



AMERICAN ACADEMY OF  
HOSPICE AND PALLIATIVE MEDICINE

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

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 this opportunity to provide input on improving our health care system to address the needs of some of the most vulnerable in our society. We applaud the Senate Finance Committee's commitment to this issue and decision to form a Working Group specifically to address policies needed to improve outcomes for Medicare patients 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.**

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.<sup>1,2,3,4,5</sup> Our members see these benefits every day in their work on the front lines of American health care,

<sup>1</sup> 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).

<sup>2</sup> 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.

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

<sup>4</sup> 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.

<sup>5</sup> 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.

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 highlighted 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.

AAHPM's responses below follow the order of issue areas listed in the Senate Finance Committee Working Group's request for comments.

### **1. Improvements to Medicare Advantage (MA) for patients living with multiple chronic conditions.**

Many MA plans have been leaders in recognizing the value of incorporating hospice and palliative care into plan benefits and appropriately reimbursing for those services to reflect the resources required to deliver palliative care appropriately and efficiently. One such program is the Advanced Illness Service implemented by Highmark (Blue Cross Blue Shield of PA). Highmark has contracted with local hospices to provide MA patients with advanced illness up to ten visits for "concurrent care," regardless of patients' eligibility for traditional hospice services or their receipt of other services (hospitalization, disease-oriented therapy, etc.). By taking these steps, Highmark has recognized that allowing patients to access concurrent care provides an opportunity for better management of patient care while leading to better outcomes and increased patient satisfaction. Emblem Health in New York has contracted with ProHEALTH Care Support to provide advanced illness care to the sickest 5 percent of MA patients through a home-based palliative care program. These patients have access to doctors, nurses and social workers who make house calls and provide 24/7 coverage.

*AAHPM recommends that the Working Group (1) support efforts to identify other MA initiatives that appropriately value chronic care management (including palliative care programs), (2) provide resources to distribute those best practices, and (3) ease additional plan adoption of those types of innovative programs.*

### **2. Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings Program, piloted Alternative Payment Models (APMs) currently underway at CMS, or by proposing new APM structures.**

We support the Working Group's focus on APMs, in particular, because we believe that APMs (existing and potential) provide the best opportunity for the Medicare program to support *all* of the services necessary for providing patients with optimal care: getting the right care to the right patients at the right time. Currently, many Medicare payment mechanisms will either not reimburse for or under-reimburse services that are critical to unlocking the potential of chronic care management. These services should include community-based, highly accessible support for:

- Pain and physical symptoms
- Psychological and emotional distress
- Spiritual needs
- Caregiving gaps
- Advance care planning to match care delivered with achievable patient and family goals

Key to the concept of APMs is their ability to give providers the flexibility they need to provide the most appropriate care needed by a particular patient while simultaneously relieving Medicare of the burden of

micromanaging care delivery. An excellent example of the potential can be found with ProHEALTH Care Support, a home-based palliative care program in New York. Based on preliminary analysis of the data made available to the program as a participant in a Medicare Shared Savings Program (MSSP) accountable care organization (ACO), this program was able to achieve a 50 percent reduction in overall spending in the 90 days after patients were enrolled in the program (compared to the 90 days before program enrollment) and a 19 percent reduction in emergency department (ED) visit days during that same time period. This program was also able to better meet patients' wishes and, for those patients who happened to die during the observation period, the majority were able to die in their homes (compared with the regional baseline of 25 percent).

- MSSP/ACOs

We believe that additional analysis is required to determine if the MSSP overall is achieving its intended goals. We do, however, agree that key to its success will be the incorporation of appropriate quality measures to ensure that the care delivered is improving outcomes and increasing patient satisfaction while protecting patients from being denied appropriate and necessary care. Currently, we do not believe that MSSP ACO quality measures adequately address the needs of beneficiaries with multiple chronic conditions, including those receiving palliative care and/or hospice services. In your review, we would oppose incorporation of the current MSSP quality measure set in other programs because we believe the measure set misses a key component of chronic condition care coordination. Many current pay-for-performance measures could result in physicians losing reimbursement for appropriately tailoring therapy to an individual patient's needs, which could disincentivize providing the best care possible.

