

June 3, 2015

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



Re: Medicare Oncology Care Model

Dr. Conway:

We are writing collectively as members of the Patient Quality of Life Coalition, a group established 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.

As you work to implement and evaluate the Oncology Care Model, we offer the following thoughts and comments on the proposed model based on the information provided by CMMI. We welcome the opportunity to meet with you to share our collective thoughts and ideas.

Quality Care Measures

The Coalition applauds CMMI for including provisions related to palliative care as part of the new Medicare Oncology Care Model, which is intended to improve the care provided to beneficiaries undergoing chemotherapy. As currently drafted, the Oncology Care Model contains three quality and performance measures related to palliative care:

- Under the Person-and-Caregiver-Centered Experience and Outcomes Quality Domain, percentage of OCM-FFS beneficiary face-to-face visits to the participating practice in which there is a documented plan of care for pain AND pain intensity is quantified.
- Under the Person-and-Caregiver-Centered Experience and Outcomes Quality Domain, practices will be required to report the percentage of OCM-FFS beneficiaries that receive psychosocial screening and intervention at least once per OCM-FFS episode.
- Under the Communication and Care Coordination Quality Domain, practices will be required to report the percentage of OCM-FFS beneficiaries with at least one palliative care consultation per OCM-FFS episode.

Patient access to palliative care services has been demonstrated to result in higher quality of care for beneficiaries. 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, research also indicates that by closely matching treatments with a patient's goals, palliative care can provide substantial cost reductions.¹

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-Ellenborg 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,

As you work to implement and evaluate the Medicare Oncology Care Model, we strongly urge you to retain the existing quality measures related to palliative care.

Care Management Plan

According to the Request for Applications, practices participating in the Oncology Care Model will be required to document comprehensive cancer care plans for all beneficiaries covered under the Model. Specifically, the care plan must include thirteen elements identified in the Institute of Medicine's (IOM) *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*.²

We urge CMMI to consider clarifying the fourth component of the care plan to read: "Treatment goals (curative, life-prolonging, symptom control, palliative care, end of life care, hospice care, or combinations of these)." The way the language currently is drafted implies that the goals of care listed are mutually exclusive. As the literature consistently shows, and the IOM report affirms, these goals are not mutually exclusive and providing access to palliative care concurrent with disease-directed therapies improves quality of care both for the patient and his or her family and ensures that patients receive only those treatments from which they will benefit and that fit within their plan of care. Unfortunately, many clinicians have been trained to view palliative care as an either-or treatment: either the patient receives disease-directed treatment or palliative care. The IOM report goes a long way to dispelling this misconception and unfortunate practice; however, due to prior confusion it is important that practice guidelines are absolutely clear that the goals of care may be both to treat the disease and to improve quality of life. We therefore strongly encourage you to clarify the language on this point.

In addition, we urge CMMI to consider adding an additional component: "A plan for addressing pain, symptoms, and side-effects of treatment." Cancer patients typically experience pain and other distressing symptoms, both from the disease and as the side effects of treatment. Untreated pain and symptoms can create a great deal of stress and suffering for patients and caregivers, and leave them to call 911 or go to the emergency department when pain and other symptoms are not managed properly. Though the Care Management Plan notes the importance of plans to address psychosocial health needs, it does not specifically mention a plan to address pain and symptoms. In order to best realize the aspirations of the IOM report and to ensure optimal patient care, the care plan must address these issues.

Episode Definition

Beneficiary participation in the Oncology Care Model is triggered by the administration of chemotherapy. We note that depending on the cancer diagnosis, chemotherapy may not be the first line of treatment or even recommended as part of the treatment regimen.

While we see the practicality in testing a model with administration of chemotherapy as a triggering event, to the extent that CMMI is considering additional oncology demonstration models in the future, we urge CMMI to consider establishing a model that would allow for the triggering event to be the point of a cancer diagnosis. If CMMI were to establish such a model, we would urge the introduction of additional quality measures and requirements which support the use of palliative care services.

spent less time in intensive care, and were less likely to die in the ICU. 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).

² Institute of Medicine Report. Levit L, Balogh E, Nass S and Ganz P, ed. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*. 2013.

Research suggests that introducing palliative care services at or near the point of diagnosis results in improved quality of life for patients.³

Program Evaluation

Finally, as CMMI begins to evaluate the Oncology Care Model, we encourage you to focus part of your evaluation on the extent to which the use of palliative care services has improved patient experience and quality of care. We urge CMMI to focus a portion of its evaluation on patient-centered care, including how palliative care helped patients navigate their care throughout the cancer continuum, and the extent to which utilization of non-physician providers improved the quality of care provided to beneficiaries. We welcome the opportunity to discuss with CMMI the specific criteria that should be used to conduct this evaluation.

Additionally, we are pleased that CMMI specifically included in the evaluation process patient surveys to document patient experiences under the model. We encourage CMMI to work with patient groups on the development of the patient surveys, and we would be glad to meet with you to share our thoughts on ways to develop the surveys.

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,

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| American Academy of Pain Management | Hospice and Palliative Nurses Association |
| American Association of Colleges of Nursing | Lung Cancer Alliance |
| American Cancer Society Cancer Action Network | Motion Picture & Television Fund |
| American Psychosocial Oncology Society | National Comprehensive Cancer Network |
| Association of Oncology Social Work | National Palliative Care Research Center |
| Association of Professional Chaplains | Oncology Nursing Society |
| Cancer Support Community | Partnership for Palliative Care |
| Center to Advance Palliative Care | Social Work Hospice and Palliative Care Network |
| Children’s National PANDA Palliative Care Team | St. Baldrick’s Foundation |
| Colon Cancer Alliance | Supportive Care Coalition |
| California State University Institute for Palliative Care | Trinity Health |
| HealthCare Chaplaincy Network | Visiting Nurse Associations of America |

³ Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med.* 2010 Aug 19;363(8):733-42.