



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically to chronic_care@finance.senate.gov

January 29, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

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

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
475 Russell Senate Building
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

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

On behalf of the nearly 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to provide input on the Bipartisan Chronic Care Working Group Policy Options Document released this past December. We continue to support the Senate Finance Committee's commitment to this issue and the formation of the Working Group to address policies needed to improve outcomes for Medicare beneficiaries with chronic conditions.

AAHPM is the professional organization for physicians specializing in hospice and palliative medicine, and our membership also includes nurses and other health and spiritual care providers committed to improving quality of life for seriously ill patients and their families. AAHPM's members focus their practice on caring for patients with serious or life-threatening illness—and their families—through the end of life. We believe that including the needs of these patients in this current discussion will be critical to addressing Medicare's chronic care management issues overall.

As we have highlighted previously, abundant data show that patients with multiple chronic conditions are among Medicare's highest-need and highest-cost beneficiaries and thus provide us with significant opportunities to improve both care quality and care value. Studies have demonstrated that high-quality palliative care (including care under the Medicare hospice benefit) can improve patient symptom

burden and quality of life, lessen psychological suffering, ease caregiver stress, improve patient and family satisfaction with care, reduce cost compared to usual care, and even prolong survival.^{1,2,3,4,5} Our members see these benefits every day in their work on the front lines of American health care, which is why we support your efforts and believe our members can play a critical role in addressing Medicare beneficiaries' chronic care needs and improving their care coordination in this context. Indeed, the National Priorities Partnership has identified palliative and end-of-life care as one of six national health priorities that have the potential to create lasting change across the healthcare system.

Our responses below follow the order of the December 2015 Policy Options Document.

RECEIVING HIGH QUALITY CARE IN THE HOME

Expanding the Independence at Home Model of Care

We appreciate the Working Group's inclusion of an expansion of the Independence at Home model and request for comment on whether the program needs modification. In its discussion of the data available on the successes of the Independence at Home model, the Working Group notes the first practice year data and preliminary performance results were issued only six months ago. However, we would like to remind the Working Group and stakeholders that the model has its roots in the Department of Veterans' Affairs (VA) Home-Based Primary Care Program, which has yielded similar positive results: high patient satisfaction, fewer emergency department visits, and lower costs.⁶ Many AAHPM members have had extremely positive experiences with the VA's Home-Based Primary Care Program and can attest to its value.

In addition, we believe that one of the many important characteristics of the Independence at Home model is that it incorporates caregiver support. We discuss this in more detail below but, by bringing greater attention to patients' caregiver needs, we can better connect the network of providers needed for care coordination programs that truly improve outcomes and increase patient satisfaction.

AAHPM supports the expansion of the Independence At Home model of care and encourages the Working Group's adoption of such a policy going forward.

The Working Group has also requested input on what additional information would be helpful in evaluating the performance, outcomes, and savings potential of the Independence at Home model. Given the demonstrated value of hospice and palliative care as well as AAHPM member experiences with the VA Home-Based Primary Care Program, we believe the committee should include metrics related to:

¹ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small cell lung cancer. *NEJM* 363(8):733-742 (2010).

² Connor SR, Pyenson B, Fitch K, et al. Comparing hospice and nonhospice patient survival among patients who die within three-year window. *J Pain Symptom Manage*. 2007;33(3):238-236.

³ Hanson LC, Usher B, Spragens L, Bernard S. Clinical and economic impact of palliative care consultation. *J Pain Symptom Manage*. 2008;35:340-346.

⁴ Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783-1790.

⁵ Penrod JD, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med*. 2010;13(8):973-979.

⁶ Edes T, Kinosian B, Vuckovic NH, et al. Better access, quality, and cost for clinically complex veterans with home-based primary care. *J Am Geriatr Soc* 2014;62(10):1954-61.

- Access to hospice services, including length of stay in hospice care
- Frequency of advance care planning services and the extent to which care delivered was consistent with documented preferences
- Patient and family experience of care

ADVANCING TEAM BASED CARE

Providing Medicare Advantage Enrollees with Hospice Benefits

Citing concerns related to disruption in care and fragmented care delivery, the Working Group is considering requiring Medicare Advantage (MA) plans to offer the hospice benefit that has been provided under traditional Medicare. While we appreciate the Working Group's commitment to care coordination, we are concerned that removing the benefit from traditional Medicare by "carving in" hospice to MA plans would create access difficulties and the precise disruption of care that the Working Group seeks to avoid.

