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219 Dirksen Senate Building
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The Honorable Ron Wyden
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219 Dirksen Senate Building
Washington, D.C. 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
131 Russell Senate Building
Washington, D.C. 20510

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
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**Re: Comments to the Senate Finance Committee's Chronic Care Working Group
Policy Options Document
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 comments on the policy options presented by the Chronic Care Workgroup last month. The Coalition continues to fully support your bi-partisan goal to improve the care of Medicare beneficiaries with multiple 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, as well as those facing the end of life. 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. Our combined membership represents the interdisciplinary hospice and palliative care team which is patient and family-centered.

Our Coalition appreciated the opportunity to meet with your staff in the fall to discuss how best to improve access to quality hospice and palliative care services in order to achieve better patient outcomes for seriously ill patients with multiple chronic conditions while reducing overall costs to the system. To reiterate, palliative care is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness—whatever the diagnosis. It is appropriate at any age and any stage of illness and can be delivered along with curative treatment. The goal is to improve quality of life for both the patient

and the family. In multiple studies, palliative care has been demonstrated to improve patient experience and satisfaction,¹ reduce caregiver burden,² and increase survival;³ it has also been shown to reduce needless hospital admissions and readmissions through effective care coordination and symptom management;⁴ and through these gains in quality, it reduces costs.⁵ A recent study showed that the receipt of palliative care consultation within two days of hospital admission was associated with 22-32% lower costs for patients with advanced cancer.⁶ Additionally, the 2014 Institute of Medicine (IOM) Report, *Dying in America*, stated that “high quality compassionate, cost effective, person and family centered care should be accessible to anyone with a serious, advanced illness”,⁷ and that the lack of access to early hospice and palliative care often leads to burdensome, unnecessary and costly health care transitions for the most vulnerable Medicare beneficiaries. Given this, we welcome the opportunity to discuss our additional recommendations below with the bi-partisan Working Group.

General Comments

Policy Options Scope

The Coalition recognizes that reforming Medicare is a difficult and complex challenge, and that the structure of traditional Medicare Fee-for-Service (FFS) cannot be easily modified to incentivize high-quality, coordinated care for patients with chronic illness. However,

¹ See e.g. MO Delgado-Guay et al. *Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team*, 115(2) *Cancer* 437-45 (2009); David Casarett et al., *Do Palliative Consultations Improve Patient Outcomes?* 56 *J Am Geriatric Soc'y* 593, 597-98 (2008) (discussing results indicating that palliative care improves quality of end of life care).

² See Laura P. Gelfman et al., *Does Palliative Care Improve Quality? A Survey of Bereaved Family Members*, 36 *J Pain Symptom Manag* 22, 25 (2008) (explaining results showing palliative care consultation services improve family-centered outcomes); P Hudson et al. *Reducing the psychological distress of family caregivers of home-based palliative care patients: short-term effects from a randomized controlled trial*, *Psycho-Oncology* (2013) (Advance online publication. doi: 10.1002/pon.3242) (finding that short palliative interventions can augment caregivers' feelings of preparedness and competence in supporting a dying relative).

³ 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.

⁴ See C Nelson et al., *Inpatient palliative care consults and the probability of hospital readmission*, 15(2) *Perm J* 48-51 (2011) (finding that palliative care consultations reduced six month readmissions from 1.15 admissions per patient to 0.7); S Enguidanos et al., *30-day readmissions among seriously ill older adults*. 15(12) *J Palliat Med* 1356-61 (2012) (finding that receipt of palliative care following hospital discharge was an important factor in reducing 30-day hospital readmissions); L Lukas et al., *Hospital outcomes for a home-based palliative medicine consulting service*, 16(2) *J Palliat Med* 179-84 (2013) (finding that total hospitalizations, total hospital days, total and variable costs, and probability of a 30-day readmission were significantly reduced after enrollment in a home based palliative care program).

