August 14, 2107

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

Dear Advisory Committee Members:

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit this letter of support for the American Academy of Hospice and Palliative Medicine (AAHPM) Patient and Caregiver Support for Serious Illness (PACSSI) payment model. New 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. The PACSSI model would provide tiered monthly PACSSI care management payments to support interdisciplinary palliative care teams (PCTs) as they deliver community-based palliative care to patients who meet eligibility criteria that include a diagnosis of a serious illness or multiple chronic conditions, functional limitations, and health care utilization. PACSSI care management payments would replace and supplement payment for evaluation and management (E/M) services.

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 5,000 social workers, researchers, 1,600 palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of patients and families. Our combined membership represents the interdisciplinary hospice and palliative care team which is person and caregiver-centered.

Serious Illness and the Role of Palliative Care

One of the key priorities of our interdisciplinary Coalition is to improve patient access to palliative care for people with serious illness. Palliative care focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis)[1] and can be provided along with curative treatment in multiple settings. The goal is to improve quality of life for both the patient and their caregivers.

Multiple studies show that with palliative care, patients with serious illness and their families can *avoid* receiving poor-quality health care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other

[1] Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. J Clinical Oncol 2012; 30: 880-887.

caregivers.[2,3] By focusing on priorities that matter most to patients and their caregivers, palliative care has been shown to improve both quality of care and quality of life. [4,5] In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.[6] Last year, the American Heart Association / American Stroke Association stated that palliative care can be a helpful complement to current care practices and can improve quality of life for cardiovascular disease and stroke patients, caregivers, and providers.[7] Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.[8] AAHPM's submission to the Advisory Committee includes numerous other examples and cited studies related to the effectiveness of palliative care within the serious illness population.

Yet despite the demonstrated benefits of palliative care, millions of Americans do not have access to these services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.[9] These patients with serious illness and their caregivers are not well served in the current fee-for-service payment system, which does not adequately reimburse interdisciplinary palliative care services.

Potential Solutions

The Coalition supports AAHPM's PACSSI payment model as it begins to close key reimbursement gaps to help Medicare beneficiaries with serious illness get the right care, in the right place, at the right time. Under the PACSSI model, palliative care programs can use the resources deemed necessary to provide the most appropriate care to the patients by the right personnel, such as nurses, case managers, social workers, and/or chaplains.

- **Interdisciplinary Palliative Care Team (PCT):**

  The capability to perform assessments and deliver services through an interdisciplinary team structured in accordance with the essential elements of the National Consensus Project, Clinical Practice Guidelines for Quality Palliative Care (http://www.nationalcoalitionhpc.org/guidelines-2013/); PCTs can include currently non-billing clinicians (e.g. nurses, social work or spiritual care professionals) who otherwise are not reimbursed under the Medicare program, as they work in conjunction with patients' other care providers and provide psychosocial and spiritual support. Participating PCTs would be required to demonstrate:

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[2] Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. JAMA. 2004 Jan 7; 291(1):88-93.

[3] Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. The Milbank Quarterly. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

[4] Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) Cancer 437-45 (2009).

[5] Casarett D, et al., Do palliative consultations improve patient outcomes? 56 J Am Geriatric Soc'y 593, 597-98 (2008).

[6] Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733-742.

[7] Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association http://circ.ahajournals.org/content/early/2016/08/08/CIR.0000000000000438 Aug 16.

[8] Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. www.innovations.ahrq.gov/content.aspx?id=3370.

[9] IOM (Institute of Medicine). 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

- **24/7 Availability:**

  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 is essential. 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.

The flexible, two-track structure of the PACSSI model will allow participation by palliative care teams of many sizes and types that serve Medicare beneficiaries in many different markets and geographies, including rural settings. This will allow a PACSSI demonstration to gather important data and experience from diverse settings, and—more importantly—provide valuable services to the largest number of patients and caregivers possible.

AAHPM's submission includes information indicating that this model will generate significant net savings for the Medicare program, in excess of any costs incurred for the PACSSI care management fees, based on several studies to date that have demonstrated reductions in cost paired with improvements in quality.

Stakeholder Engagement

This model addresses a significant need in the serious illness community and reflects the interest and input of a broad range of stakeholders including the nine national organizations within our Coalition as well as many other organizations. Several of these stakeholders represent sites that would be ready to pilot this model as early as 2018. Additionally, this model is transferrable to other payers, including private payers and publicly funded programs like Medicaid and TRICARE/Veterans Administration, for patients who meet the eligibility criteria.

Importance of Quality Metrics

The quality metrics in the PACSSI proposal reflect an emerging framework for quality performance in palliative care. The combination of patient-reported outcomes, process, and utilization measures map closely to the priorities of the field, and the phased-in approach to pay-for performance will allow critical time and resources for palliative care teams to strengthen necessary clinical and reporting infrastructure. Importantly, the PACSSI model encourages the appropriate use of hospice care with a focus to increase those in hospice care greater than 7 days.

Our Coalition, representing the interdisciplinary hospice and palliative care field, will encourage and help educate our membership about the benefits of participation in PACSSI, should it be recommended for testing by PTAC and approved and implemented by CMS. Thank you for the opportunity to submit a letter of support from our Coalition to the Physician Focused Payment Model Technical Advisory Committee. I would be happy to speak with you about our support for AAHPM's PACSSI proposal or connect you with the leadership of our Coalition. Please contact me at amym@nationalcoalitionhpc.org or 202.306.3590 if you have any questions about our support of this proposal.

Sincerely,

Amy Melnick, MPA
Executive Director
National Coalition for Hospice and Palliative Care
www.nationalcoalitionhpc.org

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)