First, we are extremely concerned that MA plans could "unbundle" the care and services that are currently provided as part of the traditional Medicare hospice benefit. Hospice and palliative medicine physicians have a long tradition of providing interdisciplinary, team-based care for patients with serious illness and their families. The team-based approach is further reflected in the large investment in infrastructure that must be made to provide such care, including robust interdisciplinary staffing with physician, nursing, social work and spiritual care professionals, in addition to home-health aides. In much the same way that primary care medical homes must invest in information technology, training, and accreditation, hospice and palliative medicine practices must ensure that the infrastructure exists to efficiently provide team-based care to patients with significant physical, psychological, interpersonal and spiritual needs. This also requires a strong commitment to interdisciplinary community care. We are concerned that MA plans that have not been involved in administering a hospice benefit and are unfamiliar with the interdisciplinary approach and infrastructure needs could undermine the resources needed to offer a high-quality hospice program to Medicare beneficiaries.

Second, we are concerned that requiring hospice providers to separately negotiate with each MA plan will increase programmatic administrative burden and could lead to a disruption of services to patients. Furthermore, given the many concerns that are known related to MA plans and the adequacy of their provider networks, we do not believe that the Working Group should subject the population of patients who require hospice services to the limited provider networks that can be offered by MA plans. Such restrictions not only drastically narrow beneficiary choice, but also risk diminishing access to vital, high-value services through end of life.

Third, we fear that MA plans might act on incentives to reduce costs by limiting access to services, inappropriately reducing the overall quality or quantity of care delivered to patients eligible for hospice, or shifting some costs to patients or hospices. For example, MA plans might offer a more limited set of services than patients are entitled to within the existing Medicare hospice benefit (as already occurs with the Program for All-Inclusive Care of the Elderly program) due to concerns about the cost of providing both hospice and curative care. Plans could also assign additional co-pays, deductibles, or prior authorization requirements for hospice that would only lead to patients and families experiencing additional stress, confusion, and financial burden. MA plans might also look to

shift to hospices the cost of care unrelated to a patient's terminal prognosis. (Hospices are currently responsible for all treatment and costs related to a patient's terminal prognosis, and they coordinate—but do not pay for—care that is unrelated.) Our concern is that this holds the potential to undermine the clinical judgement and autonomy of hospice medical directors who, with the interdisciplinary team, assess and address the complexity and multiplicity of chronic illnesses that are present in beneficiaries electing hospice and the extent and nature of suffering associated with these individuals' non-terminal morbidities in order to determine on a case-by-case basis what is related and what is not and develop a patient's care plan accordingly. Overall, seriously ill Medicare beneficiaries are a vulnerable population that is often functionally impaired, experiences numerous unmet needs, suffers with a high symptom burden, and requires many health care resources. AAHPM believes this proposed policy will change the financial incentives for this vulnerable population, and it risks compromising their care though end of life.

Therefore, **AAHPM is opposed to the proposal to shift (or “carve in”) the Medicare hospice benefit to Medicare Advantage plans.** While we strongly encourage the Working Group to eliminate this proposal, if it does proceed with its inclusion we recommend that it be first attempted as part of a limited pilot. In addition, this shift in policy would demand valid and actionable quality measurement to guard against the perverse incentives described above and to ensure transparency and accountability. In particular, we must ensure that what matters to seriously ill persons and their family not only counts but is actually “counted.”

Experience of care surveys are one particularly useful tool for identifying concerns about quality of care and informing quality improvement. **It is critical that any legislation that carves hospice into MA includes funding and a provision for CMS to implement a population-based, post-death survey that measures the degree to which Medicare beneficiaries enrolled in an MA plan receive high-quality care at the end of life.** Family and caregiver experiences of care are often the most important indicator of quality of care at the end of life since dying patients may not be able to describe their own experiences. Surveys of bereaved family members also are an efficient and valid means of studying decision making and quality of end-of-life care, avoiding the difficult and costly problem of prospectively identifying terminally ill patients. In addition, this approach minimizes the bias of missing interviews among the sickest patients who are unable to be interviewed in the last weeks of life, and it creates a method for comparing results across different settings of care and payment models. Overall, a post-death survey represents an important measure to ensure that care is consistent with patient informed preferences and goals of care.

While there is much room for growth and evolution in regards to measures that accurately evaluate the quality of hospice care, there are other existing measures that could potentially be adapted to monitor the impact of this shift in policy on patient care. These include measures previously endorsed by the National Quality Forum⁷, as well as measures included in the Hospice Item Set. While these measures are not perfect, they can serve as a foundation for tracking the quality of care of this population and eventually developing more appropriate measures.