- Medicare Care Choices Model

The Center for Medicare and Medicaid Innovation (CMMI) has launched the Medicare Care Choices Model<sup>6</sup>, a program designed to allow hospice-eligible Medicare patients to receive both curative and palliative care. The program holds the potential to demonstrate the value of providing patients with access to hospice services while receiving all other usual care, thus providing a tremendous opportunity to break down the silos presented by different Medicare payment programs, encourage care coordination, improve outcomes, and increase patient satisfaction. This program can also help to remove the false choice between curative and palliative care that Medicare rules have presented to patients. We applaud CMMI for taking this important step to improve care for Medicare beneficiaries with serious illness.

However, AAHPM believes that the Medicare Care Choices program, as designed, does not pay participants sufficiently to deliver the services required by the demonstration. We understand that Medicare financial stewardship is an important priority; however, underfunding participants not only threatens the success of the program but, more importantly, prevents patients and their families from receiving services that have significant proven benefits. We are worried that such underfunding will limit the measurable outcomes of the demonstration and, perhaps more concerning, lead to the creation of flawed Medicare payment policy that cannot adequately support high-value, community-based services for beneficiaries with serious illness and their families.

We would direct the Working Group's attention to related private payer programs, such as Aetna's (nationwide) Compassionate Care Program. In place since 2009, it expands hospice eligibility from 6 months to 12 months and allows concurrent care with all other interventions, while eliminating hospice day and dollar limits. There are also numerous emerging community-based palliative care models which are creating risk-sharing agreements with payers, health systems and ACOs to partner in care for patients

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<sup>6</sup> <http://innovation.cms.gov/initiatives/Medicare-Care-Choices/> (accessed June 16, 2015).

with advanced illness. In many markets these risk-sharing agreements provide payments to palliative care programs that are significantly higher than that offered through the Medicare Care Choices Model, in order to adequately cover the cost of delivering maximum value to the local “triple aim.” These are but two areas in which market signals can help inform adequate payment and delivery models for palliative care services.

Again, AAHPM applauds CMMI and CMS for creating the Medicare Care Choices demonstration, and we would welcome the opportunity to collaborate with the Working Group and any involved stakeholders to strengthen both this program and future payment policy.

- New APM Structures

- *Bundled Payment Projects*

We believe that bundled payment projects (e.g. the Bundled Payments for Care Improvement initiative<sup>7</sup> or otherwise) hold great potential for ensuring that care coordination that can be provided by hospice and palliative care practitioners is incorporated into care delivery models. In discussions of bundled payment projects, we understand the inclination to build episodes in the context of particular medical conditions. Because of the nature of hospice and palliative medicine, we believe it is better to structure episodes involving palliative care services as a separate bundle that commences once those services are necessary, rather than including them in a more general condition-specific bundle. However, we can envision a subset of “hospice and palliative medicine” episodes of care that focus on particular conditions. For example, a chronic obstructive pulmonary disease hospice and palliative medicine-focused episode or congestive heart failure hospice and palliative medicine-focused episode could make strong candidates for this type of initiative.

In addition, we have seen an increasing number of home-bound dementia patients that are not easily cared for by their primary care physician that could potentially benefit from an episode-based payment. Such a model would require re-imagining of the concept of “episode” given the prolonged course (often years) of advancing dementia. However, given these patients’ anticipatable functional decline and caregiving needs, an innovative care delivery and payment model could be developed. Such a model could serve also to inform innovation in care for all patients with multiple chronic illnesses whose needs are not adequately addressed by currently constructed chronic care management codes discussed in more detail below.

The incorporation of “hospice and palliative medicine” episodes also presents the opportunity to ensure that the right set of quality measures is incorporated. By taking this step, patients and families, as well as the Medicare program, would have the security of knowing that providers will be held accountable for care coordination in the following areas:

- *Measures that ensure the proper use of advance directives;*
- *Measures related to identifying and achieving patient goals of care;*
- *Measures for assessing patient symptom control;*
- *Measures to assess patient functionality related to activities of daily living (ADLs) and instrumental ADLs (IADLs);*
- *Measures that assess patient and family satisfaction; and*
- *Measures related to referring provider satisfaction.*

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<sup>7</sup> <http://innovation.cms.gov/initiatives/bundled-payments/> (accessed June 16, 2015).

