November 20, 2017

Mrs. Amy Bassano
Acting Deputy Administrator for Innovation and Quality & Deputy Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Acting Deputy Administrator Bassano,

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to respond to the request for information seeking feedback on the Centers for Medicare & Medicaid Services (CMS) efforts to promote patient-centered care that will empower beneficiaries as consumers to drive quality, reduce costs, and improve outcomes.

The Coalition is composed of the nine-leading national hospice and palliative care organizations dedicated to advancing care of patients, families and caregivers living with serious illness, as well as those facing the end of life. The organizations that form the Coalition represent more than 5,000 physicians and 1,000 physician assistants, 11,000 nurses, 5,000 professional chaplains, more than 7,000 social workers, researchers, over 1,800 hospital palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of patients and families. Our combined membership represents the full interdisciplinary hospice and palliative care team which provides person and caregiver-centered care to those with the greatest need and medical complexity.

Coalition members treat patients living with serious, advanced and potentially life-limiting illness. These individuals and their families often face a complicated and fragmented health care system that increases their risk for unnecessary emergency room visits, hospitalizations, adverse drug reactions, and conflicting, uncoordinated care. While they comprise only about 5 percent of Medicare beneficiaries, these patients drive at least 50 percent of health care spending. We believe that the Center for Medicare and Medicaid Innovation (the Innovation Center or CMMI) could dramatically improve quality of care and quality of life for these patients and their families, and are encouraged by the Administration’s commitment to patient- and family-centered care.

We are witnessing a time of transformation in health care delivery, as we have seen numerous proposals, payment models, and demonstrations seeking to test community-based patient/family-centered health care. Many of the Innovation Center’s current payment models include essential...
elements of palliative care during serious illness, including care coordination and collaborative interdisciplinary care teams. Furthermore, most of Physician-Focused Payment Model Technical Advisory Committee (PTAC) advanced payment model proposals employ care coordination strategies and collaborative care teams to improve care delivery through patient and family-centered approaches. As CMS reforms the nation’s health care delivery and payment systems, we encourage the agency to address the recommendations in the National Academy of Sciences report “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life”.¹

1. Guiding Principles and Focus Areas

The Coalition supports all six guiding principles and seven focus areas articulated in the RFI. We encourage the Innovation Center to ensure choice and competition in the market by offering appropriate incentives and tools for beneficiaries and healthcare providers to develop informed care goals and make decisions aligned with these goals.

The Coalition appreciates CMS’ specific attention to the medically complex population as it reconsiders its strategy. The Coalition brings together national organizations that have profound expertise in caring for this population, and we strongly encourage the Innovation Center to seek input from the Coalition and its members in design and evaluation.

We believe that small scale testing offers a prudent opportunity to ensure that a small number of providers test significant architectural changes to the Medicare program. This offers the flexibility to ensure the use of improvement science to revise a model, improve its design, and measure the changes with minimal investment and disruption. For example, improvement science has been particularly helpful for hospices participating in the Medicare Care Choices Model (MCCM), as it has helped them learn from each other, adapt their approaches and bolster enrollment. Furthermore, a small controlled model brings forth real-time experience with the consequences -- intended and unintended -- of the proposed model and increases the transparency necessary to support expanding the model to more participants to validate initial small-scale findings before full scalability under 1115A(c) of the Affordable Care Act authority.

There are currently several notable Health Care Innovation Awards, models, and demonstrations that support the guiding principles articulated in the RFI. For example, CMMI used an open, transparent process in creating the Oncology Care Model, which has focused on a complex population, incorporated quality measures relevant to the patient’s quality of life, and encouraged multi-payer participation. MCCM participants appreciated modifications made by the Innovation Center to address early concerns with the model. The Innovation Center’s ability to address concerns through eligibility criteria changes and applying improvement science to facilitate enrollment activities highlight the value of the Innovation Center’s ongoing commitment to being responsive while maintaining the integrity of the model design.

2. Physician Focused Payment Model

Patients who have serious, potentially life-limiting illnesses or multiple chronic conditions coupled with functional and/or cognitive 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. Individuals who receive palliative care have higher quality of life and reduced unnecessary use of hospitals, diagnostic and treatment interventions, and non-beneficial intensive care. Several studies have shown that providing palliative care leads to reduced costs. Providing palliative care to patients with serious illness is exactly the type of high quality, high value care that new payment models should be incentivizing.