⁵ See R. Sean Morrison et al., *Cost Savings Associated with US Hospital Palliative Care Consultation Programs*, 168 *Arch Intern Med* 1783, 1785 (2008) (stating "patients receiving palliative care consultation had significantly lower costs" than usual patients who did not); Joan D. Penrod et al., *Hospital-Based Palliative Care Consultation: Effects on Hospital Cost*, 13 *J Palliat Med* 973, 976 (2010) (finding "palliative care during hospitalizations was associated with significantly lower direct hospital costs."); R. Sean Morrison et al., *Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries*, 30 *Health Aff.* 454, 457 (2011) (finding overall results show patients who received palliative care had significantly lower costs than patients who did not).

⁶ May, Peter et al, *Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities*, *Health Affairs*, January 2016, Vol. 35, pp. 44-53, available at <http://content.healthaffairs.org/content/35/1/44.abstract>.

⁷ Institute of Medicine. 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

approximately 70 percent of Medicare beneficiaries are still enrolled in FFS. Therefore, we encourage the Working Group to consider the applicability of some of the proposals to reform Medicare Advantage (MA) and Accountable Care Organizations (ACO's) to the FFS program in order to improve care for beneficiaries with multiple chronic conditions in the near term.

Palliative Care Services in Multiple Settings

We recommend the Working Group consider policy options which would provide earlier access to hospice and palliative care across care settings for Medicare beneficiaries with multiple, serious chronic conditions. The core component and definition of palliative care is one in which a coordinated interdisciplinary team of providers – physicians, advanced practice nurses, physician assistants, nurses, social workers, chaplains and often other health care professionals such as pharmacists, and physical therapists work together with a patient's other health care providers on behalf of the patient *and* family. By coordinating the efforts of individual providers, palliative care not only streamlines the care seriously ill Medicare beneficiaries with multiple chronic conditions receive in the hospital, but also provides an opportunity to improve continuity of care for these patients when they are discharged. Yet the current Medicare infrastructure does not easily provide for palliative care in the community, other than within the Medicare Hospice benefit. This is a critical gap area, as many seriously ill patients with multiple chronic conditions do not have adequate support once they leave the hospital, putting them at risk for avoidable crises and readmissions. Expanding early access to palliative care and hospice for Medicare beneficiaries across settings – particularly outpatient clinics, long term care facilities, and the home – will address this gap by increasing care coordination among individual providers, and thus improving outcomes for patients with multiple chronic conditions. We strongly encourage the Working Group to continue to explore ways to ensure earlier access to hospice and palliative care for those beneficiaries enrolled in Medicare FFS, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans.

Policy Options – Targeting the Patient Population

Many of the policy proposals recommended by the Working Group requested comments on appropriate patient selection and/or criteria. The 2014 IOM Report found that within the costliest five percent of patients in the United States, approximately 40 percent have persistent high spending.⁸ Many are Medicare beneficiaries with serious, multiple chronic conditions, who will live an average of 3-5 years with their illnesses. Factors most predictive of persistent high risk and high utilization for these patients include functional dependency, pain, cognitive impairment, frailty, exhausted and/or stressed family caregivers, and behavioral health risks. These patients also often have a number of social risk factors including poverty, poor housing, food insecurity, lack of transportation, and literacy challenges. 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 additional services such as palliative care. We strongly recommend the Working Group consider using functional status as described

⁸ Institute of Medicine. 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

above as an alternative to the “numbers of chronic conditions” as functional status is a better determinant of overall health.

Specific Comments on Draft Policy Options

Section 1 – Receiving High Quality Care in the Home

Expanding Independence at Home Model of Care

The Coalition strongly supports expanding the Independence at Home (IAH)

demonstration into a permanent, nationwide program based on the results thus far. While we appreciate the Working Group’s question as to whether more data are needed to evaluate long-term performance, outcomes, and savings potential of the IAH model, we suggest that there is more than enough data from the Veterans Affairs (VA) literature, as well as a large body of evidence in medical and health policy literature, demonstrating the positive cost and quality outcomes of home-based primary care. Only by expanding the IAH beyond a demonstration program will the Center for Medicare and Medicaid Services (CMS) be able to fully quantify the long-term outcomes and savings potential. With this in mind, we offer the Working Group the following feedback on key elements of the model:

1. Practice Eligibility Criteria. For the purposes of the IAH demonstration, the practice eligibility criteria were appropriately designed to engage participants. In order to expand the program nationwide, however, the Working Group (and, by extension, CMS) may want to consider ways to include organizations that are already participating in other shared savings programs such as Accountable Care Organizations (ACOs) or the Medicare Shared Savings Program (MSSP).