While we need to develop quality measures that are cross-cutting and can be applied to all patients with serious illness, it is also important that measurement is broken down by disease category to ensure that all patients are receiving high quality care. For example, the hospice needs for cancer patients can be

⁷https://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Palliative_and_End-of-Life_Care_Measures.aspx

different than those living with dementia, and quality measures should track whether those needs are being met across populations.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations

The Working Group has requested input on the extension or a permanent authorization of Special Needs Plans (SNPs), which allow MA plans to provide coordinated care and target enrollment for particular populations. The Working Group is requesting input on SNPs that enroll beneficiaries in need of institutional level of care, SNPs that enroll beneficiaries eligible for both Medicare and Medicaid or dual eligibles, and SNPs that enroll beneficiaries with certain chronic diseases.

AAHPM is generally supportive of programs targeted to improve the delivery of care and outcomes for these patient groups. In hospice and palliative medicine, we are particularly aware of the increased challenges in care delivery and coordination of care for dual-eligibles, both in terms of the care needs of these patients as well as the costs associated with the delivery of that care. We believe that there are particular challenges to providing integrated care that warrant programs targeted to improve the care and reduce costs associated for these patients and encourage Working Group examination of extending SNPs.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

We are very appreciative of the Working Group's willingness to engage in a discussion about establishing a new high-severity chronic care management (CCM) code that clinicians could bill under the Medicare Physician Fee Schedule. AAHPM has been integrally involved in the work done to date to establish reimbursable services via chronic care management codes. One such code, CPT code 99490 for chronic care management, is cited in the Policy Options Document. AAHPM is supportive of the Centers for Medicare and Medicaid Services (CMS) policy to implement and reimburse CPT code 99490. However, we also agree with the concern expressed in the Policy Options Document that 99490 was implemented in a manner that does not address beneficiaries with *complex* chronic care management needs. As noted, these beneficiaries have "complex, time intensive, and labor intensive care management needs" that we do not believe are addressed by codes currently reimbursed by Medicare.

As a step in the right direction, AAHPM strongly supports CMS recognizing 99487, an existing CPT code for complex chronic care management. This code covers 60 minutes of clinical staff time (as opposed to 20 minutes for 99490), which reflects the greater intensity of services needed by many more seriously ill beneficiaries. As Medicare currently does not make payment for this code, we would request that the Working Group advocate for CMS to provide this important service.

We continue to believe, however, that new policies (and potentially codes) must be implemented to adequately reimburse practitioners providing services to more complexly ill beneficiaries with serious, life-limiting illness. AAHPM members care for the sickest among these patients who frequently have multiple chronic health care conditions, are often managed by medications with a high risk of interaction and adverse events, and are more likely to have an emergency department visit or hospitalization. They require high-contact, interdisciplinary, uniquely individualized care management to maximize quality of life, limit low-value interventions (like avoidable hospitalizations), and deliver the best care possible. Numerous studies have demonstrated that providing such care both improves care quality and lowers cost.

In addition, we ask that the Working Group also address previous attempts to tie utilization of CCM codes to the use of certified electronic health records (EHRs). We remain concerned about emphasis on the use of EHRs when interoperability standards have not been developed, adopted, and incorporated into certification requirements for EHR technology. Until these issues are resolved, we do not believe it should be required that practices be meaningful users of EHRs in order to be reimbursed for care coordination services.

The Working Group has solicited feedback on additional criteria to be incorporated into such a code. AAHPM believes the creation of a code should consider several principles:

- Many coordination services do not include a face-to-face visit with the patient or family but involve significant communication between health care providers, analysis of significant amounts of data, and often complex medical decision-making, which should be valued.
- The intensity of care coordination will vary with an individual patient's medical condition and needs and might not follow established time frames utilized by current care management codes, transitional care management codes, or global periods. Given this, payment should include the flexibility to address these uncertainties.
- The target population for this service should be those at highest risk for complications (including re-hospitalization and death), which maps closely to the patient population cared for by most palliative care providers. These include beneficiaries with:
 - Multiple chronic conditions whose collective burden places them at risk for significant functional decline, hospitalization or death
 - A significant dominant illness (like advanced cancer, heart failure or dementia) that places them at risk for significant functional decline, hospitalization or death
 - Significant functional impairment, irrespective of diagnosis, that places them at risk for hospitalization or death

In summary, **AAHPM encourages the Working Group to pursue the establishment of new high-severity chronic care management codes acknowledging that complex chronic care management for patients at highest risk requires a more resource-intensive set of interventions than standard chronic care management.**

