

June 22, 2015



ONE PENN CENTER WEST, SUITE 425 ■ PITTSBURGH, PA 15276
PHONE: 412-787-9316 ■ FAX: 412-787-9305
info@nationalcoalitionhpc.org ■ www.nationalcoalitionhpc.org

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
United States Senate

**Re: Comments to the Senate Finance Committee's Chronic Care Working Group
Submitted via chronic_care@finance.senate.gov**

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit policy proposals with the aim to improve the care of Medicare patients with chronic conditions. The Coalition is composed of the leading national hospice and palliative care organizations dedicated to advancing care of patients and families living with serious and often chronic conditions. The organizations that form the Coalition represent more than 4,000 physicians, 11,000 nurses, 5,000 professional chaplains, more than 5,000 social workers, researchers, 1,600 palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of Medicare beneficiaries, with serious, chronic illness. Our combined membership represents the interdisciplinary palliative care team which is patient and family-centered.

The Senate Finance Committee is to be commended for creating this new Finance Committee Chronic Care Working Group which is charged with developing and implementing policies which will improve the quality and coordination of care for this Medicare population with multiple chronic conditions. Our Coalition Members believe improved access to quality palliative care services provides one of the best opportunities to achieve better patient outcomes for seriously ill patients with

chronic conditions while reducing overall costs to the system. We encourage the Senate Workgroup to examine the recent findings and recommendations contained in the Institute of Medicine (IOM) Report, *Dying in America, Improving Quality and Honoring Preferences at the End of Life*, September 2014, National Academy Press. The overarching recommendation was that “high quality compassionate, cost effective, person and family centered care should be accessible to anyone with a serious, advanced illness”.¹ The report clearly articulates that the lack of access to early palliative care and care coordination often leads to burdensome, unnecessary and costly health care transitions for the most vulnerable Medicare beneficiaries. The Report’s many recommendations lays out a path to a reformed Medicare system that better serves the needs of Medicare beneficiaries with serious chronic conditions.

Our Coalition recommendations will focus on two of the three main stated objectives as outlined in your letter to stakeholders.

1. The proposed policy increases care coordination among individual providers across care settings.
2. The proposed policy facilitates the delivery of high quality care, improves care transitions, produces stronger patient outcomes, increases program efficiency and contributes to an overall effort that will reduce the growth in Medicare spending.

How to Improve Care Coordination? Palliative Care Services

The Coalition strongly believes that expanding earlier access to palliative care services will significantly increase care coordination among individual providers treating seriously ill Medicare beneficiaries with chronic conditions across care settings. According to the IOM Report, “early provision of specialty palliative care improves quality of life, lowers spending and helps clarify treatment preferences and goals of care”.

The core component and definition of palliative care is one in which a coordinated interdisciplinary team of providers – physicians, nurses, social workers, chaplains and often other health care professionals such as physician assistants, pharmacists, and physical therapists work together with a patient’s other doctors, in the best interest of the patient and family. Palliative care is often needed by people living with serious and chronic conditions. It provides relief from the symptoms and stress of a serious illness. Key components of palliative care include control of pain, symptoms and side effects, and psychosocial, spiritual and caregiver support. By relieving complex pain and symptoms, and providing both psychosocial and spiritual support (if needed) palliative care providers improves a patients’ ability to tolerate medical treatments and manage daily life.

One of the basic tenants of palliative care is facilitated communication between the patient, family and myriad health care professionals involved with a patient’s care to ensure the patient’s goals of care are known and honored. There is strong evidence that patients with access to palliative care services have a better quality of life and live longer.² Moreover, the use of palliative care services has been shown to result in cost savings to the health care system by reducing re-hospitalizations and burdensome transitions.³

¹ Institute of Medicine. 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

² 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.

³ 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

Coordinated Care Can Reduce Care Transitions and Result in Cost Savings

The IOM Report presents considerable evidence that the “Impact of palliative care on longevity” is a positive one and that earlier access to palliative care significantly improves quality of life. This is demonstrated by numerous research studies cited in the IOM Report which also confirm what patients and families want; “information and communication about palliative care, hospice, access to home care, emotional and spiritual support, well-being and dignity, pain relief, and a lighter symptom burden”.

