

June 22, 2015



The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance
Committee
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, D.C. 20510

Re: Comments to the Senate Finance Committee’s Chronic Care Working Group

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

We are writing collectively as members of the Patient Quality of Life Coalition (PQLC), 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. We commend the Finance Committee for establishing the Chronic Care Working Group to focus on developing the most effective policies to improve care for Medicare beneficiaries with chronic conditions and appreciate the opportunity to respond to the Working Group’s request for ideas to inform their work. The Coalition strongly recommends greater access to palliative care services as a way to significantly improve care for Medicare beneficiaries with chronic conditions. Greater utilization of palliative care will help meet the Working Group’s policy goals to increase care coordination, improve quality of care, and reduce program costs.

Expand Access to Palliative Care Services

One of the most important ways Medicare could better serve beneficiaries with chronic conditions is through expanded access to palliative care. Palliative care is an interdisciplinary model of care focused on people living with serious and chronic diseases. It provides relief from the symptoms and stress of a serious illness – whatever the diagnosis. Palliative care is provided by a team of doctors, nurses, social workers, and specialists working together with a patient’s other doctors to provide an extra layer of support.

Palliative care is appropriate at any age and any stage in a serious illness. It can start at the point of diagnosis of a serious illness, and be used alongside curative treatment. Key components of palliative care include care planning based on open, honest communication about the patient’s condition and treatment options; effective control of pain, symptoms and side effects; highly coordinated care that addresses physical, psychosocial, and spiritual needs and family/caregiver support. Given its focus on the patient and the patient’s family, palliative care improves a patients’ ability to tolerate medical treatments and carry on with daily life. It also empowers patients to play a greater role in their own

care by facilitating communication between patients, caregivers, and providers across the care continuum.

Palliative Care Improves Quality and Helps to Lower Program Spending

Significant evidence has demonstrated that patients who access palliative care services starting at the point of diagnosis and onward,¹ have better quality of life and live longer.² In every setting in which it has been tested, including hospitals, clinics, and at home, palliative care improves care quality for the sickest and most vulnerable patients across all diseases.³ Patients report a higher quality of life, less pain and fewer symptoms, and higher satisfaction with their care. 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.⁴

The use of palliative care services has been shown to reduce costs. One successful model is Aetna's Compassionate Care Program, which uses care managers who conduct 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 followed.⁵

Greater access to palliative care would provide Medicare beneficiaries with multiple chronic conditions better coordinated care, particularly for the costliest five percent of patients in the United States who have persistent year-after-year high spending.⁶ This spending is associated with poorly coordinated care and failure to treat pain and symptoms, which drives patients to the emergency department and leads to unnecessary hospitalizations.

Palliative care improves the quality of health care. Palliative care supports patients and helps prevent medical crises stemming from unmanaged pain and symptoms, and helps match treatment plans with patients' values, preferences and goals so that patients receive the care they want.

The use of palliative care services also has been shown to reduce costs. Better care for high-risk, high cost patients leads to reduction in reliance on 911 calls, emergency department visits, hospital admissions and readmissions and leads to consistent and substantial reductions in associated health care spending.

¹ Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. *J Clinical Oncol* 2012; 30: 880-887.

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 Smith S, Brick A, O'Hara S, Normand C. Evidence on the cost and cost-effectiveness of palliative care: a literature review. *Palliat Med.* 2014 Feb;28(2):130-50.

⁴ 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.

⁵ 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).

⁶ Institute of Medicine. 2015. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

Unfortunately, in the current Medicare fee-for-service system patients don't always have access to palliative care services. There is a significant opportunity to provide Medicare beneficiaries with multiple chronic conditions access to critical palliative care services.

Barriers to Expand Access to Palliative Care Services

In order to ensure greater access to palliative care services for individuals with chronic conditions, the Working Group will need to address existing barriers in the current Medicare reimbursement structure, as well as look at new innovative payment models that will incentivize providers and health systems to provide patients better access to palliative care services.

