August 21, 2014

Dr. Patrick Conway
Acting Director
Centers for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Care Choices Model

Dr. Conway:

We are writing collectively as members of the Patient Quality of Life Coalition. The PQLC was created to advance the interests of patients and families facing serious illness. The Coalition includes more than 20 nongovernmental organizations representing the interests of health professionals, health care systems, and patients.

The Coalition applauds CMS for developing the Medicare Care Choices Model (MCCM), which will allow hospice-eligible beneficiaries not enrolled in hospice to continue concurrent curative care services. We appreciate Gigi Kuberski, Cindy Massuda and Lynn Miescier of your staff taking the time to meet with our Coalition recently to discuss this new demonstration program. We understand this program will be implemented as previously communicated. However, our organizations want to ensure that as CMMI begins to consider the evaluation process, including the research questions that will be asked and analyzed, that certain issues be considered and that CMMI work with our Coalition Members who represent both providers and patients of hospice and palliative care.

As you work to implement and evaluate the MCCM program, we offer the following thoughts and comments of the model based on the information provided by CMS. We welcome the opportunity to meet with you to share our collective thoughts and ideas.

Palliative Care Services

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families. Palliative care focuses on the relief of pain, symptoms, and stress associated with serious illness and can be provided together with curative treatment. Not only do patients with chronic illness who receive palliative care consultations have better quality of life, but research indicates that by closely matching treatments with a patient’s goals, palliative care can provide substantial cost reductions.1 However, these quality and cost improvements are contingent on a well-designed intervention.

1 For example, a 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant reductions in laboratory and ICU costs. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenborgen M, Litke A, Spragens L, Meier DE. Cost savings associated with hospital palliative care consultation programs. Arch Intern Med 168(16)1783-1790 (2008). Similarly, a 2011 study found that Medicaid patients at four New York hospitals who received integrated palliative care consultations incurred $6,990 less in hospital costs during a given admission, spent less time in intensive care, and were less likely to die in the ICU. Morrison RS, Dietrich J, Ladwig S, Quill T,
We encourage CMS and CMMI to work with organizations who are experts in palliative care and hospice during the evaluation of this model to ensure that the inferences drawn from the evaluation are as accurate as possible.

**Patient Qualifications**

In order to participate in the MCCM, a beneficiary must have received a diagnosis of one of the following chronic illnesses: terminal cancer, chronic obstructive pulmonary disease, congestive heart failure, or HIV/AIDS. A beneficiary must have no previous hospice experience; receive a prognosis of six months or less to live; and, must have experienced at least two hospitalizations and three office visits with a referring healthcare provider related to their qualifying diagnosis within the previous twelve months. We are concerned the proposed list of qualifications is too restrictive and would unnecessarily deny participation in the MCCM program to beneficiaries who could benefit from it. For example, not all individuals with a terminal cancer diagnosis necessarily would have a minimum of two inpatient hospitalizations within the preceding twelve month period. In addition, the Request for Applications (RFA) is unclear as to whether CMS defines the term “hospitalizations” to include outpatient as well as inpatient services. As CMMI and CMS evaluates this program and considers adoption or expansion, we request consideration be given to amending the eligibility criteria to include beneficiaries who within the previous twelve months meet two criteria: (1) have experienced three office visits and (2) have two inpatient hospitalizations (hospital observation admissions or emergency room visits).

**Quality Measures**

The RFA notes the MCCM will adopt quality measures that include those selected for the Hospice Quality Reporting Program “as well as additional measures focused on pain management, care coordination/case management, care transitions, communication, patient-centered goals, patient/family satisfaction and measures selected for the HQRP.” Unfortunately the RFA does not articulate which specific measures CMMI will include or whether these measures will have been endorsed by a broad stakeholder consensus panel such as the National Quality Forum. We urge CMS to work with a broad coalition of stakeholders, including the Patient Quality of Life Coalition, when choosing the appropriate quality measures.

**Payment for Services**

Hospices participating in the MCCM will be paid a $400 per beneficiary per month (PBPM) fee that is meant to cover the cost of care coordination and case management services provided by the hospice. The RFA states that hospices providing services for less than 15 days in a calendar month will be paid a $200 PBPM fee. The PBPM fee has no beneficiary co-payment or deductible. Under the MCCM, services that Medicare covers under Parts A, B, and D must be billed separately and are not part of the PBPM payment, though the MCCM-participating hospice bears responsibility for managing these items and services. According to the RFA, MCCM hospices “are expected to engage in shared decision making; care coordination and case management of the patient, family, and his/her providers; ensure that the patient’s pain and symptoms are managed; offer appropriate levels of counseling; and address other care needs based on a comprehensive assessment and plan of care that follow the hospice [conditions of participation].”

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2 The Request for Applications (RFA) is available at [http://innovation.cms.gov/Files/x/MCCM-RFA.pdf](http://innovation.cms.gov/Files/x/MCCM-RFA.pdf)
We appreciate CMS’ acknowledgement that additional payment is needed to help offset the cost of providing these care coordination services to beneficiaries enrolled in the MCCM. However, we are concerned the $400 PBPM fee (prorated to $200 for partial month enrollees) may prove insufficient to cover the true cost of these services.

Evaluation / Research Process

We understand that CMMI’s model has an intentionally narrowly drawn patient population in order to better determine whether the program is successful before expanding to all hospice-eligible beneficiaries. We welcome the opportunity to discuss with CMMI specific criteria that will be used to determine what additional chronic conditions, if any, the agency intends to consider in future demonstration programs.

Additionally, the Coalition would like the opportunity to discuss CMMI’s detailed plans for program evaluation in order to better understand CMMI’s evaluation plan. For example, in the RFA CMMI states that “Our objective in testing this Model is to address research questions focused on whether the model would: 1. Increase access to supportive care services provided by hospice; 2. Improve quality of life and patient/family satisfaction; and 3. Inform new payment systems for the Medicare and Medicaid programs.” These are worthy research foci, but we encourage you to narrowly tailor your research questions, and inferences made from the results, to the model that is being studied. We also encourage you to consult with leaders in the field of palliative care and hospice research as you work to evaluate this model.

Stakeholder Involvement

While we recognize the great effort CMS has undertaken to launch this new model, we are concerned with the apparent lack of stakeholder involvement in the creation and development of the model. We urge CMS to work with all stakeholders focused on hospice and palliative care as the agency implements and evaluates this new model of care. The undersigned organizations would welcome the opportunity to share our thoughts and ideas on how the MCCM program can be improved if CMS chooses to expand or revise this demonstration project.

We look forward to working with CMMI as you develop this important initiative. We will reach out to you and your staff to schedule a meeting to further discuss our ideas and concerns. In the meantime, if you have any questions, please contact Keysha Brooks-Coley with the Patient Quality of Life Coalition at 202-661-5720 or Keysha.brooks-coley@cancer.org.
Sincerely,

American Academy of Hospice and Palliative Medicine
American Academy of Pain Management
American Association of Colleges of Nursing
American Cancer Society Cancer Action Network
American Heart Association / American Stroke Association
Association of Professional Chaplains
C-Change
Catholic Health Association of the United States
Cancer Support Community
Center to Advance Palliative Care
CHE Trinity Health
Colon Cancer Alliance
Lung Cancer Alliance
National Palliative Care Research Center
National Comprehensive Cancer Network
Oncology Nursing Society
Partnership for Palliative Care
Social Work Hospice and Palliative Care Network
Supportive Care Coalition

cc: Gigi Kuberski, CMMI
    Cindy Massuda, CMMI
    Lynn Miescier, CMMI