There is strong evidence that palliative care can reduce unnecessary hospital admissions and re-admissions which are not only costly and risky for vulnerable patient populations but cause distress, pain, and emotional turmoil in patients and their families. A growing body of evidence suggests that the risks of hospitalization in terms of hospital acquired infections and other hazards is a significant contributor to increased and earlier mortality. Avoidance of unnecessary hospitalization achieves the triple aim of better quality, better care, and lower costs.

Efforts should be made to target palliative care towards the patients with the greatest need, the costliest five percent of patients in the United States who have persistent year-after-year high spending.⁴ Required documentation of functional and cognitive status measures could help primary care providers proactively identify high risk, complex, chronic care patients who would benefit from palliative care. Factors most predictive of persistent high risk and high utilization include functional dependency, pain, cognitive impairment, frailty, exhausted stressed family caregivers, behavioral health risks, and social factors including poverty, housing, food insecurity, lack of transportation, and literacy challenges. There are multiple validated short instruments available for quick office assessment of function, cognition, caregiver, and social support needs. The Coalition would be pleased to offer this additional information about these instruments if requested.

The interdisciplinary palliative care team supports patients and families and helps prevent medical crises by helping to match treatment plans with patients’ goals. Palliative care patients report a higher quality of life, less pain and fewer symptoms, and higher satisfaction with their care. Better care for high-risk, high cost patients leads to reduction in reliance on 911 calls, emergency department visits, and hospitalizations and leads to consistent and substantial reductions in associated health care spending. Two examples of the benefits of palliative care for patients with chronic illness are:

1. Reduction in ED visits. Patients who received in-home palliative care were less likely to visit the emergency department or be admitted to the hospital than those receiving usual care, resulting in significantly lower costs of care than those who did not receive palliative care (\$95.30 vs. \$212.80 per day)⁵.
2. Reduction in hospitalizations. Patients discharged with home-based palliative care were 3.7 times less likely to be readmitted than those discharged to home without palliative care, and five times less likely to be readmitted than those discharged to nursing facilities.⁶ Additionally,

\$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, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3):454-463 (2011).

⁴ Institute of Medicine. 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

⁵ Brumley R, Enguidanos S, Jamison P, Seitz R, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *J Am Geriatr Soc.* 2007 Jul;55(7):993-1000.

⁶ Enguidanos S, Vesper E, Lorenz K. 30-day readmissions among seriously ill older adults. *J Pal Med.* 2012 Dec;15(12):1356-61. doi: 10.1089/jpm.2012.0259.

patients enrolled in a palliative home-care program had fewer hospital stays (0.4 versus 1.3 admissions) in their last two months of life than did patients receiving usual care⁷.

Palliative care provides wraparound support that addresses the most significant drivers of cost, while greatly improving the quality of life for patients and their families.

Examples of Successful Private Payer Palliative Care Initiatives

Many private payers through the Medicare Advantage plans have worked to include palliative care into their programs with excellent reported results. We urge the Committee to examine the following two examples, or others, of palliative care integration and innovation in the Medicare Advantage program for Medicare beneficiaries with serious chronic illness.

- [Aetna's Compassionate Care Program](#)
- [Highmark's Advanced Illness Management Program](#)

These programs use care managers and a palliative care team based approach to provide a comprehensive assessment of the patient's needs by consult with the patient, their physician's, and the patient's family.

How to Expand Access to Palliative Care Services

We urge the Working Group to examine policies that, if enacted, would increase earlier access to palliative care services for the appropriate Medicare beneficiaries with serious, chronic illness.

Chronic care management codes:

In its calendar year 2015 Medicare Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services (CMS) finalized a policy to create a new code to provide reimbursement for the management of chronic care services for Medicare beneficiaries. Although this is a clear recognition that these services are needed, we are concerned that CMS undervalued the amount of the reimbursement for the code to truly reflect the amount of work care coordination entails for patients with serious, complex chronic illness. Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants (patient, multiple specialists, non-health care personnel, and family members) concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

We urge the Working Group to review the parameters and valuation of the chronic care management code to ensure that this code provides a more adequate reimbursement for the level of services we expect for appropriate complex chronic care management.