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. The Coalition encourages CMS to focus on incentivizing the provision of palliative care through physician specialty models because that will support several of the identified guiding principles. Palliative care is, by its nature, patient-centered care. Developing care plans and focusing on care coordination allows patients to “take ownership of their health” and gives them “the information to make choices as they seek care across the continuum” (Innovation Center Guiding Principle #3). Incorporating palliative care at the point of diagnosis for patients with a serious illness is a benefit design that “ensures cost effective care that also leads to improvements in beneficiary outcomes” (Innovation Center Guiding Principle #4).

The Coalition recommends CMMI explores new accountable payment mechanisms, based on patient need and disease severity, to provide palliative care services to patients in all stages of serious illness who are not yet eligible for or willing to enroll in hospice care. These services would improve the value of care delivery as well as quality of life for patients suffering with many different types of serious illness – such as cancer, chronic obstructive pulmonary disease (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 at home.

The Coalition strongly supports the American Academy of Hospice and Palliative Medicine (AAHPM) proposed payment model to support palliative care for this population, Patient and Caregiver Support for Serious Illness (PACSSI), which is currently under review by the Physician-Focused Technical Advisory Committee (PTAC). We further recommend that any

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model proposed to the Innovation Center for testing that involves care of people living with serious illness include provisions for palliative care provided by an interdisciplinary team in accordance with the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 3rd Edition. In addition, such models should include specific mechanisms to support access to quality palliative care, including payments that can sustain the full interdisciplinary palliative care team, which is comprised of not only physicians, but also nurses, social workers and chaplains who are not allowed to bill for their services under the current fee-for-service structure.

We note that while models like PACSSI will be valuable for the most intensive and complex patient population, they do not support short-term collaboration with the treating providers. These alternative models also do not explicitly incentivize treating providers to develop certain skills that are needed with the medically complex/seriously ill/high-need, high cost population, such as symptom management or “having a difficult conversation” skills. While a dedicated monthly payment to support home-based care for the medically complex/seriously ill/high-need, high-cost population is important, this payment model is not a fit for many other patients in need of palliative care – particularly those being actively managed by another specialty provider, such as oncology or cardiology. CMS should test providing a distinct payment to cover the palliative care team’s services, such as an additional episode payment made alongside the payment for the other specialist. This could be accomplished by enhancing the monthly case management fee to a level that supports a full interdisciplinary team, thus providing the flexibility to provide both medically necessary and cost-effective treatment.

Role of Hospice: As CMS reforms the health care delivery system, we reiterate the need to encourage the development of a robust continuum of care that reflects the diverse range of beneficiary needs. Along that continuum, it is imperative that we preserve the comprehensive, all-inclusive nature of the hospice benefit, and that patients receive timely referral and access to hospice. We support models with guiding principles that focus primarily on the needs and desires of the beneficiary and family and allow participation of multiple types of providers in a full range of care settings. As this continuum evolves, we must be careful not to overtly or unintentionally adversely impact successful care delivery models like hospice, but rather to integrate hospice and its care model in the larger continuum of care in a manner that preserves vital access for beneficiaries.

For any models addressing care of people living with serious illness that PTAC may recommend to the Innovation Center for implementation, we strongly encourage maintaining the guiding principles of the RFI and including measures of hospice utilization to drive effective care coordination, assure timely access to hospice care and improve quality of care. 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, 28% percent of hospice patients die within 7 days of electing hospice, with a median length of stay of only 23 days.

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We also urge CMS to incorporate patient experience, timeliness of care, and assessment of psychosocial needs together with response to symptoms. We applaud CMMI’s quality measures used in the Oncology Care Model and would suggest that these be adapted and utilized in most other models:

1) Percentage of OCM-FFS beneficiary face-to-face visits to the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified
2) Percentage of OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per OCM-FFS episode
3) Percentage of OCM-FFS beneficiaries with at least one palliative care consultation per OCM-FFS episode

One desirable outcome of a PTAC recommended model would be an increase in patients referred to hospice and an increase in their length of stay in hospice. We encourage the Innovation Center to require quality measures for accountability tied to payment that include the percentage of patients who died receiving hospice care and the percentage of patients who received a specified minimum number of days of hospice care.