We note that the model prescribes that an IAH practice should be multidisciplinary, and can employ or ensure access to a variety of providers (e.g., social workers, physician assistants, and pharmacists). **We support this criterion, and suggest that it would be beneficial to add chaplains to the list of possible team members.**

2. Beneficiary Eligibility Criteria. The original eligibility criteria for the IAH demonstration were effective because they successfully targeted the patients who most needed the intervention.⁹ Although it was a controversial decision, limiting patient eligibility to those who had experienced a post-acute episode of care essentially guaranteed that the patient had some degree of functional impairment. Furthermore, implementing clear and objective inclusion criteria reduced the likelihood of gaming the system. While there may be a need to revisit the beneficiary eligibility criteria once the program is expanded, the only potential change we would suggest is making the benefit available to Medicare Advantage (MA) beneficiaries, as well as FFS beneficiaries.

⁹ Patients were eligible for the IAH demonstration if they: 1) Had two or more chronic conditions; 2) Had Medicare FFS; 3) Needed assistance with two or more functional dependences; 4) Had non-elective hospital admission within the last 12 months; and 5) Had received acute or subacute rehabilitation services in the last 12 months.

3. Identification and Recruitment Efforts. The Working Group can strengthen the IAH model by encouraging CMS to develop strategies to help programs with case finding (e.g., proactively matching patients and providers). For instance, CMS could use its claims data to populate a list of high-risk patients which it could then provide to the practice.

In response to the Working Group's question on the use of HCC scores, we note that while these scores can be a helpful component of identifying high-risk patients, it is also critical to integrate claims-based means of identification. The challenge with using HCC scores alone in the IAH population is that doing so assumes a standard distribution of spending within a certain score. Yet because the IAH demonstration focuses on patients within an HCC score who have also had a utilization event within the past year, the patients will be skewed to the right (meaning the majority will have greater-than-average spending). As a result, when CMS computes the cost-savings calculation, it looks like the program actually has a higher cost when looking at HCC scores alone. Given this, we recommend that CMS exercise caution in interpreting the results if it continues to use HCC scoring to identify patients and evaluate program effectiveness.

4. Data and Feedback Reports. Prior to scaling up the IAH demonstration, it is critical that the Working Group review CMS's capacity to provide timely data back to participating providers. Some practices reported that it took up to two years to receive their first year cost and quality data, making it very difficult to "course-correct" or identify patients they need to target. This must be addressed before the program expands into a nationwide program.

5. Financial Incentives. A significant challenge with the initial phase of the IAH demonstration was the long delay between the launch of services and the delivery of financial information and payment. The lack of start-up funding, paired with no interim reporting or reconciliation meant that programs in this demonstration – even highly successful ones – did not see additional payments for approximately 21 months. This made it difficult in initial years for any of the programs to invest in the proper infrastructure to continue meeting IAH requirements; meanwhile, the patients they served were very costly. If Congress/CMS attempts to bring the IAH model to scale with the existing financial structure, it is likely that only commercial or for-profit practices will be able to participate; non-profit payers simply do not have enough capital. One potential solution may be providing an "advance" administrative payment to practices based on a portion of what their expected performance might be. This payment can then be subtracted (or paid back if unsuccessful) from resultant shared savings.

6. Quality Measures. The original quality measures for the demonstration were appropriate. While some providers pushed back on the measure that requires an in-home medication reconciliation within a certain timeframe post-discharge, this measure helped ensure that practices provided services every day of the week. This was critical given that the largest discharge day is Friday, and readmissions are most likely to occur within 72 hours of discharge. In general, providers in this demonstration supported the quality measures that enforced operational redesign, as they helped hold providers accountable.