Chronic care management code: 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. The Coalition supports the addition of this new code. However, we are concerned that CMS undervalued the amount of the reimbursement for the code. Care coordination requires extensive interaction with the beneficiary to develop care plans, discuss options with the beneficiary, follow up with multiple specialists and providers in other settings, and to assure continuous coordination and communication among and between all professional and formal and informal caregivers. Beneficiaries with multiple morbidities often require long consults with a professional just to understand what is going on with a patient.

The amount of reimbursement is one problem. The other challenge is the inflexibility inherent in only permitting providers to seek reimbursement once every 30 days. While this may be sufficient for some patients, others with multiple problems may see real health benefits, and reduced need for repeated acute care, if their care is managed more frequently. In order for chronic care management to be an adequate service to beneficiaries, providers should maintain regular contact to ensure the beneficiary's care is properly managed. The Working Group should urge CMS to review the parameters and valuation of the chronic care management code to ensure that this code provides a more adequate reimbursement for the services we expect health care professionals, including non-physician professionals, to deliver in order to have real chronic care management.

Reimbursement for Non-Physician Professionals: As the Working Group develops policies to address the needs of beneficiaries with chronic conditions, we urge the adoption of policies that will provide accurate reimbursement for non-physician professionals who perform palliative care. While some members of the interdisciplinary palliative care team (such as palliative care medical specialists and nurse practitioners) are eligible to bill directly to the Medicare program, many members of the team including some nurses, social workers, and patient navigators are prohibited from directly billing Medicare. As a result, the lack of reimbursement negatively impacts the widespread use of these valuable members of the interdisciplinary team. Clinical social workers, professionally educated and skilled to assess and intervene in the complex psychosocial environments and outcomes of patients with chronic conditions, are greatly underutilized in these settings, often due to reimbursement issues. We urge the Working Group to consider expanding reimbursement options to include non-physician professionals on a palliative care team.

Quality Measure Development: We are pleased that Medicare is expanding the use of quality measurement, and tying more performance metrics to reimbursement. Such efforts, if done effectively, can help improve the quality of care provided to patients. However, more needs to be done with respect to developing patient experience quality measures. Currently there are no palliative care related measures in the Medicare Advantage Five-Star Quality Rating System or the Medicare Shared Savings Program. While the Hospital Inpatient Quality Reporting Program does include patient experience from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), this survey does not capture patient experience from those who were too sick to participate in the survey or who died in the hospital. However, numerous stakeholder groups are on record in support of these measures being developed. The National Quality Forum (NQF) Measures Application Partnership has repeatedly cited palliative care as a high leverage measure gap, and the Institute of Medicine's report "Dying in America" also stressed measurement in this area. We urge the Working Group to work with CMS to ensure that palliative care quality measures are included in all of Medicare's quality-based performance programs.

Advance Care Planning Codes: Advance care planning allows providers and their patients (as well as their families and/or caregivers) to discuss and make known the patients' treatment preferences. The advance care planning process can begin at any stage or state of health, and should center on frequent conversations with family members and care providers.⁷

Unfortunately, most Medicare beneficiaries do not have an advance care plan in their medical record. According to a recent study funded by the Agency for Health Care Research and Quality (AHRQ) only 12 percent of Medicare beneficiaries have developed an advance care plan with their medical provider.⁸ Oftentimes, medical professionals are not involved in the planning process, and they may be unaware of the existence of such plans,⁹ reducing the likelihood that the patient's preferences will be carried out.

Currently advance care planning discussions are being billed under other Medicare-covered services (usually as part of the evaluation and management codes), which may not be appropriate for particularly lengthy encounters for patients with complex medical needs. The current reimbursement structure not only fails to take this complexity into account, but also fails to provide CMS with the ability to track the use of advance care planning services. Advance care plans are a critical component to providing patient centered care to patients with multiple chronic conditions. Health care providers on the palliative care team, including the palliative care physician, nurse, and social worker should be appropriately reimbursed for the time spent with a patient to develop the care planning document.