Finally, we recognize that palliative care is provided by teams that are hosted in a wide variety of practice settings, including small and rural practices, large group practices, hospices, nursing facilities, community hospitals, academic medical centers and large national companies/vendors and integrated networks. When considering models that care for patients with serious illness, we recommend that the Innovation Center give preference to models that will allow a broad range of participating practices, including some that may not be positioned to accept downside risk for shared losses. There is growing attention to value-based care delivery for seriously ill patients and caregivers by large health care providers, health plans (including Medicare Advantage, or MA plans) and policymakers. This attention is also highlighting remaining gaps in our knowledge, such as how to identify the right patients (eligibility), how to ensure they are receiving the right care (quality measurement), and how to ensure we are controlling costs (spending measurement and benchmarking). An alternative payment model demonstration focused on the seriously ill can generate invaluable data to narrow these gaps, but only if it allows participation by many types of palliative care providers, caring for patients throughout the course of serious illness, in communities of all types.

3. Mental and Behavioral Health Model that supports Consumer-Directed Care

Mental and behavioral health are areas where the Innovation Center could significantly expand its work. We commend the Innovation Center’s September 2017 Summit on Behavioral Health Payment and Care Delivery Innovation, which could help guide CMMI in developing robust models in this area. Research, publication, and programs by the National Institutes of Health on Aging, the National Academy of Science, Engineering, and Medicine, the Institute of Medicine, Alzheimer’s Diagnostic Guideline Validation: Exploration of Next Steps: Workshop Summary. Washington, DC: The National Academies Press, 2012.
Medicine, the Substance Abuse and Mental Health Service Administration,\textsuperscript{15} the Administration on Community Living,\textsuperscript{16,17} and the Health Resources and Services Administration\textsuperscript{18} contribute to the advancement of new model concepts. These presenters offered a range of strategies and approaches that can guide the Innovation Center as it develops its mental and behavioral health delivery and research strategies. Specifically, these national leaders, as well as the Department of Veterans Affairs and the CMS state waiver authority, support some consumer-directed care and market-based innovation through waivers and limited grants.

One potential opportunity is to improve care for beneficiaries with dementia, who utilize 2-3 times as many Medicare dollars compared to age-matched controls.\textsuperscript{19} Approximately 17 percent of hospice patients have a primary diagnosis of Alzheimer’s and related dementias. These patients receive, on average, 105 days of hospice care. Because dementia can follow a somewhat less predictable course than other terminal illnesses, however, it can be challenging for families and clinicians to know when to seek hospice services. The National Alzheimer’s Project\textsuperscript{20} and the Institute of Medicine recommend a demonstration project that extends the hospice model of care beyond the current hospice eligibility requirements to include dementia patients with uncertain prognosis but high need. We believe that hospice’s holistic and comprehensive approach could significantly reduce hospitalizations and health care costs while improving quality of life for patients with dementia.\textsuperscript{21}

For beneficiaries with advanced Alzheimer’s disease and related dementias, access to palliative care services should be strengthened. While front line primary and specialist physicians would continue to manage care for this population, a palliative care team is well equipped to improve communication about goals of care, symptom management, care coordination across settings and over time, and family caregiver support. Policies that incent MA plans to assure network adequacy (that is, access to clinicians with training in the basics of palliative care) as well as access to specialty level consultation when appropriate; requirements for SNFs and CHHAs to demonstrate adequate access to certified palliative care\textsuperscript{22}, and network inclusion of hospitals with either Joint Commission advanced certification or work toward eligibility for such certification would markedly improve access to this evidence-based model of high value care\textsuperscript{23,24,25,26}.

\textsuperscript{21} Institute of Medicine. \textit{Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.} https://www.nap.edu/read/18748/chapter/1#iv, 2015.
Hospice and palliative care providers are well-positioned to participate in this area and address the unmet needs of the Alzheimer’s and related dementia population.

4. Consumer-Directed Care & Market-Based Innovation Models

The Coalition supports CMS’ desire to empower consumers by providing greater choice and transparency in health care options. We support consumers being given more information about the quality of care delivered by providers, and about the costs the consumer will be expected to pay so that they can anticipate and plan for costs. That said, it is our experience that choices from a consumer standpoint must be made on benefit design and quality, rather than solely on price. An emphasis on price alone does not provide consumers with sufficient information to weigh the costs and benefits of a plan’s offerings. Consumers currently lack tools and information on how well their health plans and providers are equipped to care for medically complex/seriously ill/high-cost, high-need patients. We encourage CMMI to focus transparency and consumer education efforts in this area to foster better patient choices. We know that choosing plans and providers that deliver quality care to the seriously ill, like palliative care, results in cost-savings to the healthcare system.

