



January 29, 2016

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 on the Bipartisan Chronic Care Working Group Policy Options Document**

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

We are writing collectively as members of the Patient Quality of Life Coalition (PQLC), created to advance the interests of patients and families facing serious illness. The Coalition includes more than 25 organizations representing the interests of health professionals, health care systems, and patients.

We commend the Finance Committee for establishing the Bipartisan Chronic Care Working Group (Working Group) to focus on developing the most effective policies to improve care for Medicare beneficiaries with chronic conditions. We appreciate the opportunity to respond to the Working Group's *Policy Options Document*. As we commented in response to the May 2015 request for comments, the Coalition strongly recommends greater access to palliative care services as a way to significantly improve care for Medicare beneficiaries with chronic conditions. Greater utilization of palliative care will help meet the Working Group's policy goals to increase care coordination, improve quality of care, and reduce program costs.

The Coalition appreciates the time and effort required to produce the *Policy Options Document*. We believe that it includes a number of constructive options that would, if implemented, advance the shared goals of improved care for Medicare beneficiaries with chronic conditions. We are disappointed, however, that the policy options are not focused more on addressing Medicare's traditional fee-for-service (FFS) program, which is comprised of 70 percent of Medicare beneficiaries. Most central to our concerns is that the importance of palliative care for individuals with chronic illness is not sufficiently reflected in the *Policy Options Document*. The evidence base demonstrating the beneficial effects of palliative care on both patient outcomes and the cost of care for patients with serious chronic conditions continues to build. For example, a study released this month showed that cancer patients with comorbid conditions who received a palliative care consultation within two days of admission to a hospital had overall hospital costs reduced by 22-32 percent.<sup>1</sup>

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

Palliative care is an interdisciplinary model of care that focuses on people living with serious and chronic diseases. It provides relief from the symptoms and stress of a serious illness, whatever the diagnosis. Palliative care is provided by a team of doctors, nurses, social workers, and other providers working together with a patient's other doctors to provide an extra layer of support.

Palliative care is appropriate at any age and any stage in a serious illness. Palliative care services should be provided at the point of diagnosis of a serious illness, and be used alongside curative treatment. Key components of palliative care include care planning based on open, honest communication about the patient's condition and treatment options; effective control of pain, symptoms and side effects; and highly coordinated care that addresses physical, psychosocial, and spiritual needs and family/caregiver support. Given its focus on the patient and the patient's family, palliative care improves a patient's 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.

As we have more fully documented in our June 22, 2015 comment letter to the Working Group, palliative care improves quality of care and helps to lower Medicare program spending.<sup>2</sup> Yet despite the solid evidential basis in support of palliative care, existing barriers in the current Medicare reimbursement structure make it difficult for beneficiaries to access it. In our June comment letter, we outlined policy changes to address those barriers, some of which are not included in the *Policy Options Document*. We would appreciate the opportunity to meet with you, and members of your staff to discuss these options and our concerns with some of the options that have been included.

We have identified some of these concerns in what follows:

### **Advancing Team-Based Care**

#### **Providing Medicare Advantage (MA) Enrollees with Hospice Benefits**

Under existing law, if a MA enrollee qualifies for and elects to receive Medicare's Hospice Benefit, the beneficiary either: 1) switches to traditional Medicare or; 2) remains in MA, but hospice services are reimbursed under Medicare's traditional FFS program and are not incorporated in the government's capitated payment to the plan for that enrollee. For the MA beneficiary electing, this "carve-out" policy can create a complex set of coverage rules, potentially causing disruptions and discontinuities in care. For the MA plan, the carve-out fragments financial responsibility and accountability for the enrollee's care.<sup>3</sup>

The Working Group is considering requiring MA plans to offer the hospice benefit that currently is provided under traditional Medicare. Under the policy as described, MA plans would have to provide the full scope of the Medicare hospice benefit, including the required team and written care plan. To make this change in policy work effectively, the current capitation payment would need to be adjusted

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<sup>2</sup> PQLC Letter to the Senate Finance Committee's Chronic Care Working Group, [www.cancersupportcommunity.org/MainMenu/Get-Involved/Public-Policy-and-Advocacy/Letters-Supported/-Comments-on-Senate-Finance-Committee-Chronic-Care-Working-Group.pdf](http://www.cancersupportcommunity.org/MainMenu/Get-Involved/Public-Policy-and-Advocacy/Letters-Supported/-Comments-on-Senate-Finance-Committee-Chronic-Care-Working-Group.pdf).