- *Per Member Per Month Palliative Care Programs*  
Perhaps the most promising current opportunity to ensure that chronic care management needs are being met is the creation of a *per member per month* (PMPM) palliative care program. Again, this allows providers to best allocate the available funding to meet the needs of the particular patient being served rather than trying to coordinate care in the context of a single set of possibly out-of-date codes payable under Medicare. Of course, we would expect accountability for providers, including documentation of necessity and participation in quality improvement programs based on measures such as those discussed above. However, this flexibility will allow for providers to better meet the care coordination of patients whose needs might not currently align with the fee-for-service payment system.
- *Integrated Health System Approaches*  
Integrated health systems have created very successful alternatives to fee-for-service payment and, in many parts of the country, have invested substantially in palliative care services in their hospitals, clinics and communities. Systems like Kaiser Permanente, Intermountain Health, and Geisinger Health System have been key innovators in palliative care delivery, and many of our members serve as clinicians, educators and leaders in these organizations. The proven benefits of palliative care are central to the mission of integrated health systems: delivery of high-quality, population-based health care within a capitated budget, a model likely to be influential in all future health care delivery in the U.S.

Finally, we believe each of these models would be best constructed to match care delivered to patient needs and anticipate resource utilization. AAHPM agrees that payments under any model will have to include scenarios where there is some variation in resource use in order for the payment mechanism to achieve efficiencies. At the same time, resource use cannot be so wildly variable that it becomes impossible to rationally price services. In hospice and palliative medicine, we can envision episodes that are structured by patient acuity, need for services and supports, and prognosis. Such episodes would allow providers to tailor care to individual needs and payers to appropriately value and reimburse high-value care. Numerous published and proprietary models exist for individual patient risk scoring, prognostication, and future cost prediction, many of which are actively in use by payers and providers nationwide.

The opportunity created by these models is the ability to adequately identify and fund *all* of the services necessary to enhance the care that is delivered and improve the patient experience. These are often services that are not currently separately reimbursable under fee-for-service Medicare or are difficult to account for under a CPT code-based valuation and claims submission system. However, it is important to note that without adequately funding these care models, the Medicare program will simply be recreating past mistakes. ***AAHPM recommends that the Working Group invest in these models that allow providers to utilize the services most appropriate for improving the care needed by patients, provide an opportunity to adequately fund those necessary services, and reward providers who improve outcomes by providing the most appropriate care—not just care that can be reflected by a particular CPT code.***

### **3. Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions**

While we have several specific recommendations for the Medicare fee-for-service program, AAHPM firmly believes that future reform must become more patient-centric in developing models that span across different payment programs. Patients should have access to programs that best fit their needs regardless of whether the

“payment system” is fee-for-service, Medicare Advantage, or a private insurance plan. Attempting to solve care coordination programs in the silos of each type of payment system will only exacerbate the obstacles our health care system presents to getting the right care to the right patients at the right time.

At the same time, we are realistic about current infrastructure constraints and would suggest several improvements to ensure that the patients we serve are receiving adequate care coordination.

- Chronic Care Management Codes

As you are aware, Medicare recently started reimbursing for care provided according to their Chronic Care Management codes. These codes were designed to provide additional resources for the chronic care management of patients who would benefit from these services that did not exist under the current coding structure. While we are supportive of the concept, we believe that the implementation of these codes has been flawed in two general ways:

- 1) The codes could be better structured to focus on a patient population that would benefit from more intense care coordination; and
- 2) Current reimbursement levels are inadequate to provide care coordination for sicker, more complexly ill beneficiaries.

AAHPM, in cooperation with other medical specialty societies, has repeatedly requested that CMS establish payment for chronic care management services targeted to the sickest Medicare patients. This is also the patient population that is the most costly to Medicare on a per capita basis. We call this service “complex chronic care management (CCCM)” and believe it presents much more potential for chronic care management given limited available resources.

CCCM has been demonstrated in numerous clinical trials to improve quality of care for the most complex patient population. CCCM is a resource-intensive service that requires a team of trained health care professionals acting together to implement individualized care plans for patients whose clinical condition makes them at high risk for hospitalization or visits to the ED. Importantly, many of these patients should not be treated using published guidelines and standard care, as they are not always appropriate for older or more complexly ill individuals. Standard recommendations often involve affirmative interventions, such as adding medications, performing diagnostic tests, undergoing surgery, or being hospitalized. However, the patient population our organizations have been discussing with CMS will not benefit from—and may actually be harmed by—interventions currently recommended for less sick individuals (e.g., an 85-year-old patient with dementia, diabetes and functional impairment who is on multiple medications and requires a caregiver or a disabled dual-eligible 35-year-old schizophrenic patient with diabetes). On the other hand, these recommended interventions are often appropriate for the majority of Medicare beneficiaries with two or more chronic conditions, who are at the other end of the spectrum of team-based coordinated care (e.g., a 65-year-old patient with diabetes, high cholesterol and hypertension who is trying to avoid vascular complications).