If CMMI does implement models that involve consumers making choices based on price, we caution against asking consumers to make such choices without providing equally transparent data on quality and proof of adherence to guidelines. We strongly encourage CMMI to focus efforts at first in increasing transparency on quality and proof of adherence to guidelines – including extensive consumer testing to ensure that such information is easily accessed, understood and used. Only when these steps are accomplished should CMMI consider asking consumers to make choices based on price.

To expand Consumer-Directed Care, CMS must collaborate with both health plans and providers to make necessary patient-centered changes. For Medicare Advantage plans, public reporting should include an indicator of how well-prepared plans and their networks are to assist medically complex/high-need, high-cost patients and their family caregivers with serious illness. Such data-driven indicators should be prioritized over other aspects of care that plans currently report.

For instance, a composite indicator, comprised of the following, can empower consumers to assess a plan’s capacity to provide palliative care when serious illness strikes:

1) What palliative care response is available 24/7, and how many of their programs are certified as meeting standards?
2) How many network hospitals have The Joint Commission advanced certification in palliative care?
3) Does the plan have a palliative care training program for their case managers? For their network providers?

For hospitals, public reporting must include whether the hospital has a palliative care team and/or the ability to connect with and refer to community-based palliative care programs.

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Additionally, CMS must emphasize the patient experience/HCAHPS score in the Value-Based Purchasing program; this will both empower consumers to make more informed decisions and increase cost-effectiveness by improving patient experience.27

The Coalition strongly encourages new models to integrate social and spiritual supports as part of the care continuum, and ensure that psychosocial and spiritual needs are provided at all stages of care. The hospice and palliative care community has over 35 years of experience providing interdisciplinary care that addresses all the patient’s needs – medical, mental, emotional, family, and spiritual. These requirements support community-based, person-centered care that promotes choice and competition in the market.

This would address the gap of supportive services when a beneficiary is not in a community-based care model (i.e. home health or hospice). Although there are models that focus on the clinical coordination of care, we encourage the Innovation Center to test the behavioral health needs of the beneficiary and family to reduce the burden on the health care system when a beneficiary or family is under stress. It is imperative to harness the expertise of hospice and palliative care providers that are well equipped to assess the mental and behavioral health needs of both beneficiaries and their family caregivers to ensure high quality person-centered care.

**5. Medicare Advantage (MA) Innovation Model – Expansion or Small-Scale Testing Opportunity**

Given that as much as 5 percent of the MA population is medically complex/seriously ill/high-need, high cost, MA must have increased flexibility in benefit design for this population. The current MA Value Based Insurance Design (VBID) model is too restrictive, both in geography and in defining eligible beneficiaries by a single diagnosis. The seriously ill population cannot be defined by diagnosis alone; this population faces a combination of a life-limiting illness(es), functional impairment, and overwhelmed family caregivers. Algorithms exist to proactively identify this population, but because of the varied and co-existing diagnoses, the MA plans are limited in benefit re-design.

CMS should consider a VBID model that specifically targets the medically complex/multimorbid/seriously ill/high-need, high-cost population by incorporating factors such as functional limitations and need for supports into its eligibility criteria. This would address the limitations of the current VBID model for this population, and give the plans flexibility to alter their approaches to be more patient-centered in meeting their enrollees’ needs. It may also allow plans to expand existing programs from their commercial business lines, helping them leverage best practices and lessons learned from the private market. A recent summary of successful health plan approaches in caring for this population can be found in the recent publication from the Center to Advance Palliative Care, Serious Illness Strategies.

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Additionally, many seriously ill Medicare beneficiaries require personal care and safety supports to remain safely in their homes and avoid falls, exacerbations of illness, etc. Yet MA plans are limited in their coverage because of requirements that restrict required services to “skilled needs.” There is a strong need for flexibility in coverage of and payment for non-skilled personal supports. Allowing MA plans new opportunities for benefit design around these services will not only improve consumer care and outcomes, but will increase choice and competition in the market.

