaller Palliative Care Teams because of the higher impact that a single high-cost patient would have on their total revenues.
- **Risk Corridor.** If total spending on services to all patients covered by a particular health plan exceeded a pre-defined percentage above the total amount of PACSSI Bundled Payments that the Palliative Care Team received from the health plan, the patients' health plan would pay all or part of the spending above that percentage and the Palliative Care Team would only be responsible for the balance. Conversely, if the total spending fell below a pre-defined percentage of the total amount of PACSSI Bundled Payments, the patients' health plan would retain a portion of the savings.

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