



## COALITION MEMBERS

February 13, 2023

American Academy of Hospice  
and Palliative Medicine  
(AAHPM)

Association of  
Professional Chaplains  
(APC)

The Catholic Health Association  
of the United States  
(CHA)

Center to Advance  
Palliative Care  
(CAPC)

HealthCare  
Chaplaincy Network™  
(HCCN)

Hospice and Palliative  
Nurses Association  
(HPNA)

National Association for Home  
Care & Hospice  
(NAHC)

National Hospice and  
Palliative Care Organization  
(NHPCO)

National Palliative  
Care Research Center  
(NPCRC)

Palliative Care Quality  
Collaborative  
(PCQC)

Ms. Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-4201-P  
PO Box 8013  
Baltimore, MD 21244-8013

**CMS – 4201-P Via electronic submission at [regulations.gov](https://www.regulations.gov)**

**Re: Medicare Program Contract Year 2024, Proposed Rule**

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the proposed rule revising Medicare Advantage (MA), Medicare Part D, the Medicare cost plan, and the Programs of All-Inclusive Care for the Elderly (PACE) regulations for contract year 2024.

The National Coalition for Hospice and Palliative is dedicated to improving the care of people with serious or life-limiting illnesses by convening the field, advocating for equitable policies and improved health outcomes, establishing best practices, and sharing resources. We have worked with our [member organizations](#) to develop these comments that focus on the changes and request for comments outlined in the proposed rule focused on the Programs of All-Inclusive Care for the Elderly (PACE) as well as those that aim to advance equity in MA organizations.

It has been estimated that the majority of individuals eligible for nursing home-level care (and thus PACE) are [in need of palliative care](#). Our Coalition was pleased to see the National PACE Association acknowledge this need in their recent publication about [integrating palliative care into PACE](#) operations, co-created with one of our Coalition members. It is from this perspective that we submit our comments.

**General Recommendation: Eliminate the phrase “palliative care, comfort care or end of life care services”.**

The Coalition strongly recommends CMS eliminate this phraseology entirely. Combining these words in a single phrase may only serve to associate palliative care with the end of life, which is not accurate. Palliative care is appropriate at any stage of illness, and access should be based on need, not prognosis.

**In fact, palliative care has already been [defined](#) by CMS, as follows: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice."** (CMS, [42 CFR 418.3](#)) We believe that it is important for CMS to define the term “palliative care” to be used by PACE organizations in a uniform manner nationwide, and for the definition to be consistent with the existing CMS definition in use in both the hospice and skilled nursing regulations and elsewhere. Nothing inherent in the definition of palliative care implies withholding of care or treatment.

Moreover, the term “comfort care” has no true medical or regulatory definition, and we strongly recommend that CMS – and PACE organizations – not use this term to indicate any specific service. Finally, “end of life care” may be referring to the combination of services that is typically delivered while enrolled in “hospice,” and we are assuming that the PACE organizations’ intent is to delineate a change in care plan that mimics the hospice benefit. Please see our comments below in Participant Rights on the end-of-life aspect of PACE care delivery.

**Contracted Services (§ 460.70) 195-197 – Access to Medical Specialists:** The Coalition appreciates the oversight that CMS has provided which has noted the failure by a majority of the PACE organizations (POs) audited in 2021 to provide necessary access to medical specialists. CMS is seeking comments regarding adding specific specialties. CMS seeks comment on whether palliative medicine should be included. The Coalition strongly supports and appreciates CMS’s recognition that the PACE population may require timely access to palliative medicine and strongly recommends its inclusion as a minimum required service.

As noted, the majority of nursing home-eligible people in the U.S. have unmet palliative care needs, and since PACE exists to address these needs comprehensively, the exclusion of expert symptom management and treatment decision-making support runs counter to the goals of PACE. According to the [National PACE Association](#), three of the top five chronic conditions in PACE are [diabetes](#) with complications; polyneuropathy; and [congestive heart failure](#) – all conditions that carry a heavy symptom burden and for which palliative medicine has been shown to improve quality of life.

**Recommendation:** As providers responsible for comprehensive services that optimize quality of life, we believe it is imperative for palliative medicine be added as a minimum required contracted service for PACE.

