Center to Advance Palliative Care

June 22, 2015

The Honorable Orrin Hatch Chairman, Senate Finance Committee United States Senate Washington, D.C. 20510	The Honorable Ron Wyden Ranking Member, Senate Finance Committee United States Senate Washington, D.C. 20510
The Honorable Johnny Isakson Co-Chair, Chronic Care Working Group United States Senate Washington, D.C. 20510	The Honorable Mark R. Warner Co-Chair, Chronic Care Working Group United States Senate Washington, D.C. 20510

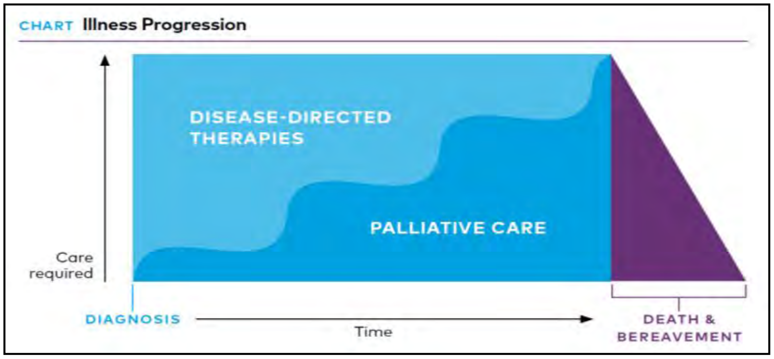
Re: Comments to the Senate Finance Committee's Chronic Care Working Group

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

The Center to Advance Palliative Care (CAPC) thanks the Senate Finance Committee for the opportunity to submit policy proposals that will improve the care of Medicare patients with chronic conditions. We applaud the creation of the new Finance Committee chronic care working group which is charged with developing and implementing policies which will improve the quality of care for this vulnerable population. As the national leader in palliative care program development and growth, we believe that palliative care provides the single best opportunity in health care to achieve better patient outcomes while reducing overall costs to the system.

What Is Palliative Care?

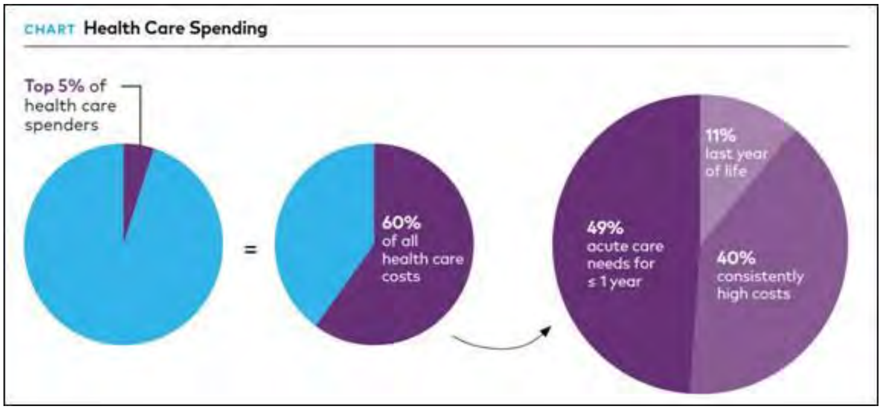
Palliative care is a type of care that focuses on the quality of life of those with serious illness. It provides relief from the symptoms and stress of a serious illness – whatever the diagnosis. Specialty-level palliative care is provided by a team of doctors, nurses, social workers, and other providers who work together with a patient's other doctors to provide an extra layer of support. Generalist-level palliative care can be provided by all physicians and nurses who treat people with serious illness. It is appropriate at any age and any stage in a serious illness and can be provided along with curative treatment. Key