While the Coalition urges the Working Group to consider these points if it decides to expand the IAH demonstration into a permanent, nationwide model, we want to reiterate our support for this evidence-based intervention. We encourage CMMI to continue working with existing participants and other interested stakeholders as it determines whether or not to proceed with the expansion, whether through its own authority or through the efforts of the Working Group.

Section 2 – Advancing Team Based Care

The Coalition appreciates the Working Group’s recognition in this section that Medicare beneficiaries can benefit from access to an IDT of health care providers, and that often access to this team is hindered due to reimbursement challenges. Hospice and palliative care is an excellent example of a team-based approach to care as core members of the team include physicians, nurses, social workers and chaplains and other health care professionals as needed.¹⁰ However, under the Medicare FFS, only physicians and other qualified health care personnel, such as advanced practice nurses, are reimbursed for their services, as determined by the Physician Fee Schedule (PFS). This means that the important work of social workers, chaplains and other personnel necessary to ensure care coordination and communication with patient and families is not directly reimbursed by Medicare FFS. Institutions desiring to provide this interdisciplinary care must find other ways to pay for non-physician providers, generally through a mix of hospital funding and philanthropic support. This can be extremely difficult for palliative care programs outside of large hospitals, thus limiting access to only a fraction of Medicare beneficiaries with chronic conditions who would benefit from interdisciplinary care. Therefore, we recommend the Working Group consider policy options which would expand reimbursement to include non-physician providers across care settings.

Providing Medicare Advantage Enrollees with Hospice Benefits

Hospice is an important Medicare benefit that provides palliative care for terminally ill patients who have six months or less to live. People who receive hospice are also no longer receiving conventional treatment for their underlying disease as a condition of receiving hospice benefits.

In the background of this subsection, the Working Group states that “Medicare Part A provides coverage for hospice care...if a beneficiary has been certified as having a life expectancy of six months or less, *has accepted palliative care instead of curative treatment*, and has signed a statement choosing hospice care instead of other Medicare-covered treatments for their terminal illness and related conditions.” Before commenting on the specifics of the policy option that follows, the Coalition would like to clarify that palliative care is not limited to hospice, and many patients receive palliative care *alongside* curative treatment. The phrasing used in the Policy Options Document implies that palliative care is an “either/or” option, which could result in discouraging providers from referring a patient with multiple, complex chronic conditions to palliative care because the patient is not dying. We respectfully request that the Working Group change the italicized portion of the sentence above to “...*has agreed to forego curative*

¹⁰ National Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care* 3rd edition 2013.

treatment...”, and incorporate palliative care into other proposed policy options that are not limited to beneficiaries with terminal illness who have elected hospice.

The Coalition strongly opposes the proposal to “carve in” hospice to Medicare Advantage (MA) programs due to the potential impact of such a massive policy change on current access to hospice and its negative impact on patients and families. Hospice has never been a covered benefit under MA. MA enrollees who elect hospice revert to fee-for-service when they elect hospice care, allowing them to access the hospice of their choice without any network limitations, additional costs, or pre-approval from the MA plan. This also helps streamline administration for hospices and ensure the integrity and quality of the hospice benefit. There is no evidence that MA beneficiaries endure any fragmentation or gaps in care.

The Chronic Care Working Group’s proposal to “carve-in” hospice under MA has many potential flaws. Based on hospices’ experience with private commercial insurance and Medicaid managed care, we are concerned that the proposal would negatively impact beneficiaries and families, hospices, and the Medicare program in the following ways.

Limiting Beneficiary Access to the Hospice of Their Choice.

If hospice is carved-in to MA, beneficiary access could be severely limited. Network adequacy requirements call for plans to contract with a bare-minimum number of providers based on statistical formulas and geography. Small, community-based providers, faith-based providers, and others might be left out, leaving beneficiaries and their families without access to those programs who might have served their loved ones or family friends. MA plans could also assign additional co-pays, deductibles, or prior-authorizations for both in-network and out-of-network hospice utilization, adding financial and bureaucratic stress and confusion to patients and their families during the most stressful of times.