We believe it is essential that the Medicare program recognizes the differences between CCCM—which lies at one end of the spectrum of chronic care management—and the more standard, guideline-based chronic care management (also known in the medical community as “disease management” or what we might call “standard” chronic care management, or SCCM). AAHPM has worked closely with several other medical specialty societies to outline the scope of what we believe should be included as part of both

CCCM and SCCM services and provided that information to CMS. A joint letter<sup>8</sup> to CMS includes an outline of the scope of services and target patient populations for each.

It is clear that the current CCM codes are designed and paid a rate intended to support SCCM. We support this, as most patients receiving SCCM do not need to be managed with a comprehensive care plan or special management of care transitions because they are cognitively intact and capable of managing their own medications and interactions with the health care system. As a result, primary care and some specialty practices may very well be able use the current CCM reimbursement to build the team-based infrastructure necessary to deliver valuable standard chronic care management services to a less-complexly ill population.

However, the current CCM codes do not adequately reimburse providers to deliver *complex* chronic care management services. While we understand that patients requiring CCCM are a smaller proportion of the Medicare population, we believe that these are the Medicare beneficiaries most in need: as was stated in your request for input, the Medicare Payment Advisory Commission (MedPAC) has identified that 46 percent of all Medicare spending is on beneficiaries with 6 or more chronic conditions. ***AAHPM recommends that the Working Group pursue a strategy that directs resources to these Medicare beneficiaries that are driving Medicare spending by distinguishing between CCCM and SCCM services and recognizing the resource differentials required to deliver the services adequately.***

- Advance Care Planning Codes

AAHPM firmly believes that a comprehensive approach to chronic care management must include the opportunity to discuss advance care planning (ACP) with patients if they so desire. Under current Medicare fee-for-service reimbursement mechanisms, these activities are not funded. AAHPM has been working with CMS to incorporate two newly created CPT codes that describe *complex* advance care planning. Complex ACP involves one or more meeting(s) lasting 30 minutes or more, during which the patient's values and preferences are discussed and documented and used to guide decisions regarding future care for serious illnesses. These consultations are voluntary on the part of the patient, and the patient's preferences are paramount. The patient may choose to include his/her family or caregiver (if applicable) in the decision making process.

ACP is a critical component of delivering comprehensive care coordination for patients given that peer-reviewed research shows that ACP leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression and lost productivity. ACP is particularly important for Medicare beneficiaries because of the incidence of multiple chronic illnesses.

In the calendar year (CY) 2015 Medicare Physician Fee Schedule, CMS declined to assign a value to the complex ACP codes and, therefore, Medicare currently does not pay for these services. While we are hopeful that CMS will propose an appropriate value for these codes when it releases the CY 2016 Medicare Physician Fee Schedule proposed rule later this month, ***AAHPM recommends that the Working Group support policies that recognize the value of advance care planning as part of comprehensive care coordination services that are person-centered and appropriately reimburse for the delivery of those services.***

As such, we would like to also highlight the Care Planning Act of 2015. In its reintroduction as S. 1549, AAHPM was pleased that the legislation ensures flexibility to allow for ACP for those with "serious or life

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<sup>8</sup> [http://www.aahpm.org/uploads/advocacy/CCM\\_Comments\\_Joint%20Letter-Proposed\\_Rule\\_CY\\_2015\\_FINAL\\_9\\_2\\_14.pdf](http://www.aahpm.org/uploads/advocacy/CCM_Comments_Joint%20Letter-Proposed_Rule_CY_2015_FINAL_9_2_14.pdf) (accessed June 19, 2015).

threatening illness” and not only advanced illness. However, we also believe there needs to be flexibility for reimbursement outside of the palliative care interdisciplinary team, to recognize that such restrictions may unintentionally exclude those in smaller practices, rural areas, etc. Further, ACP is a multistep process which reimbursement should recognize.