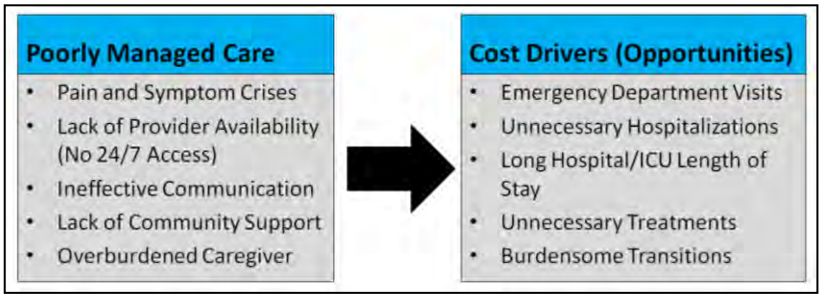
components of palliative care include control of pain, symptoms and side effects, and psychosocial, spiritual and caregiver support. By relieving complex pain and symptoms, palliative care improves patients' ability to tolerate medical treatments and carry on with daily life. It also empowers patients to play a greater role in their own care by facilitating communication between patients, caregivers, and providers across the care continuum.

Palliative Care both Improves Quality and Reduces Cost for Individuals with Multiple Chronic Conditions and Functional Limitations

Fifty to sixty percent of healthcare spending is driven by just 5% of patients. This top 5% of patients can further be stratified into three groups.[i] Those who had acute spending one year and went back to baseline the following year accounts for 49% of the top 5%. These are individuals who are ostensibly benefiting from the treatments they are receiving, as evidenced by their return to baseline. Those who are in the last year of life account for just 11% of the top 5%. These are individuals who would benefit from additional communication, pain and symptom management and care coordination, but ultimately control a relatively small portion of spending. The last group of patients is characterized by those who have consistently high medical costs year after year. These individuals, who have multiple chronic conditions and functional limitations, will not have their illness "cured," but will live for many years with their diseases. These individuals account for 40% of the top 5%.



Spending in this population is driven by poorly controlled pain and symptoms, poorly coordinated care, and failure to discuss treatment goals and options with patients. Palliative care fills these gaps in care and improves quality for these highest-risk, highest-cost patients. In every setting in which it has been tested, including the hospital, in the clinic, and at home, palliative care improves care quality for the sickest and most vulnerable patients across all diseases.[ii] Patients report a higher quality of life, less pain and fewer symptoms, and higher satisfaction with their care. Families and caregivers likewise experience less stress and psychological debility, and



Poorly Managed Care

- Pain and Symptom Crises
- Lack of Provider Availability (No 24/7 Access)
- Ineffective Communication
- Lack of Community Support
- Overburdened Caregiver

Cost Drivers (Opportunities)

- Emergency Department Visits
- Unnecessary Hospitalizations
- Long Hospital/ICU Length of Stay
- Unnecessary Treatments
- Burdensome Transitions

greater satisfaction with the care received by their loved one. By focusing on the quality of care, palliative care provides wraparound support that addresses the most significant drivers of cost, while greatly improving the quality of life for patients and their families.

Policy Recommendations

In order to ensure that Medicare beneficiaries are receiving care that will improve quality of life, reduce the need for emergency interventions, and that will align with patient goals and values, the Center to Advance Palliative Care suggests the following policy recommendations.

1. Direct the Center for Medicare and Medicaid Services to include palliative care measures in all relevant quality- and value-based programs, including the Medicare Advantage Five-Star Quality Rating System.

A great deal of work has already been done to create new payment and delivery models in the Medicare program. It is the task now to ensure that these programs are implemented in a way that improves care quality for those facing multiple chronic conditions and functional limitations. One of the most powerful tools Medicare has to ensure these new models' success is quality measurement. However, there are currently no palliative care related measures in two of the most impactful Medicare programs: the Medicare Advantage Five-Star Quality Rating System and the Medicare Shared Savings Program. This is despite repeated stakeholder calls for these measures. The NQF Measures Application Partnership repeatedly cites palliative care as a high leverage measure gap, and the Institute of Medicine's Report "Dying in America" also stressed the importance of quality measurement in this area.