And unlike typical MA enrollees, hospice patients do not have the luxury of waiting several months for an open-enrollment period to change plans to elect the hospice of their choice – more than one-third of hospice patients die within a week of electing hospice. More than half of all hospice patient die within three weeks of electing hospice care.

Diluting the Quality and Integrity of the Hospice Benefit

Hospice is a comprehensive, interdisciplinary benefit that meets *all* of the patient’s physical, psychological, spiritual and familial needs related to the terminal prognosis. The hospice interdisciplinary team (IDT) includes physicians, nurses, social workers, chaplains, volunteers, and other professionals as required by the patient and their families. Versions of a “hospice lite” model might become available in the community and could undermine the integrity of the hospice benefit, incentivizing plans to offer only a diluted and less effective set of services. It is easy to imagine a plan paying for pain relief therapies, but shortchanging the spiritual and emotional counseling that it is so important to patients and families at the end of life -- not only for the patient, but their families too.

Undermining the Autonomy of the Hospice Medical Director

Currently, hospices are responsible for all treatment and costs related to the patient's terminal prognosis, while still coordinating (but not paying for) care unrelated to the terminal prognosis. For example, a late-stage cancer patient might receive palliative care, social services, and family supports through hospice, but continue to see his/her ophthalmologist and get Part D coverage for glaucoma treatments. In these cases, the hospice medical director makes the determination regarding what is and is not related to the terminal prognosis, and unrelated care is covered under traditional fee-for-service.

We are concerned that MA plans would undermine the autonomy of the hospice medical director, and require hospices to pay for services/care that is unrelated to the terminal diagnosis. Hospices are not designed to assume risk for these costs; a shift of this nature could threaten the financial sustainability and viability of hospice programs.

Increasing the Administrative Burden for Hospice Providers

The proposal to carve-in hospice under MA would significantly increase hospices' administrative burden. Rather than a single claims process, hospices would be required to negotiate, manage and process claims from each MA plans with whom they contract. The carve in would create redundancy, complexity, and increased administrative cost for both hospices and MA plans, but adds very little value – either in terms of quality or cost of care – to the consumer or the taxpayer.

Threatening the Financial Stability of Hospice Programs

Finally, and most fundamentally, an MA carve-in would likely undermine the financial viability of many hospice programs. It is presumed that under this proposal, MA plans would be able to set their own (likely lower) reimbursement rates for hospice care. This change would come at a time when hospices have already faced multiple Medicare reimbursement reductions, a series of costly regulatory changes, and more recently, a complete overhaul of the Medicare hospice payment system. The cumulative effect of these changes has been a permanent reduction in hospice rates of more than 10 percent.

As the Working Group moves forward with this effort to improve care for Medicare beneficiaries with chronic conditions, we strongly urge you not to carve hospice into the MA program. This proposal would impair beneficiaries' access to quality hospice care, increase costs and administrative burdens for hospice programs, and is opposed by many stakeholders, including some of our nation's largest health insurance plans. However, if you do insist on proceeding with a hospice carve-in, it is critical that any policy change include safeguards designed to protect patient choice and the integrity of the hospice benefit. We also suggest mandating a pilot or demonstration phase, coupled with a robust evaluation, that would allow us to better understand the unique impact this change would have and make modifications to ensure the sustainability of hospice.

Expanding Access to Hospice and Palliative Care - Medicare Care Choices Model (CMMI)

Finally, as you deliberate over potential policy options to improve the care of Medicare beneficiaries with terminal illness, the Coalition suggests that the Working Group recommend

