February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1461-P – Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations; Proposed Rule
79 Fed. Reg. 72760 (December 8, 2014)

Dear Administrator Tavenner:

We are writing collectively as members of the Patient Quality of Life Coalition, which was created to advance the interests of patients and families facing serious illness. The Coalition includes more than 25 nongovernmental organizations representing the interests of health professionals, health care systems, and patients. The Coalition appreciates the opportunity to provide comments on the proposed changes to the Medicare Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program.

Ensuring individuals with serious illness – including Medicare beneficiaries – have access to palliative care services is a primary goal of the coalition. Palliative care professionals work with patients and their family caregivers to ensure proper communication and coordination, provide expert management of pain, nausea, fatigue, and other symptoms of their disease or condition, as well as support for family and other caregivers. Palliative care is appropriate at any age and at any stage of a serious illness, and can be provided along with curative treatment.

B. ACO Eligibility Requirements

8. Required Process to Coordinate Care

CMS proposes to add a new requirement to the ACO eligibility rules to require an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination. CMS also proposes to require applicants to describe how they intend to partner with long-term care and post-acute care providers to improve care for beneficiaries.

The Coalition supports increasing care coordination for Medicare beneficiaries. We encourage CMS to consider including provisions in the ACO eligibility rules that require an ACO to describe in its application how it will provide beneficiaries with serious illness access to palliative care services throughout the care continuum.

Palliative care teams work with patients to mitigate the burden of their disease and/or treatment regimens. Specifically, palliative care teams – which include both physicians and non-physician practitioners including social workers – provide an important set of services that can help ACOs more effectively manage the care of seriously ill patients including: education about pain management, facilitation of support systems for the patient and the family on-call physician, advance practice nurse symptom management consultations for home-bound patients, review of treatment protocols that are taking place (including reviewing medications, oxygen regimen, skin care, titration process, and other

services), education of family members on stages of palliative care and the physical decline of the patient; and, if necessary, face-to-face evaluations for continued hospice eligibility.

Research has demonstrated that the use of palliative care services improves the quality of care for individuals. For example, a 2010 study comparing individuals with metastatic non-small-cell lung cancer who received palliative care services early after diagnosis had a better quality of life. Fewer patients who received palliative care services developed depressive symptoms (16 percent compared to 38 percent for those who received no palliative care services) and the median survival rate was longer for those who received palliative care services.[1]

The use of palliative care also has been shown to reduce health care costs. Individuals' whose care is managed by palliative care professionals have reduced hospitalizations or re-hospitalizations. For example, 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.[2] Similarly, 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.[3]

Increasingly, palliative care models have been implemented in many different ways throughout the health care system. One national program uses care managers to provide a comprehensive assessment of the patient's needs by telephone and consult with the patient, physician, and the patient's family. These care managers provide education and support, give assistance with pain medications and psychosocial needs, and help ensure that advance directives are in place and in compliance.[4] Another study focused on nurse-led, palliative care-focused interventions focused on physical, psychosocial and care coordination provided in consultation with oncology services for patients with advanced cancer in a rural area. The study concluded that those receiving the palliative care services had higher quality of life and mood scores compared to those receiving oncology services alone.[5]

Given that palliative care services have been shown to both increase the quality of care provided to individuals and reduce health care costs – two goals of the ACO program – we strongly urge CMS in the future to include provisions in the ACO eligibility rules that require an ACO to describe in its application how it will provide beneficiaries with serious illness access to palliative care services throughout the care continuum.

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[1] 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.

[2] Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3)454-463 (2011).

[3] 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).

[4] Krakauer R, Spettell CM, Reisman L, Wade MJ. Opportunities to improve the quality of care for advanced illness. *Health Affairs* 28(5)1357-1359 (2009).

[5] Bakitas M, Doyle Lyons K, Hegel MT, Balan S, Brokaw FC, Seville J, Hull JG, Li Z, Tosteson TD, Byock IR, Ahles TA. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer. *JAMA* 2009;302(7):741-749.

Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the Medicare Accountable Care Organization proposed rule. 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 Association of Colleges of Nursing

American Cancer Society Cancer Action Network

American Heart Association | American Stroke Association

Association of Oncology Social Work

C-Change

Cancer Support Community

Catholic Health Association of the United States

Center to Advance Palliative Care

Colon Cancer Alliance

Motion Picture & Television Fund

National Comprehensive Cancer Network

National Palliative Care Research Center

Oncology Nursing Society

Partnership for Palliative Care

Supportive Care Coalition

Visiting Nurse Associations of America