Lastly, we agree that MA plans should compete for beneficiaries based on quality and cost. Tools and information must be made available to beneficiaries, including how prepared the MA plan and its network are to provide palliative care in the context of serious medical illness and assist medically complex/seriously ill/multimorbid/high-need, high-cost patients and their family caregivers. A composite data-driven indicator, comprised of the following, can empower consumers to assess a plan’s capacity to provide palliative care when serious illness strikes:

1) What palliative care response is available 24/7, and how many of their programs are certified as meeting standards?
2) How many network hospitals have the Joint Commission advanced certification in palliative care?
3) Does the plan have a palliative care training program for their case managers? For their network providers?

As you may know, hospice has never been covered under MA. MA enrollees who elect hospice revert to fee-for-service when they elect hospice care, allowing them to access the hospice of their choice without any network limitations, additional costs, or pre-approval from the MA plan. Beneficiaries can continue MA covered benefits (e.g., vision or dental care) through their MA plan and receive care unrelated to their terminal illness under fee-for-service. This allows beneficiaries a wide choice of hospice providers, streamlines administration for hospices, and ensures that the beneficiary enrolled in hospice receives the full range of hospice services.

The current arrangement reflects many of the priorities articulated in the RFI. By carving hospice out of the Medicare Advantage program, patients are assured a wide selection of providers that are incentivized to earn their business. Patients are also able to receive truly patient-centered care, and are protected from the administrative and bureaucratic burdens imposed by managed care plans.

As participation in the Medicare Advantage program has grown and data suggests approximately 25 percent of hospice patients were previously enrolled in MA, stakeholders such as the Medicare Payment Advisory Committee, the Senate Finance Committee, and others have considered policy changes that would require hospice programs to contract with managed care plans. Although NHPCO, and other Coalition Members, have expressed serious concerns about such a broad policy change previously, the Coalition is interested in further research and analysis to support whether the change aligns with the principles articulated in the RFI for small scale testing. We believe small scale testing supports transparent model design, price transparency, and evaluation, while maintaining consumer choice and enhancing consumer protections.
To better understand the impact of such a broad policy change, the Coalition recommends that CMS start by conducting baseline data analysis, like analysis conducted for hospice payment reform for hospice beneficiaries previously enrolled in MA. The hospice payment reform reports have limited information on MA beneficiaries. MedPAC’s analysis in the Report to Congress: Medicare Payment Policy (March 2014) offers a comparison of hospice utilization between beneficiaries in FFS Medicare and MA in Table 13-9 based on 2010 – 2012 analytic files. This analysis is not substantive enough to fully adopt MedPAC’s recommendation without testing because it cannot determine whether payment policy changes to the Medicare Hospice Benefit after 2012 have influenced MA decedent population outcomes including hospice length of stay and live discharge rates. We encourage CMS to develop an analytic plan that goes beyond the indicators MedPAC analyzed to clarify referral relationships between MA plans and hospices, patient access and satisfaction, ensure meaningful quality measures, specify required conditions for the model, and that these measures and conditions align closely with MA plan star rating status.

As strong proponents of patient-centered care, we support the assumption that the hospice carve-in could support the goals of MA plans to use its “flexibility to develop and test innovative models”, which may “promote integrated, coordinated care, consistent with the goals of the MA program.” We also share MedPAC’s concerns, as an MA carve-in is considered, about ensuring coverage of the full scope of the hospice benefit as defined in the Social Security Act. We further emphasize the need to ensure there are beneficiary protections and program integrity measures to address potential compliance issues. We are also interested in the recommendation to utilize the MA risk model to determine the levels of capitated payments. However, it is imperative the hospice community can review and comment on the risk model and participate in a collaborative discussion regarding the modeling prior to small scale testing of the carve-in.

The analysis would also improve transparency in the indicators that CMS has articulated as areas of interest. For example, information on timing of hospice referral, live discharge rates from hospice, hospice lengths of stay, levels of care utilization, demographic information, and patient/family satisfaction are needed to understand transition and care patterns and to ensure reliable quality of this person-centered care model. Once analysis and stakeholder input are received, we may support a limited testing model for MA plans to include hospice. Such a model should clearly articulate hospice patient and family protections to ensure the full range of hospice services, including pain and symptom management, emotional and spiritual counseling, in-home services and supports, and that services included in the care plan are reliably carried out.

