

May 16, 2022

COALITION MEMBERS

American Academy of Hospice
and Palliative Medicine
(AAHPM)

Association of
Professional Chaplains
(APC)

The Catholic Health Association
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(CHA)

Center to Advance
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(PAHPM)

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(SWHPN)

Society of Pain & Palliative
Care Pharmacists
(SPPCP)

Chris Smith Ritter, Ph.D.
Acting Deputy Director &
Patient Care Models Group Director
Center for Medicare and Medicaid Innovation

Sent via email

RE: National [Coalition](#) for Hospice and Palliative Care Recommendations for Integrating Palliative Care Capabilities and Specialists into Population-Based Models

Dear Dr. Ritter:

The National Coalition for Hospice and Palliative Care appreciates the continuing dialogue with your team at the Center for Medicare and Medicaid Innovation (CMMI). We would like to take this opportunity to offer suggestions for integrating palliative care capabilities and specialists into population-based models such as accountable care organizations (ACOs). As we have discussed, the drive towards value alone has not yet motivated most ACOs to ensure access to high-quality palliative care for their attributed beneficiaries, and we recommended that specific waivers, quality incentives, and benefit enhancements be deployed so that ACOs have both the resources and the incentives to deliver better care for their patients living with serious illness.

Below we offer more specific recommendations for these waivers, quality incentives, and benefit enhancements. These recommendations are meant to accomplish three goals:

1. Ensure that all relevant practices and facilities participating in accountable care models have the **requisite knowledge, skills, and processes** to assess for unmet palliative care needs, hold meaningful conversations with patients and their families/caregivers, and deliver timely and effective symptom management.
2. Ensure that all beneficiaries with serious illness and complex needs have **access to specialty palliative care teams**, for both consultation and ongoing care in the community.
3. Define the **core services** that must be included when community-based palliative care is provided to ensure high quality care is delivered to seriously ill individuals.

Definitions

Requisite serious illness knowledge, skills, and processes: Any entity that assumes responsibility for the quality and cost of a population should have demonstrated capabilities in:

- assessing for symptom distress
- assessing for functional impairment
- assessing for caregiver burden
- screening for psycho-social and spiritual needs
- holding meaningful shared decision-making conversations
- managing pain, symptoms, and medications
- referring to specialty palliative care teams or hospice, as warranted

Community-based palliative care services: [As we have discussed with CMMI in the past,](#) community-based palliative care should provide the following core services:

- Proactive identification of high-risk beneficiaries
- Comprehensive assessment of symptoms and stressors impacting quality-of-life
- Expert management of symptoms and stressors by an interdisciplinary care team
- Patient and caregiver education and support, explaining what to expect, clarifying goals and values, supporting shared decision-making, and advance care planning
- Aide services to meet personal care needs
- Care plan coordination across all providers and community services, including formal relationships with community organizations
- Ongoing support of patients and families including telehealth with 24/7 access

The [Clinical Practice Guidelines for Quality Palliative Care](#) should be used to establish required structures and processes of care.

Community-based palliative care teams: Any entity providing specialty palliative care in community settings must demonstrate an interdisciplinary team that includes, but is not limited to, a Doctor of Medicine or Doctor of Osteopathic Medicine, Advanced Practice Nurse and/or registered nurse, a social worker, and access to chaplaincy and pharmacist. A minimum of one team member must be certified in hospice and palliative care, highly encouraged to be a prescriber.

To advance equitable access, we further recommend inclusion of community health workers/doulas/lay navigators in the model to enhance engagement among historically marginalized groups. The Coalition can provide some of the emerging evidence on this, if it would be helpful.

Recommendations to Build Overall ACO Capabilities

- Include a quality incentive for completion of training. We suggest an annual bonus that can vary with the number or proportion of clinicians (outside of palliative care specialists) completing annual training. The bonus can be earned by annual submission of

documentation and attestation, with random audits to mitigate the risk of fraudulent submissions.

Annual training should, at a minimum, include: an overview of palliative care; basic communication skills and cultural humility in the context of serious illness; assessment for symptoms, function, caregiver burden; medication burden and use; and pain management.

- Allow serious illness to be considered a skilled need for Part A home health benefits. While existing waivers allow beneficiaries to access home health regardless of homebound status, there are at least another 10 percent of beneficiaries estimated to need home health services who are seriously ill but do not present a skilled need, as currently defined. For beneficiary eligibility, [this identification summary](#) prepared through discussion with private payers may serve as a helpful resource.

The home health agencies participating in this waiver will need to demonstrate competency in palliative care or formal collaborations with specialty palliative care teams and should be encouraged to increase home health aide services for this population.

Recommendations to Support Access to Specialty Palliative Care

- Add a new benefit enhancement to pay for community-based palliative care services. We recommend that participating ACOs be allowed to bill for comprehensive palliative care services under a new care management code. Participating ACOs must include entities that meet the community-based palliative care definition above, and eligibility should be affirmed by CMMI before payments can proceed.

We realize that implementation of this recommendation would require more consideration, and the Coalition would welcome the opportunity to assist in this process.

We further recommend a payment approach that recognizes varying resource needs across an episode of care, such as:

- A higher initial payment in the first month
 - An additional payment, under an additional code, to reimburse for an initial comprehensive palliative care assessment
 - A U-curve to accommodate early intensity and later exacerbations
 - An outlier policy
- Exclude home health and hospice providers from ACOs' CEHRT requirements until federal investment is made. Many home health and hospice providers – especially smaller agencies and those that focus on rural and under-served populations – do not have the capital to meet the current CEHRT requirements, and yet they are essential to ensure high-quality care across the diversity of seriously ill Medicare beneficiaries. Moreover, there are very few existing EHR products for this sector that are currently ONC-certified, and we estimate it will take several more years for these products to be available nationwide.

Because the NCHPC strongly believes that interoperable data ecosystems are essential, especially for this population, we recommend that CMMI provide upfront funding and technical assistance to help home-based care providers develop CEHRT. This recommendation aligns with CMMI's stated goal in its recent strategy refresh to increase the number of safety-net providers participating in APMs and "*address barriers to participation for providers that serve a high proportion of underserved and rural beneficiaries*".

Recommendations to Continue Existing Waivers

In addition to the recommendations above, we urge CMMI to continue utilizing the following waivers from the Direct Contracting and ACO Reach model in all future models:

- Waiver to allow telehealth to be furnished regardless of geographic location and to allow a beneficiary's home to serve as an originating site.
- Waiver to allow beneficiary access to home health benefits without meeting "homebound" requirement.
- Waiver to allow concurrent hospice benefits with all other benefits.
 - Because experience with concurrent benefits is limited, we recommend that CMMI provide technical assistance and peer learning on concurrent care best practices.
- Waivers to exempt certain instances of beneficiary cost-sharing.
 - We recommend that CMMI issue guidance to highlight the codes for chronic care management, complex chronic care management, principal care management, advance care planning, and cognitive assessment & care planning as prime targets for cost-sharing elimination.

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In conclusion, we believe that incentivizing requisite skills together with targeted financial support for specialty palliative care services will drive high-value, equitable care during serious illness for Medicare beneficiaries attributed to accountable care organizations. We hope that the recommendations herein provide you with new ideas and priorities as you continue to drive improvements in the care of Medicare beneficiaries with serious illness via population-based models.

We would welcome the opportunity to discuss these recommendations with you and your staff and further support your work. Amy Melnick, Executive Director, amym@nationalcoalitionhpc.org, will work with your staff to coordinate a convenient time to discuss these recommendations in more detail. Thank you for your consideration.

Coalition Signatories

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