We would add that other programs have supported these services through programs that move beyond the creation of codes. Blue Cross Blue Shield of Michigan has completed an Advance Care Planning Physician Group Incentive Project—which provides incentives for physician organizations to improve ACP efforts—and created a mechanism to reimburse advance care planning services. Other payers, like Excellus Blue Cross Blue Shield of New York and the Colorado Medicaid program, are also directly reimbursing practitioners for ACP services. These organizations and many others have recognized the value of ACP services and are investing in them.

#### 4. The effective use, coordination, and cost of prescription drugs.

Hospice and palliative medicine physicians are particularly interested in ensuring that accountability for prescription drugs is properly incorporated into the delivery system and associated quality reporting programs. In fact, we believe it is a crucial aspect of coordinating care for those with chronic conditions, particularly those with multiple serious chronic conditions. Our focus on maximizing quality of life for seriously ill patients includes ensuring that all medication management is delivering high value and is tailored to help meet achievable, patient- and family-centered goals.

***AAHPM recommends that the Working Group support policies that encourage the identification of a medication steward to promote medication stewardship and encourage coordination.*** Because hospice and palliative medicine is inherently grounded in a team-based approach to delivering care and coordinating all of the patient’s care needs, we believe that our members have the ability to serve as responsible stewards of their patients’ medication regimens. Therefore, hospice and palliative medicine providers are in a position to help improve the outcomes their patients’ experience and to determine whether there are unnecessary treatments contributing to declines in patient health and/or increased financial liability for both the patient and the Medicare program.

Our specialty has played an important role in identifying opportunities to improve patient experience while reducing unnecessary costs, including ineffective prescribing. For example, in a recent study, palliative care researchers found that discontinuing statins for patients at the end of life was safe and resulted in an increase in patient satisfaction.<sup>9</sup> While this is only one example, a commitment to addressing issues around polypharmacy is important for outcomes, cost, and patient satisfaction but will only be able to materialize if patient care is managed by an effective steward with the expertise to provide that service.

As part of AAHPM’s commitment to stewardship in the prescription medication arena, we have outlined guidelines for the effective use of prescription drug monitoring programs (PDMPs)<sup>10</sup>. We believe it is of paramount importance to ensure that prescription drug utilization is coordinated and managed and, without effective stewards of that utilization, we run the risk that patients living with serious or life threatening illness—such as cancer, AIDS, chronic obstructive pulmonary disease, end stage kidney disease, heart failure, and sickle cell disease—will be unable to get the medications they require for timely, effective treatment of their pain and suffering. In many instances, we have seen PDMPs utilized primarily as law enforcement mechanisms rather than

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<sup>9</sup> Abernethy AP, Kutner JS, Blatchford, PJ, et al. Safety and Benefit of Discontinuing Statin Therapy in the Setting of Advanced, Life-Limiting Illness: A Randomized Clinical Trial. *JAMA Intern Med.* 2015; 175(5):691-700. doi:10.1001/jamainternmed.2015.0289.

<sup>10</sup> [http://aahpm.org/uploads/advocacy/AAHPM\\_Guidelines\\_PDMPs.pdf](http://aahpm.org/uploads/advocacy/AAHPM_Guidelines_PDMPs.pdf) (accessed June 16, 2015).



as tools to guide clinical decision-making. However, properly implemented PDMPs can help prescribers and dispensers understand patient histories and tailor treatments effectively. For these reasons, *AAHPM recommends that the Working Group support policies that will encourage an effective network of state PDMPs as well as policies that implement regular, formal assessments of PDMP effectiveness, including clinical usability and impact on patients' legitimate access to medications.*

In addition, *AAHPM recommends that the Working Group support research and programs that encourage a Medicare approach to prescription drug utilization that focuses on the value of the treatments prescribed rather than blunt measures that simply attempt to assess the costs of prescribed medications.* We believe this can be accomplished by ensuring that Medicare incorporates quality measures regarding specific prescribed drugs. We fear that crude spending measurements for medications prescribed to patients receiving hospice and palliative care could result in patients being denied care necessary as part of these services. We also think that it is important for the Working Group to support programs that distinguish between drugs that are prescribed to a patient for hospice and palliative care services and drugs that are prescribed to a patient for other reasons. Any confusion in the measurement between the purposes of these prescriptions could have a very deleterious effect on patient care.

## **5. Ideas to effectively use or improve the use of telehealth and remote monitoring technology.**

AAHPM appreciates that telehealth is specifically addressed in your request for comments as we believe that policies supporting telemedicine will enhance our ability to care for medically complex patients. As we think about the needs of patients with multiple chronic conditions, many will essentially need access to some level of care for 24 hours a day 7 days a week. Increasing access to telehealth and remote monitoring will help to ensure that patients' needs are being met and that we can avoid unnecessary hospitalizations and spending.