revising Medicare policy to allow Medicare beneficiaries who are receiving hospice care to also receive concurrent treatment if they so choose. This means that a beneficiary would retain the option of electing the Medicare or Medicaid hospice benefit at any time, regardless of whether they are in MA or traditional Medicare, including dual eligible individuals. Giving Medicare beneficiaries the choice to continue with treatment once they have elected to receive hospice services would likely increase early hospice enrollment, lead to greater use of palliative care services, and facilitate more cost-effective use of health care at the end of life. A targeted version of this benefit design applicable to beneficiaries who have received certain diagnoses, and who meet other qualifications, is currently being tested under the Center for Medicare and Medicaid Innovation's (CMMI's) Medicare Care Choices Model in select hospices. We urge the Working Group to consider a policy change that would implement this policy to apply program-wide. Giving Medicare beneficiaries the choice of whether or not to continue with treatment once they have elected to receive hospice services would likely lead to greater use of palliative care services, and a more cost-effective use of health care at the end of life.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The Working Group proposes establishing a new high-severity chronic care management (CCM) code that clinicians could bill under the PFS. The Coalition agrees with the Workgroup's acknowledgement that reimbursement under the newly established CCM code is insufficient for the complexity of treating patients with serious, complex chronic illness. Care coordination for these patients requires both specialized training in managing serious illness and interdisciplinary communication, as well as additional time beyond the 20 minutes that is covered by the original CCM code. The Coalition also agrees with the Working Group's assessment that the code providing enhanced reimbursement may not yield measurable improvements in quality if it is improperly defined. Therefore, we submit the following specifications for the group's consideration:

1. Patient Criteria. The Coalition recommends the Working Group use functional status as the primary criterion for patient eligibility rather than the number of chronic conditions. A patient could present with any number of chronic conditions (e.g., diabetes, high blood pressure, fibromyalgia) and yet have relatively straightforward needs in terms of care coordination. Therefore, functional status is a much better measure of the need for intensive care coordination; key indicators include limited function and/or cognition, frailty, poor quality of life for the patient and family, and evidence of social risk. Using this criterion will increase the likelihood that providers target the patients most likely to benefit from intensive care coordination and see commensurate improvement in the quality of care provided.

2. Types of Providers. As we described in a previous section, reimbursement for non-physician providers under the Medicare PFS remains a significant barrier, preventing patients with serious illness access to high-quality coordinated care from an IDT. **To help address this barrier, we recommend that the Working Group consider this proposed code be available to a wider set of providers.** This includes non-physician members of the palliative care team such as social workers, chaplains and clinical nurse specialists who traditionally cannot bill Medicare for

their services. Consideration of this change could promote greater utilization of the IDT and ensure that patients' biopsychosocial and spiritual needs are addressed.

The Coalition recommends that CMS temporarily institute this code in order to provide the Secretary of the Department of Health and Human Services (HHS) sufficient time to monitor and evaluate the code, and make any necessary adjustments.

Section 3 – Expanding Innovation and Technology

Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The Working Group is considering giving MA plans the flexibility to establish a benefit structure that varies based on individual enrollees and their health status regarding chronic conditions. This could include offering supplemental benefits specifically tailored to their chronic conditions. **The Coalition supports giving MA plans the flexibility to provide tailored benefits for its members with the goal of improving care for beneficiaries with multiple chronic conditions.** Often the “one size fits all” approach to delivering health care is neither appropriate nor beneficial. Again, our Coalition recommends the Working Group use functional status as a criterion for determining how the benefits should be tailored, rather than the number of chronic conditions alone. We urge the Working Group to specify that palliative care is an evidence-based intervention that should be made available to all Medicare beneficiaries with serious illness, and to consider making palliative care a required benefit. We also support the expansion of MA plan provider networks to allow for greater inclusion of provider and non-clinical professionals to address the holistic needs of the patient. **Finally, the Coalition supports waiving cost sharing requirements for this service and potentially other items and services related to the treatment of the chronic condition(s).**

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The Coalition is very pleased to see that the Working Group accepted our recommendation to consider social supports as a necessary component of care for Medicare beneficiaries with multiple chronic conditions. If implemented, this proposal would allow MA plans to offer a wider array of supplemental benefits (i.e., non-medical benefits such as social supports) than are permissible under current regulations. **We strongly support this proposal and suggest that the Working Group specify the following supplemental benefits are part of the new package: housing, food, transportation, support for co-pays and deductibles, reduced cost sharing, family caregiver and personal care support. We also encourage the group to expand the availability of these supplemental benefits beyond MA and into FFS.**