6. Beneficiary engagement in model development and participation

We appreciate the Innovation Center’s recognition of the lack of beneficiary engagement in the development of models that could improve participation in new models. The Coalition supports the need for beneficiary engagement in the development of models through coordinated focus, town hall meetings, or public engagement activities and welcomes the opportunity to participate in stakeholder engagement activities. These investments may delay model implementation, but are extremely valuable and necessary to ensure beneficiary perspectives are thoughtfully considered.
Furthermore, we believe there are resources throughout the federal government that supplement the beneficiary and community perspectives. For example, the Administration for Community Living, Health Resources and Service Administration, and the Department of Veterans Affairs all support community-based approaches to health care delivered through small scale testing or grant funding. We are also pleased to see that the National Academy of Science, Engineering, and Medicine through the Roundtable for Quality Care for People with Serious Illness is conducting work in the community to better understand the needs of caregivers for the seriously ill as well as publish meaningful reports and hold public meetings. The efforts of the PEW Charitable Trust on Improving End-of-Life Care, Moore Foundation’s focus on Community-based approaches for the seriously ill, and the Hartford Foundation’s support of Serious Illness & End-of-Life are all seeking to support improvements of health care for the most vulnerable population. The work of these organizations helps to convene expertise, further research, and inform the public of the complex needs in caring for the seriously ill population. However, it is the Innovation Center that has the authority and mechanism to drive payment models – and therefore changes in delivery models and organizational and clinician behavior - in a new direction. A new model would make a tremendous positive impact for the seriously ill and their families.

7. Waiver Authority Considerations

We support expanding the waivers afforded under the NexGen ACO model to new models for telemedicine, post discharge home visit, and skilled nursing facility 3-day stay. We stress the need for hospices to participate in new models so long as they continue to “primarily engage” in providing hospice care in accordance with 1861(dd)(2)(A)(i) of the Social Security Act. A specific waiver is not required, but specifically allowing hospices to participate in new models is paramount to testing whether the hospice model of care could affect consumer-directed, patient-centered care, and stimulate choice and competition as part of healthcare system delivery and payment reform.

Given that the medically complex/serious illness/multimorbid/high-need, high cost population is highly diverse in medical and social support needs, and accounts for an outsized portion of health care spending, Advanced APMs must have increased flexibility in benefit design for these patients. Many seriously ill Medicare beneficiaries require personal care and safety supports to remain safely in their homes and avoid falls, exacerbations of illness, etc. Yet, most models are limited in their coverage because of requirements that restrict services to “skilled needs.” There is a strong need for flexibility in coverage of non-skilled personal supports.

Conclusion

In closing, we are poised to support the development of payment models by participating in stakeholder meetings and offering input to refine our delivery system to accommodate the unmet needs of seriously ill patients and their families. We believe that such an approach ensures a comprehensive continuum of services, including the critically important hospice benefit. The Coalition and our members are eager to work with you on the future direction of CMMI projects, and other efforts improve the care and quality of life of individuals with serious illness. We would be pleased to bring experts and leaders from the hospice and palliative care field, along with health plans that are innovating successfully in the care of this population, to CMMI to discuss these ideas with you and your staff.

Please let us know how we can best assist CMS/CMMI in this remarkable effort to promote patient centered care and test market reforms that will lead to improved quality, choice and outcomes and reduce cost and provider burden. Amy Melnick, Executive Director of the Coalition can be reached at amym@nationalcoalitionhpc.org or 202.306.3590 or Zinnia Harrison at zharrison@nhpco.org. We can provide more information about our Coalition and help CMS connect to our Member Organizations. Thank you for your consideration of our comments.

Sincerely

National Coalition for Hospice and Palliative Care member organizations are:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- Association for Professional Chaplains (APC)
- Center to Advance Palliative Care (CAPC)
- Health Care Chaplaincy Network (HCCN)
- Hospice and Palliative Nurses Association (HPNA)
- National Hospice and Palliative Care Organization (NHPCO)
- National Palliative Care Research Center (NPCRC)
- Physician Assistants in Hospice and Palliative Medicine (PAHPM)
- Social Work Hospice and Palliative Care Network (SWHPN)