EXPANDING INNOVATION AND TECHNOLOGY

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

AAHPM shares the Working Group's goal of innovating MA benefit design to meet the needs of chronically ill Medicare beneficiaries—as detailed previously, our members focus their practices on the sickest among these patients. In considering such benefit adaptation, we would prioritize the following:

- Aligning benefit design with patient and family need, recognizing that patients with more chronic illnesses require higher intensities of service
- Ensuring access to essential services (like hospice care, as detailed above)
- Providing incentives to create necessary infrastructure (like home-based primary care and home-based palliative care, as detailed above)
- Eliminating (or capping at nominal amounts) copays or coinsurance for high-value services like high-intensity care management and home-based interdisciplinary care

We would also like to ensure that any proposed benefit adaptations be carefully considered to prevent any incentives for MA plans to restrict access to valuable services by beneficiaries with chronic illness.

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

The Working Group has requested input on allowing MA plans to offer a wider array of supplemental benefits, which could include medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. **AAHPM is extremely supportive of this proposal.**

While we believe that these concepts should also be incorporated into fee-for-service Medicare, we do believe these concepts should be extended in any flexibility given to MA plans:

- ***Interdisciplinary Care:*** The Policy Options Document appropriately identifies social services as those that should be available. Hospice and palliative medicine physicians have a long tradition of providing interdisciplinary, team-based care for patients with serious illness and their families. This also requires a strong commitment to interdisciplinary community care, which includes coordination with a patient's primary care physician. Social and spiritual services are important pieces to the full continuum of care from which patients benefit and should be reflected in Medicare (fee-for-service and MA alike) coverage and payment policies. In addition, ensuring rules allow for nurse practitioners employed by hospices (even when not serving in an "attending" capacity) and physician assistants employed by hospices to submit claims for services provided to patients would reflect the benefit patients receive from the care delivered by these professionals.
- ***Medical Team Conferences:*** CPT codes already exist that describe these types of services. Team-based care simply cannot exist without medical team conferences. The failure to compensate these services is a major impediment to move toward more team-based care. As health care options and approaches have multiplied exponentially, a team-based approach helps ensure that a patient's care is being coordinated among numerous services and professionals.
- ***Telephone Services:*** These services can be a valuable and efficient alternative to face-to-face visits for certain patients and in appropriate circumstances. Physicians simply do not have the time or resources to engage in these services unless they are compensated.
- ***Analysis of Computer Transmitted Data:*** These are non-face-to-face services that require time and effort on behalf of physicians and other health professionals and which should be compensated.

IDENTIFYING THE CHRONICALLY ILL POPULATION AND WAYS TO IMPROVE QUALITY

AAHPM thanks the Working Group for putting a national spotlight on the ongoing lack of measures that can be used to adequately monitor the quality of care for individuals with multiple chronic conditions. We remind the Working Group how much work remains to be done on this front. Not only do we lack measures in this realm, but our nation has yet to even reach consensus on how to define a denominator that most appropriately captures the chronically ill population.

Recognizing these serious gaps, AAHPM, in collaboration with the Hospice and Palliative Nurses Association, recently set off to identify a portfolio of scientifically rigorous quality measures that would matter most for patients with palliative care needs across all settings. (See *Measuring What Matters* at <http://aahpm.org/quality/measuring-what-matters>). Unfortunately, after a thorough analysis, we found that there are more gaps in measurement in this area than there are fills. We also found broad

inconsistencies regarding which measures are required by various groups from accrediting organizations to payers. As the population ages and the demand for this type of care grows, the ability to accurately and meaningfully assess quality throughout the country and across care settings is increasingly important.

As such, AAHPM 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's 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 Congress to put pressure on CMS to expeditiously allocate these funds and to fast-track the development of measures that focus on health care outcomes for individuals with chronic disease.**

Per the Working Group's recommendations, AAHPM wholeheartedly supports the prioritization of measure development work in the following areas:

- Patient and family engagement, including person-centered communication, care planning, and patient-reported measures
- Shared decision-making
- Care coordination, including care transitions and shared accountability within a care team
- Hospice and end-of-life care, including the process of eliciting and documenting individuals' goals, preferences, and values; quality of life; receipt of appropriate level of care; and family/caregiver experience of care
- Alzheimer's and dementia, including measures for family caregivers, outcomes, affordability, and engagement with the healthcare system or other community support systems

On the issue of dementia specifically, the current Hospital CAHPS survey is flawed in that it is based on a sample of live discharges and fails to capture patients who die in the hospital. It also does not include individuals discharged to a skilled nursing facility. As a result, the survey often fails to account for how dementia patients fare in the hospital. It is critical that CMS expand this survey so that it collects information about this vulnerable patient population, but doing so will require a significant investment of resources.