Reimbursement for the Palliative Care Team:

Quality palliative care is provided by a team of professionals, including physicians, nurses, social workers and chaplains and other health care professionals as needed.⁸ However, based on the Medicare fee-for-service system, only physicians and other qualified health care personnel, such as nurse practitioners, are reimbursed for their services. The important work of social workers, chaplains

⁷ Riolfi M, Buja A, Zanardo C, Marangon CF, Manno P, Baldo V. Effectiveness of palliative home-care services in reducing hospital admissions and determinants of hospitalization for terminally ill patients followed up by a palliative home-care team: a retrospective cohort study. *Palliat Med.* 2014 May;28(5):403-11. doi: 10.1177/0269216313517283.

⁸ National Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care* 3rd edition 2013.

and other personnel necessary to ensure care coordination and communication with patient and families is not directly reimbursed by Medicare.

As a result, the lack of reimbursement negatively impacts the widespread use of these valuable members of the interdisciplinary team outside of the acute care facility setting. We recommend the Working Group consider expanding reimbursement options to include non-physician professionals.

Reimbursement for a Bundled Palliative Care Payment:

The Coalition recommends that the Working Group explore the possibility of creating a bundled palliative care payment that would cover the dynamic, coordinated services provided by the palliative care team. The physicians and nurse practitioners who serve on the palliative care team can bill for their services like any other eligible provider in the fee for service Medicare program, but the social workers, nurses, and chaplains are not supported by this billing, nor is the amount of time providers spend speaking with patients, their families, and other providers as they work to ensure the highest quality, most efficient coordinated care. We encourage the Working Group to explore policy options so that Medicare can pay for all facets of palliative care in all health care settings, including the home and community based settings.

Stronger Patient Outcomes through Quality Measurement and Development: Transparency and accountability through public reporting of aggregate quality and cost measures for all aspects of the health care system is needed according to the IOM Report. The Coalition recommends the Working Group support the financing to develop, test and validate quality measures in the area of palliative care and care coordination. The National Quality Forum (NQF) Measures Application Partnership has also repeatedly cited palliative care as a high leverage measure gap that needs to be remedied.

The Coalition also strongly recommends that CMS should include palliative care measures in all relevant quality and value-based programs throughout their various programs. For example, as the hospital inpatient readmissions reduction program demonstrates, one of the most powerful tools Medicare has to ensure these new models' success is quality measurement. However, there are currently no palliative care related measures in the Medicare Advantage Five-Star Quality Rating System nor the Medicare Shared Savings Program.

Reduce Burdensome Transitions – Consider Social Support Coverage

The Coalition encourages the Working Group to focus its attention on policies that will reduce and eliminate the perverse incentives and program misalignments in Medicare that lead to high rates of burdensome transitions between care settings. Major reforms are needed to reduce or eliminate incentives that lead to unnecessary use of services (hospital days, intensive care, emergency room care, and ambulances), because of burdensome transitions among care settings, and late enrollment in hospice, all of which jeopardize the quality of life for those with serious, complex chronic illness.

Various medical settings have financial incentives to keep beneficiaries cycled through different care settings and institutionalized even though most people prefer to stay in their homes with the appropriate medical, social, and personal care supports (such as direct care workers, transportation and meal assistance). The Coalition recommends the Working Group seeks meaningful payment reform which would allow beneficiaries improved access to long term services and support with assistance with activities of daily living. It is often the activities of daily living (non-medical needs such as transportation, adequate nutrition or assistance with bathing) that lead those with complex chronic conditions to utilize the health care system. A [recent New York Times front page story](#) illustrated the confusing and cruel care transitions faced by Medicare beneficiaries with complex chronic illness and

the perverse financial incentives which exacerbate the problem.⁹ The Coalition encourages the Working Group to focus some attention on Medicare beneficiaries who may have basic needs for food, housing, or transportation, or help navigating the health system or following a treatment plan. Most hospitals or physician practices are not equipped or funded in any way to provide such services, yet it is these issues that are driving patients to utilize the health care system.