We believe that current impediments to increasing access to telehealth services involve both the inadequate funding of those services as well as regulatory obstacles to proliferation of the technology. *AAHPM recommends that the Working Group pursue policies that ensure telehealth services are adequately funded (particularly as part of fee-for-service Medicare) and streamline Federal regulations that might slow the ability of providers to utilize telehealth technology (e.g., requirements for HIPAA compliance).*

*AAHPM also recommends that the Working Group support policies that encourage states to collaborate, through the use of state medical board compacts, to create common licensure requirements for providing telehealth services.* This is necessary to facilitate multistate practices and allow for physicians to provide services across state lines.

## **6. Strategies to increase chronic care coordination in rural and frontier areas.**

AAHPM believes that addressing the access issues experienced by patients living in rural and frontier areas will require a multifaceted approach. Of course, there must be a focus on ensuring that the IT infrastructure exists to enable the utilization of telehealth services as described above. Provider capacity and training in certain areas also become a critical component. In addition, there are other types of support that can help ensure that patients in rural settings receive the care that they need. For example:

- Our health care system is often more geared toward what happens in hospitals, medical offices, and surgery centers. However, chronic care coordination programs must recognize and address the fact that more basic needs (e.g. appropriate housing, food, and basic care), separate from traditional acute care

hospital issues, contribute to increased health care costs and readmissions. The system could save significant resources if we could incorporate assessments and interventions to address the needs of our compromised elderly. This may require outside-the-box thinking as well as collaboration and coordination across lines of governmental agencies, volunteer and community agencies, and private sector practitioners. As an example, how many drop-in air conditioners could we purchase for the cost of treating one frail elder for heat injury? If our focus remains restricted to improving existing programs (e.g., Medicare Advantage, ACOs) and limited to strictly "medical" interventions (e.g., prescription drugs), our health improvement gains will be modest at best.

- Given that some geographic settings might not have the facility-based services that would otherwise be utilized by patients and providers, programs could invest in palliative care models that help keep patients at home, supplying them with home aid even if not strictly homebound (which could be thought of as something similar to a home hospice model). Unfortunately, we currently find that home visit reimbursements do not cover the costs for physicians in ambulatory care practices and, therefore, patients often do not receive a home visit to assess living conditions until very late in the progression of their conditions.
- Rural providers often find a lack of understanding or familiarity among patients and other providers regarding what care coordination can offer and achieve. We support education and awareness efforts designed to increase exposure to and understanding of proven models of care that demonstrating how coordinated palliative care can improve quality of life while at the same time ensure available resources are used more efficiently. These efforts should begin with medical students. Public education is equally important, though such efforts must be targeted to the education level of the intended audience. For example, in southern West Virginia, comprehension level is documented to be 8<sup>th</sup> grade or less in some counties.
- We support efforts to create regional care organizations, already being pioneered in some health systems. In Alabama, the Medicaid population has been divided into Regional Care Organizations in an attempt to get all interested parties to collaborate to improve overall "care" and decrease costs.

A good example of a program designed to address the issues faced in rural palliative practice is Stratis Health and Fairview Health—Expanding Rural Palliative Care. This partnership, with funding from UCare, seeks to build and strengthen rural community capacity for palliative care based upon established quality metrics. Ucare is investing in services it sees as crucial to both the health of its members and the sustainability of its business model.

We would also like to add, however, what our members consistently see in practice is that many patients lack access to resources in addition to technology. Our members also find that these obstacles present themselves in every geographic setting, not just rural and frontier settings. We have found that the complex medical patient can become more complex when the patient is isolated. That isolation can be exacerbated by distance but it can also be caused by lack of access to technology, absence of caregivers in the home, and/or socioeconomic status risk factors—and all of this can occur even in highly populated areas. ***AAHPM therefore recommends that the Working Group restructure this section to focus on addressing isolation that impedes the ability of patients to access care, regardless of the geographic setting.***

We also believe that legislation such as that proposed by S.1354, the Medicare Patient Access to Hospice Act of 2015, which would permit physician assistants (PAs) to remain serving as attending physicians for their patients who chose to enter hospice care, can help to address workforce issues that may contribute to isolation issues, geographic or otherwise. This bill will help ensure continuity of care for vulnerable patients transitioning to

hospice who rely on PAs as their principal health care professional, as well as improve access to timely, high-quality health care in rural and other medically underserved areas.