2. A plan to address patients' palliative care needs should be an eligibility requirement for ACO programs.

Accountable Care Organizations are tasked with managing care for a population across settings. To participate as a Medicare ACO, an entity should be required to create a plan for how they will ensure that people with serious illness receive care that is in accordance with their personal values and preferences, and that will help them achieve the highest quality of life possible. This will ensure that legacy care gaps are not simply recreated by these new multi-provider entities, and that that ACOs use this new payment framework to support person-centered, higher quality care.

3. Improve primary care capacity to deliver generalist palliative care through education and training policy.

All providers who treat individuals with multiple chronic conditions and functional limitations should have the skills and training to provide pain and symptom management, and to communicate effectively with patients and their families about disease progression, what to expect, and patient goals and preferences. Unfortunately, current medical school curriculum and post-graduate medical education do not provide adequate training in these skills. We urge the Working Group to explore mechanisms within the Medicare program to ensure that those providers who treat Medicare patients have the skills necessary to provide high quality palliative care to a chronically ill and aging population.

4. The Working Group should investigate opportunities to create a bundled payment for palliative care services for individuals whose illnesses have significantly impacted function and quality of life.

Palliative care is not currently paid for by Medicare. The physicians and nurse practitioners who serve on the palliative care team can bill for their services like any other eligible provider, but the social workers, nurses, and chaplains are not supported by this billing, nor is the amount of time providers spend speaking with patients, their families, and other providers as they work to ensure the highest quality, most efficient care. Generally, about 50% of a hospital palliative care program's service costs are covered by billing, and this figure is much lower for programs that serve patients in the community. Philanthropy has supported the shortfall in some programs, but program growth is still hamstrung by lack of funding, and the vast majority of people who need palliative care do not receive it. Medicare must discern a way to support this high-value care for a growing high-need population.

There are many models of palliative care delivery, but there are a few key aspects of palliative care that must be in place to ensure the highest-value care. We suggest investigating a bundled payment that will ensure access to the following services:

i. <u>Comprehensive pain and symptom management</u>. This service requires specialized medical skill in assessing and treating pain and symptoms caused by the disease, and by the various concurrent disease-directed treatments.
ii. <u>Patient-centered communication and goal setting</u>. This is the foundation of any palliative care intervention—determining what matters most to the patient and matching treatment plans with those goals.
iii. <u>Family and caregiver support</u>. Family caregivers are an extension of the clinical care team, conducting wound care and complex medication management, providing psychosocial support,

and supporting a patient in his or her activities of daily living. Many emergency department visits are caused by exhausted or poorly supported caregivers.

iv. Practical and social supports. A palliative care program must network with community social support services, and have the skill to identify when the root cause of medical crisis is actually lack of a practical resource.

v. Interdisciplinary team. It is neither possible nor efficient to have one type of professional responsible for the myriad services (medical, nursing, psychosocial, spiritual) included in a palliative care intervention. Physicians, social workers, advanced practice nurses, nurses, chaplains, and other providers all provide unique, high-value services.

vi. Meaningful 24/7 clinical response. Given the complexity and often intense pain or symptom distress in this population, 24/7 access to clinicians is necessary to avert 911 calls and emergency department visits.

We believe these changes to Medicare policies will greatly improve access to palliative care for the Medicare population with multiple chronic conditions, and will accordingly improve quality of life for these individuals while reducing the need for costly emergency interventions and the incidence of non-beneficial treatments. Thank you again for the opportunity to submit these ideas, and please do not hesitate to contact Emily Warner, Director of Health Policy at Emily.warner@mssm.edu or 212.201.2688 if you have any questions or would like additional detail on the information or recommendations included in this proposal.

Sincerely,

Diane e. Meier

Diane Meier, MD
Director

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[i] IOM (Institute of Medicine). 2015. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

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