Advance Care Planning (ACP):

The Coalition strongly supports the need to strengthen both the *quality* and the *quantity* of clinician-patient communication for patients with chronic illness. Advance care planning conversations and appropriate ACP documentation is just one aspect of this communication. Discussions regarding goals of care and conversations which lead to shared decision-making “is an essential component of quality care”.¹⁰ The Coalition supports advance care planning that is focused on on-going high quality conversations between the health care team and the patient and family about values and preferences and not simply focused on document completion alone.

The Coalition supports Medicare reimbursement for the interdisciplinary team to initiate and conduct these crucial conversations and has communicated its support to CMS for their proposal to reimburse qualified health care providers for these conversations. We anticipate these codes will be re-published in the upcoming physician fee schedule with appropriate reimbursement. However, if CMS declines to reimburse for these services we strongly recommend the Senate Finance Committee communicate its concerns with this CMS policy. The Coalition will continue to advocate for public policy proposals that acknowledge the time, expertise, and skill necessary to have these conversations. The aim of these conversations is “to develop a coherent care plan that meets the patient’s goals, values and preferences”.¹¹

Electronic Health Record:

The Coalition is supportive of changing the electronic health record (EHR) to safely and securely document a patient’s advance care plans and preferences for goals and settings of care. Historically, advance care planning documentation and data standards were minimal. However, there is great potential to promote a standardized approach to appropriate advance care planning through the EHR. The Coalition supports efforts to make advance care planning a meaningful and universal component in the HER and encourages the Committee to examine ways in which the changes to the EHR can impact and improve the care of those with chronic illness.

Centers for Medicare and Medicaid Innovation (CMMI):

The Coalition would like to bring to the Committee’s attention three examples of payment models that CMMI has begun to test which could be informative as the Committee begins its work. All three models apply to beneficiaries with chronic illness. The [Medicare Care Choices Model \(MCCM\)](#) will allow hospice-eligible beneficiaries not enrolled in hospice to continue concurrent curative care services. CMMI is working on the [Advanced Primary Care Model](#) to focus on Medicare beneficiaries who would most benefit from improved care coordination as well as the [Medicare Oncology Care Model](#), focused on improving cancer care for beneficiaries. These models seek to incorporate palliative care into the treatment of patients with complex chronic conditions.

⁹ Nina Bernstein, New York Times, September 25, 2014 Family fights health-care system for simple request to die at-home.

¹⁰ Institute of Medicine. (2014). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC: National Academies Press.

Accountable Care Organizations (ACOs):

In order to be eligible to participate in the ACO program, applicants must demonstrate certain eligibility requirements. In an effort to include care coordination for Medicare beneficiaries, we urge the Working Group to expand the ACO eligibility rules to require an ACO specifically to describe in its application how it will provide beneficiaries with serious illness access to palliative care services throughout the care continuum.

Conclusion

The National Coalition for Hospice and Palliative Care, and our member organizations, thank the Senate Finance Committee for your willingness to engage with the broad stakeholder community and for your dedication to improving the health of those with chronic conditions. Reforming chronic care in America is a national imperative. We look forward to future stakeholder engagement opportunities as the Senate Working Group on Chronic Conditions continues this important work on behalf of our nation's Medicare beneficiaries. If you have any questions, please do not hesitate to contact Amy Melnick, Executive Director of the Coalition at amym@nationalcoalitionhpc.org or 202.306.3590.

ORGANIZATIONS IN COALITION AND SUPPORTING STATEMENT

[American Academy of Hospice and Palliative Care \(AAHPM\)](#)

[Association of Professional Chaplains \(APC\)](#)

[Center to Advance Palliative Care \(CAPC\)](#)

[Health Care Chaplaincy Network \(HCCN\)](#)

[National Palliative Care Research Center \(NPCRC\)](#)

[Social Work Hospice and Palliative Network \(SWPHN\)](#)