### **7. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers.**

We believe that many of the ideas already discussed will help encourage patients to play a greater role in their care. We certainly believe that more frequent contact with a team that is dedicated to managing the patient's care will increase patient involvement, and this empowerment will amplify with the use of health information technology. However, *AAHPM recommends the Working Group also focus on the importance that the involvement and support of a patient's caregivers play in successful care coordination, coupled with psychosocial support services.*

We have seen the needs of these caregivers become more complex, but our reimbursement system has not found an adequate mechanism for providing them with the necessary assistance throughout a patient's continuum of care. Patient involvement and caregiver support are also aided by the incorporation of psychosocial and spiritual cares services (as provided by social workers and chaplains), which are shown to have a direct impact on patients' health outcomes and patient satisfaction. Hospice and palliative care teams are multidisciplinary for this very reason—they care not only for the patient but work to ensure that the needs of caregivers are being addressed as best as possible. However, this is often difficult for our members to achieve in an environment that does not reimburse for the provision of these services. But, by engaging patients, bringing greater attention to their psychosocial and caregiver needs, incorporating these needs into care coordination programs, and ensuring resources are available to support these services, we can better connect the network of providers needed for care coordination programs that truly improve outcomes and increase patient satisfaction.

### **8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

In order to achieve these goals for the most seriously ill beneficiaries, AAHPM believes that providers must be properly trained in team-based care. This means that primary care providers should be trained in generalist-level palliative care principles and practices. These include communication skills with patients and families; competent pain and symptom management; and the ability to coordinate and ensure quality of care across the continuum. Training should include skills needed to initiate and lead goal-setting and advance care planning discussions. When advance care planning and goal-determination discussions are routinely integrated into primary care, the care provided is matched to what matters most to patients and families (that is, "patient-centered") and enables continuing conversations when there are changes in the patient's health. High-quality online and face-to-face clinician communication training options already exist, but the resources to ensure that providers have access to them do not.

In order to address these education issues, AAHPM has provided tremendous support for the Palliative Care and Hospice Education and Training Act (PCHETA) introduced by Senator Wyden in the 113<sup>th</sup> Congress as S. 641 and expected to be reintroduced soon. If enacted, PCHETA would implement exactly the type of programs that we think are necessary to utilize primary care providers and care coordination teams effectively, as suggested by your letter. The bill would achieve this by establishing Palliative Care and Hospice Education Centers to improve the training of interdisciplinary health professionals in palliative care as well as develop and disseminate curricula relating to palliative care, provide students with clinical training in appropriate sites of care, and provide

traineeships for advanced practice nurses. In addition, PCHETA would authorize grants or contracts to schools of medicine, teaching hospitals and GME programs to train physicians (including residents, trainees, and fellows) who plan to teach palliative medicine, including training in palliative medicine through a variety of service rotations, such as consultation services, acute care services, extended care facilities, ambulatory care and comprehensive evaluation units, hospice, home health, and community care programs.

Students graduating from medical, nursing, social work, and pharmacy schools today have very little, if any, training in the core precepts of pain and symptom management, advance care planning, communication skills, and care coordination for patients with serious or life-threatening illness. Further, there is a large gap between the number of health care professionals with palliative care training and the number required to meet the needs of the expanding population of seriously ill patients. PCHETA offers exactly the sort of interdisciplinary skills training AAHPM believes is necessary to ensure that providers are appropriately engaged in the type of work needed to coordinate care for patients living with chronic conditions. While we understand that this is outside the scope of the Senate Finance Committee, we believe that a comprehensive approach to improving care coordination for beneficiaries with chronic conditions will include ensuring that the workforce and infrastructure exist to support those patients.

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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. In much the way that primary care medical homes 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, which includes coordination with a patient's primary care physician. Given these characteristics, we believe it is important that the Working Group ensure that hospice and palliative physicians are a key part of its ongoing discussions, 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.

We thank you again for the opportunity to provide input and applaud the focus you are bringing to coordinating care for those living with multiple chronic conditions. Our Academy's physician leaders would 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@aaahpm.org](mailto:jkocinski@aaahpm.org) or 847-375-4841.

Sincerely,



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President