We also remind the Working Group of the importance of ensuring that measure development is evidence-based and clinician-led. It is critical that CMS partner with medical specialty societies, and AAHPM stands ready to lend both clinical and technical expertise to these efforts.

EMPOWERING INDIVIDUALS AND 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 potential code discussed that would be directed at more complex patients in need of chronic care management. **AAHPM is very supportive of this proposal, and we encourage the Working Group to seek input on additional services to which a copayment waiver might appropriately apply (e.g. the medical team conferences or data analysis services described above).**

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

AAHPM is very grateful that the Working Group has highlighted the need to address care planning for patients who are diagnosed with a serious, life-threatening illness. Our members focus their professional lives on caring for such patients and know well the spectrum of needs that arise in the wake of such an event.

We have several comments and concerns, however, that we would urge the Working Group (and, subsequently, CMS) to consider, if such a service were to be created:

- Creating a “one-time visit” code may unintentionally fragment care. Making payment available for a one-time visit may incent providers who are not otherwise involved in a patient’s care to deliver the service and take advantage of the payment. Such “one-off” care planning services risk not being coordinated with a patient’s ongoing care and may add much more confusion than value. This risk may be highest among the most vulnerable beneficiaries—including those with advanced frailty or cognitive impairment—who are currently targets for many types of exploitation. If such a code were to be created, we would recommend that CMS establish specific code requirements to ensure that the service is coordinated within the overall plan of care. AAHPM would welcome the opportunity to assist the Working Group and/or CMS in developing such requirements.
- It is unclear how adding a “one-time” care planning visit would add value to existing services. CMS already makes payment on several codes that support the care planning services, including the Advance Care Planning codes, Care Plan Oversight codes, Evaluation and Management (E/M) prolonged services codes and, to some degree, Transitional Care Management codes. There are also several existing CPT codes for valuable interdisciplinary services (including the team-based conference code we reference earlier) which CMS currently does not reimburse but, if paid, would support higher value care planning. We recommend that the Working Group engage stakeholders (including CMS) to identify and support existing/ongoing opportunities to improve payment for care planning and coordination.
- Valuable care planning services should not be limited to beneficiaries with specific diagnoses. The Working Group requested specific feedback on the types of diagnoses that may be serious or life-threatening and the extent to which the nature of the services delivered should be tailored to specific condition. We appreciate the nuance in these questions, as our members deliver highly personalized care to individual patients based on their individual needs, and those needs can vary based on diagnosis. However, creating diagnosis-specific service eligibility or requirements would both create a significant administrative burden for providers and, more concerning, limit access to valuable services for patients with diagnoses that are not included. Should this service be established, we recommend that the Working Group instruct CMS to describe the target population in terms of patient-oriented characteristics (functional status, unmet needs, expected course of illness) rather than specific diagnosis.
- Care planning services should be integrated into any chronic care management services. The Working Group asked for specific feedback on interaction of this code with the proposed high-severity chronic care management (CCM) code. We strongly support integrating care planning into any high-severity CCM services and would encourage the Working Group and CMS to reimburse any high-severity CCM codes sufficiently to support this vital function. AAHPM again stands ready to work with you in this important endeavor.

OTHER POLICIES TO IMPROVE CARE FOR THE CHRONICALLY ILL

Increasing Transparency at the Center for Medicare & Medicaid Innovation

The Working Group is considering whether CMMI models should be subject to rulemaking. AAHPM would be concerned about such a change in that it may not allow CMMI to be as nimble as it needs to be. However, we appreciate the attention to transparency as we believe it is critical to ensuring that evaluations are rigorous and that models adopted as success are measuring the right things and driven primarily by quality rather than cost savings. Engaging stakeholders when designing evaluations and in ongoing measurement efforts is key to such a transparent process.

We thank you again for the opportunity to provide input on these policy options and applaud the focus you are bringing to coordinating care for those living with multiple chronic conditions. We hope the Working Group will be sure to engage hospice and palliative care providers in its ongoing discussions and policy development, as we offer a valuable and unique perspective on coordinating all of a patient's needs at the most clinically vulnerable moments of their lives. Our Academy's physician leaders would certainly welcome any opportunity to provide additional information or comment. Please address questions to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



Christine S. Ritchie, MD MSPH FACP FAAHPM
President