As the Working Group describes in the Policy Options Document, the current FFS model creates incentives to cycle patients through various care settings, even though most would prefer to stay in their homes. One of the factors that serve to keep patients with multiple chronic conditions institutionalized is the lack of appropriate social and personal care supports available in the home- and community-based settings. It is often the lack of assistance with activities of

daily living such as eating, bathing, and toileting that lead those with complex chronic conditions to utilize the health care system. There is increasing recognition of the role that social determinants of health play in overall health. CMMI recently announced a new demonstration project, the Accountable Health Communities Model, which will screen beneficiaries and link them to existing social services and supports in the community. We encourage the Working Group to monitor the results of this demonstration project and incorporate any lessons learned into this policy proposal.

Maintaining ACO Flexibility to Provide Supplemental Services

The Chronic Care Working group is considering clarifying that ACOs participating in the Medicare Share Savings Program (MSSP) may furnish a social service for which payment is not made under Medicare FFS. **The Coalition supports this proposal as it would allow ACOs the flexibility to provide social supports (such as those discussed in the previous subsection) in addition to traditional medical care.** We also recommend that palliative care services – including those services provided by non-physician providers – which may not be directly reimbursed under the Medicare program be promoted under this expansion.

Section 4 – Identifying the Chronically Ill Population and Ways to Improve Quality

Ensuring Accurate Payment for Chronically Ill Individuals

The Coalition strongly supports the Working Group’s consideration of a study examining whether the use of functional status would improve the accuracy of risk-adjusted payments. As we have already mentioned, the number of chronic conditions is an inferior predictor of the resources needed to care for the patient than issues such as function, cognition, frailty, and family and caregiver burden (as well as behavioral and mental health status). Therefore, we encourage the Committee to conduct this study, including examining the challenges in providing and reporting functional status information.

Developing Quality Measures for Chronic Conditions

The Coalition supports the Working Group’s goals to increase transparency and accountability through public reporting of aggregate quality and cost measures for all aspects of the health care system. The National Quality Forum’s (NQF) Measures Application Partnership (MAP) has also repeatedly cited palliative care as a high-leverage measure gap that needs to be addressed through the development and implementation of relevant quality measures. The Coalition is pleased that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to develop a formal plan for the development of quality measures that target existing gaps and authorizes \$15 million per year for each of fiscal years 2015 through 2019 to fund the development of physician quality measures. Nevertheless, we are seriously concerned by CMS’ lack of expediency in addressing this critical need. To date, CMS has yet to release any of those funds. **To ensure an adequate portfolio of quality measures that truly improves patient care, we urge the Senate Finance Committee to communicate with CMS and urge allocation of these funds and to fast-track the development of measures that focus on health care outcomes for individuals with chronic disease.**

However, we recommend a cautious approach to mandating specific quality measures for the complex chronically ill patient. Our collective experience developing measures in palliative and end-of-life care tells us that it is extremely difficult to develop feasible, valid, reliable, and actionable quality outcome measures for this complex patient population. Broadly, the Working Group must recognize that clinical outcomes measures similar to those looking at outcomes for a single condition (e.g., reducing HbA1c in diabetes patients) are lacking for people with serious illness, due to the multi-morbidity and multi-setting nature of the patient population. Moreover, the few palliative care outcomes measures that do exist may not perform well in the real world where the patient's condition and care needs are often rapidly changing. Take the following measures:

1. Concordance of Treatment with the Patients' Goals of Care. While this measure appears appropriate at face value, patients' goals often change based on context (e.g., the passage of time, change in their disease progression, etc.). Additionally, the field does not currently have a reliable way to capture this information and share it across settings. The measure concept makes good sense, but applying it as specified in the real-world clinical care of complex chronically ill patients could lead to significant oversimplification and misinterpretation.

2. Elimination of Symptoms Such as Pain, Shortness of Breath, Agitation, and/or Depression. Again, the measure concept is reasonable, but in reality, it is often neither safe nor possible to completely eliminate symptoms, for a whole host of reasons. All drugs have side effects, and patients may decide that the tradeoffs for relieving symptoms are intolerable (e.g., a patient would rather be in pain if it means staying conscious). Measures that address the processes of assessing and managing symptoms in accordance with the patient's needs and goals are more appropriate than simple outcome measures in this setting.