In the calendar year 2015 Medicare Physician Fee Schedule final rule, CMS indicated that it would create two new codes for advance care planning but would not provide reimbursement for either code. Rather, CMS will consider whether to pay for these codes in the future. While the Coalition applauds CMS for its consideration of creating advance care planning codes, we urge the Working Group to

⁷ Institute of Medicine. (2014). *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: National Academies Press.

⁸ Teno J, Lynn J, Wenger N, et al. Advance directives for seriously-ill hospitalized patients: effectiveness with the Patient Self-Determination Act and the SUPPORT intervention. *J Am Geriatr Soc* 1997;45:500-7.

⁹ Virmani J, Schneiderman LJ, Kaplan RM. Relationship of advance directives to physician-patient communication. *Arch Intern Med* 1994;154:909-13.

encourage CMS to ensure that providers are adequately reimbursed for the services provided under the codes, and that non-physician practitioners are able to bill for services using these codes.

Expansion of Existing Policy Options

The Coalition is pleased with recent CMS initiatives that have been developed to ensure more Medicare beneficiaries receive care through alternative payment models. These models encourage greater care coordination, thereby improving the quality of care provided to beneficiaries, and reducing health care costs for beneficiaries and the Medicare program at large.

The Need for More Demonstration Projects: The Centers for Medicare and Medicaid Innovation (CMMI) is currently testing important new delivery models – like the Medicare Care Choices Model (MCCM) which allows hospice-eligible beneficiaries not enrolled in hospice to receive curative care and palliative care services concurrently. The ability to test new approaches to care and take successful models to scale is important for improving the way Medicare delivers and pays for services. There is a need for additional models to be tested that address the care of beneficiaries with multiple chronic conditions throughout the care continuum, and not just at end of life. We encourage the Working Group to direct CMMI to develop new models that would allow Medicare beneficiaries with chronic conditions to have access to palliative care services starting at point of diagnosis.

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, the Working Group should work with CMS 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.

Graduate Medical Education (GME): Another opportunity to improve care for Medicare beneficiaries with chronic conditions is to improve the education of physicians through Medicare's GME program. The Accreditation Council for Graduate Medical Education (ACGME) mandates that residents meet certain core competencies. In its June 2010 report to Congress, the Medicare Payment Advisory Commission noted that encouraging graduating residents to demonstrate basic knowledge in geriatric care would have important benefits for Medicare beneficiaries.¹⁰ We urge the Working Group to require HHS require that graduating residents demonstrate basic knowledge of palliative care medicine.

Palliative Care Hospice Education and Training Act: The Coalition is also actively advocating on behalf of the Palliative Care Hospice Education and Training Act, legislation that was introduced during the 113th Congress, and will be re-introduced this Congress. The legislation addresses three policy objectives that would help to ensure that more individuals have access to palliative care services by addressing the need to train more physicians, nurses, social workers, and other health professionals in the medical subspecialty of palliative care, the need to educate the public and providers about the availability of palliative care, and the need for a greater investment in evidence-based research specific to palliative care, and symptom management. While this legislation is outside the jurisdiction of the Senate Finance Committee, it nonetheless presents three important policy issues that need to be

¹⁰ Medicare Payment Advisory Commission, Report to Congress: Aligning Incentives in Medicare (Washington: MedPAC, June 2010), chap. 4.

addressed in order to ensure that Medicare beneficiaries are provided better quality of care through greater access to palliative care services. We urge the Working Group to consider this legislation as you develop policy proposals to improve the Medicare program for beneficiaries with chronic care needs.

Conclusion

We look forward to working with you and members of the Working Group as you develop ideas to improve the Medicare program for individuals with chronic conditions. 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 Cancer Society Cancer Action Network
American Heart Association / American Stroke Association
American Psychosocial Oncology Society
Association of Oncology Social Work
C-Change
Cancer Support Community
Catholic Health Association of the United States
Center to Advance Palliative Care
Motion Picture & Television Fund
National Comprehensive Cancer Network
Oncology Nursing Society
Partnership for Palliative Care
Prevent Cancer Foundation
Supportive Care Coalition
Visiting Nurse Associations of America