



**Comments on the Bipartisan Chronic Care Working Group Policy Options Document
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Dear Working Group,

Many thanks for the vital work you are doing, and for the opportunity to offer comments. We are an independent health system in upstate New York that has been active in disease state management, hospice, and palliative care for many years now. We operate an acute care hospital, skilled nursing facility, home health program, primary care services (PCMH recognized), and a host of life transitions, care coordination, and population health initiatives. We also partner in a Medicare ACO and our state’s DSRIP program. We have provided an inpatient palliative care consultation service since 2008 (operated by The Community Hospice, Inc.) and an outpatient palliative home care service since 2013 (operated by our affiliate, the Visiting Nurse Service of Northeastern New York). We hold fee-for-service, advantage, gain sharing, and capitated contracts with multiple payors, including Medicare. We appreciate the opportunity to comment on the important work you are shepherding for our country and our most vulnerable citizens. We wholeheartedly support the comments submitted by the *National Coalition on Hospice and Palliative Care*. However, given our specific experience in population health management using a broad-based community-centered ambulatory palliative home care service, we would like to offer the following three Comments. Our goal is to make palliative home care available to all chronically ill populations, including traditional FFS, Advantage, and ACO. We, therefore, suggest that you expand your study and policy considerations to the entire patient population, and that you add to your considerations the designation of a national palliative care benefit.

Comment 1. Receiving High Quality Care in the Home

Coordinated, team-based care can improve health outcomes for seriously ill Medicare beneficiaries, including dual eligibles, those with significant social, behavioral, and mental

health determinants, and those with co-morbidities. However, it is not feasible to expect a scalable expansion of the IAH demonstration model whereby large, nation-wide numbers of individual primary care practices buy in. In our relatively small service area of northeastern New York, there are over 100 primary care practices. To go to a national roll-out to even 15% of primary care practices will be daunting. We recommend a concurrent and more scalable approach: *that traditional home health agencies be incentivized to expand to provide coordinated, team-based care*, particularly as affiliates of Patient Centered Medical Homes. This recommendation is based on the palliative homecare advanced illness programs that have been successfully demonstrated by multiple health systems to date, including our own Care Choices Program (*Journal of Hospice and Palliative Medicine*, Dec., 2015, DOI: 10.1177/1049909115617139). This program reduced hospitalizations by 69%, working under the direction of primary care and specialist physicians across dozens of practices. By adding appropriate palliative care components (medical director, palliative trained nurses, social workers, chaplains, volunteers, and 24/7 visit capability), *outpatient palliative home health teams* can provide coordinated, team-based homecare over a large service area for a significant number of primary care practices at the same time. This is already happening in many locales, funded by capitated arrangements with MCOs and demonstration money. The bump-up funding for this model could be a simple capitated per diem, like the Hospice Routine Home Care Rate, but much less. This approach would be rapidly scalable and measurable. Some adjustment to the traditional home health admission criteria may have to be made for the advanced illness population (e.g., replacing the “skilled need” requirement with a “palliative performance scale” score in order to recognize that functional status – as in activities of daily living – is a greater driver of utilization in chronically ill populations). ACOs should be given the flexibility to deliver this model of care on capitated, value-based, and shared savings arrangements with home health agencies.

This recommendation recognizes the significance of palliative care as an evidence-based model of clinical care for patients with life threatening illnesses. The Policy Options Document only mentions palliative care in the context of Hospice (page 8). While the type of care Hospice provides is indeed palliative care, the larger application of palliative care is upstream (earlier than end-of-life) in advanced illness populations: those chronically ill patients whose disease is progressing. These are the largest consumers of health care spending and the frequent flyers to Emergency Rooms. Please note that the WHO World Health Assembly has made a priority recommendation that palliative care be integrated into all national health structures. Please review the full Resolution attached, and consider it an integral part of this Comment, particularly the evidentiary data referred to in the opening sections (WHA 67.19 May 24, 2104). Multiple United States’ medical associations have issued clinical guidelines recommending palliative care be provided concurrent with standard care, earlier than end-of-life. One example is the American Society of Clinical Oncology recommendation for the provision of palliative care immediately upon diagnosis of metastatic cancer (ASCO, 2012).

This recommended intervention also can be applied to complement and coordinate with other Policies Under Consideration:

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

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

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

Maintaining ACO Flexibility to Provide Supplemental Services

Comment 2. Providing Medicare Advantage Enrollees with Hospice Benefit.

We agree with other hospice and palliative care comments that there are significant risks to terminally ill patients and to hospice providers themselves in converting the current “carve out” to a “carve in”. Those risks should deter any wholesale conversion, and at best invite a well-thought out demonstration project. We encourage a demonstration project not only so that risks are properly assessed, but also that any positives can be highlighted. A potential positive is the better integration of hospice into emerging health delivery systems and population health initiatives, whereas today hospice is a stand-alone program with difficult and often deterring criteria for patients and families to accept.

A better approach to addressing some of the access issues relate to late use of Hospice would be to re-structure the statutory Hospice benefit itself. Yes, the current reimbursement structure has recently been overhauled, but this does not address the existing barriers to hospice for advanced illness patients with multiple co-morbidities and social and behavioral determinants. We recommend that the existing Part A benefit be re-structured to revise the admission criteria related to the current barriers of prognosis and waiver of all other Medicare benefits related to the terminal illness. Using a more appropriate functional status assessment as a key criteria would recognize the need for palliative care much earlier than the current hospice length of stay, and eliminate the current dis-connect between standard care and end-of-life care for Medicare beneficiaries. A transitional model, rather than a disconnected either/or model, will better serve the population, foster shared medical decision-making, allow for more frequent and in depth goals of care conversations, and result in higher and earlier awareness of the true wishes of patients and families as well as the reality of end-of-life status when that time comes.

Comment 3. Developing Quality Measures for Chronic Conditions

Just as “Hospice and end-of-life care” is a related Topic Area bullet (p. 22), so too should be palliative care. One possible bullet to be added: “Palliative Care, as part of advanced illness management, including patient-centered medical decision-making, pain and symptom management, caregiver support, communication skills, advance care planning, frequent goals of

care discussions, interdisciplinary care, care coordination, and rigorous attention to the relief of suffering and enhancement of quality of life.” There is a large body of evidence to assist CMS with the development of applicable and do-able measures for palliative care. We encourage this study and the development of measures.

Thank you again for the opportunity to comment, and we look forward to working with you and many colleagues on the next steps.

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