**Plan of Care (§ 460.106)** The Coalition supports changes to clarify and codify the minimum requirements for a participant’s plan of care to “emphasize the ongoing responsibilities of the

IDT to monitor and revise the plan of care to determine effectiveness; and define the involvement of the participant and/or their caregiver in the plan before it is finalized”. We appreciate CMS’ proposals to implement additional requirements that must be included in a participant’s plan of care, including requiring information on pain management needs. However, there are additional aspects of participant assessment and care planning that, when unaddressed, lead to unnecessary suffering, hospitalization, and institutionalization and we recommend that the care plan content requirements be expanded to include the domains of palliative care *that do not already* overlap with the existing PACE plan of care rules.

**Recommendation:** The Coalition recommends that CMS incorporate factors identified through a comprehensive palliative care assessment into PACE participant care plans, including non-pain symptoms, caregiver burden, participant's cognitive status and decision-making capacity, financial vulnerability, spiritual concerns, and more. Additional detail about comprehensive palliative care assessments can be found in the National Consensus Project Clinical Practice [Guidelines](#) for Quality Palliative Care.

### **Participant Rights (§ 460.112)**

The Coalition commends CMS for strengthening and revising the Participant Rights section. PACE is, and should remain, highly patient and family centered, and participants’ rights are critical to this program. We commend CMS for including in the proposed rule that patients and families choosing PACE need to understand their rights, especially, as CMS notes, as they pertain to the *“provision of palliative care, comfort care, and end-of-life (EOL) services ...along with the right to receive this information, in writing, before the PO implements palliative care, comfort care, or EOL services.”* However, as previously noted, the Coalition strongly disagrees with this phraseology and believes that associating these terms only exacerbates patient and family confusion.

CMS also states that it does not seek to define the terms and that it believes it is important for PACE organizations to define the terms within their respective programs. The Coalition strongly disagrees with this position, and instead recommends that CMS apply a uniform definition of palliative care across PACE using CMS’ existing definition found at 42 CFR 418.3. Further, we recommend that the regulations clarify that no PACE organization should use the term “palliative care” to equate to the termination of curative treatment or other services.

**Recommendation:** The Coalition strongly supports CMS’s efforts to ensure informed decision-making by PACE participants and their families. To achieve this, we recommend:

- CMS should require PACE organizations use the definition of palliative care (42 CFR 418.3.) that is consistent with the existing definition of palliative care in Medicare regulations, and clarify that the provision of palliative care cannot necessitate the termination of other services.
- CMS should require PACE organizations to provide participants near the end of life who elect to forgo disease-directed care with written notification that specifies which PACE services are

impacted, explains consent for care transitions, and reminds the participant of the ability to withdraw consent for termination of curative treatments.

- CMS should require PACE organizations to remind participants and their families about their ability to disenroll from PACE and receive care through the Medicare hospice benefit if they so choose.

## Health Equity

The Coalition strongly supports CMS' overall goal of addressing health disparities as a foundational element across the agency and CMS' approach of embedding the principles of health equity in the design, implementation, and operationalizing of policies and programs to support health for all people served by the Medicare program. As such, the Coalition supports CMS' proposals to advance health equity in the MA program through its proposals to more clearly articulate the populations that may require accommodations specific to their needs; to require inclusion of providers' cultural and linguistic capabilities in MA provider directories; to require the development, maintenance, and implementation of procedures to identify and offer digital health education to enrollees with low digital health literacy; and to require activities that reduce health disparities to be included in MA organizations' quality improvement programs. We believe these activities will support more equitable access to and delivery of care for MA beneficiaries.

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Thank you for the opportunity to submit these comments. Please do not hesitate to contact me (Amy Melnick, Executive Director, 202.306.3590, [amym@nationalcoalitionhpc.org](mailto:amym@nationalcoalitionhpc.org)) if you have any questions or would like to discuss these issues with our Coalition's many experts. Our Coalition would welcome the opportunity to meet with CMS staff and share further ideas that can ensure consistency in the care of beneficiaries with serious illness across Medicare programs – not only PACE, but also skilled nursing, acute care, and other settings. Palliative care remains a new field, and careful use of language, integration of key assessments, inclusion of person-centered quality measures, and other approaches can help to ensure both quality and cost-effectiveness throughout Medicare's programs. If such a dialogue is feasible, please contact me to begin the arrangements. Thank you,

Sincerely,



Amy Melnick, MPA  
Executive Director  
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