Therefore, while the Coalition supports the Working Group's proposal to have CMS develop measures that specifically pertain to the care of individuals with chronic disease, we encourage both entities to consider that in the realm of serious illness, process measures that are valid and actionable are often more effective in improving care quality than outcome measures. We would strongly support CMS testing measure concepts related to occurrence and documentation of patient and family communication about the goals of care; occurrence and documentation of a comprehensive symptom assessment; occurrence and documentation of family caregiver needs; and rate of referral to and length of stay in hospice for beneficiaries who die. In order to do this effectively, the Working Group and CMS must allocate enough resources to ensure that these measures are tested and validated across patient populations and care settings. In the meantime, the Coalition encourages the Working Group and CMS to coordinate its efforts with the NQF's recently announced Palliative and End-of-Life Care Project. When seated in mid-February 2016, the Standing Committee for this project will evaluate new and previously endorsed measures related to palliative and end-of-life care.

Section 5 – Empowering Individuals & Caregivers in Care Delivery

Encouraging Beneficiary Use of Chronic Care Management Services

The Working Group is considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code described above. **The Coalition is strongly supportive of this proposal and removing beneficiary cost sharing to minimize any barriers to using chronic care management services.**

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer’s/Dementia or Other Serious or Life-Threatening Illness

The Coalition supports the concept of reimbursing providers for time associated with discussing diagnoses, treatment and care plans for those beneficiaries diagnosed with life-limiting or life-threatening illness. However, given the number of recent proposals and initiatives surrounding advance care planning (ACP), the **Coalition wants to emphasize that we are primarily concerned with the need to strengthen both the *quality* and the *quantity* of clinician-patient communication for patients with multiple, serious chronic illness.** The aim of goals of care conversations is “to develop a coherent care plan that meets the patient’s goals, values and preferences”;¹¹ however, the progression of serious illness means that it is often necessary to have multiple conversations over time to revisit the care plan and make changes as appropriate. In order to ensure that these visits have a meaningful impact on quality of life for patients diagnosed with serious illness, it is critical that the conversations include the following components:

1. *Discussion of what matters most to the patient as the disease progresses, and a clear explanation of what the disease progression is going to look like;*
2. *Financial planning;*
3. *Assessment of home safety;*
4. *Assessment of the physical, intellectual, and financial capacity of the family and caregivers to handle the responsibility of caring for someone with serious illness; and*
5. *Appointment of a surrogate.*¹²

The Coalition feels strongly that all Medicare beneficiaries diagnosed with serious illness should be given the opportunity to have these conversations with an IDT, regardless of diagnosis or prognosis. If the Committee moves forward with this proposal, the Coalition strongly encourages this service include diagnosis of any serious or life threatening illness but strongly cautions against naming specific diseases as rare, very serious diseases will be inadvertently left off the list. In fact, having these conversations early and often will help patients and their families know what to expect, and will allow them as much dignity and autonomy as possible while they manage their conditions. Furthermore, helping patients develop a care plan

¹¹ Institute of Medicine. 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

¹² Morrison RS, Meier DE. Palliative care. *N Engl J Med.* 2004; 350:2582-2590. doi: 10.1056/NEJMcp035232

based on the likely evolution of their disease(s) (and ensuring there are proper systems in place to give effect to the patients' wishes) will reduce the likelihood that they experience avoidable crises, 911 calls, ED visits, and hospital admissions – resulting in overall cost savings to the health system.

Conclusion

The National Coalition for Hospice and Palliative Care, and our member organizations, thank the Senate Finance Committee Chronic Care Working Group for your leadership and 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. We would be pleased to have the opportunity to meet with you again in the coming months. 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

MEMBER ORGANIZATIONS IN THE NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

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

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

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

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

[Hospice and Palliative Care Nurses Association \(HPNA\)](#)

[National Hospice and Palliative Care Organization \(NHPCO\)](#)

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

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