<sup>3</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2014, [http://medpac.gov/documents/reports/mar14\\_entirereport.pdf](http://medpac.gov/documents/reports/mar14_entirereport.pdf).

to account for hospice services. The Working Group also says that the MA five-star quality measurement system would need to be updated to include such indicators as health outcomes and appropriate level of care.

The Coalition supports all Medicare patients having access to hospice care, including patients enrolled in an MA plan. However, we have a number of questions about how the proposed policy would be designed. Our priority is to make sure that any policy changes will improve both beneficiary access to hospice services and coordination of those services with the rest of their care. We caution the Working Group to ensure these policy changes do not produce unintended effects on beneficiaries, such as impeding access to hospice providers, or adding to their out-of-pocket costs. Key questions to address include:

- Would MA plans be permitted to limit which hospice providers they cover?
- Would MA plans be permitted to charge beneficiaries cost-sharing?
- Would MA plans be permitted to use prior authorization or other utilization management techniques that can limit access?

The Coalition also urges the Working Group to consider a change in policy to make it more likely that patients who could benefit from hospice services are better able to take advantage of them. Under current policy, a beneficiary who elects the hospice benefit is required to forego curative treatment. The termination of curative treatment can discourage beneficiaries from electing hospice care, thereby forgoing the palliative care that can improve their quality of life.

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

### **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

The Working Group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Physician Fee Schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. The current chronic care management code covers a portion of that labor-intensive cost. However, under this new high-severity code payment option, providers who require more than the typical allotted time per month because of the severity of their patients' conditions would receive higher reimbursement.

The Coalition supports this proposal in general and recommends, in response to the Working Group's questions about beneficiary and provider eligibility, the following.

We appreciate the need to ensure that eligibility for the higher payment is constrained correctly to avoid unintended effects such as increasing Medicare physician payment costs without achieving commensurate improvements in the quality of care provided to beneficiaries with multiple chronic conditions. We believe, however, that a threshold of five or more chronic conditions would set the bar far too high, limiting the applicability of the new code to many fewer patients and their providers than appropriate. We believe that the more appropriate criterion for this new code would be three or more chronic conditions. Additionally, we strongly encourage the Working Group to consider implementing functional impairment as a potential criterion for this code. Functional impairment is defined as difficulty performing, or requiring the assistance of another person to perform one or more activities of daily living, including bathing, dressing, toileting, grooming, and/or feeding. It has been demonstrated as a stronger predictor of patient outcomes than diagnosis, and therefore would be a better indicator of the need for high-intensity services than the number of chronic conditions alone.

With respect to the types of providers eligible for payment under the new code, the Coalition recommends that the eligibility list of providers span to registered nurses (RNs), social workers, and professional chaplains. Each of these non-physician providers may play significant roles in caring for beneficiaries with multiple chronic conditions, including helping them to navigate the complexities of obtaining appropriate and timely services to address their health problems and the related personal and family stresses that tend to accompany them. Medicare should recognize their value through the payment system. Although the *Policy Options Document* references the Physician Fee Schedule, many non-physician providers currently are unable to bill under that payment mechanism. The Coalition strongly supports allowing these non-physician providers to use the proposed high-severity code, and urges the Working Group to explain the mechanism they recommend for non-physician providers to bill under it.

The Coalition also recommends the new code be temporarily implemented, and that the Secretary of the Department of Health and Human Services be given the authority to continue, discontinue, or modify the code based on effectiveness, clinician and patient feedback, utilization of the code, and other factors.

Finally, the Coalition recommends the removal of beneficiary cost sharing for beneficiaries who qualify for this new code. This is necessary to prevent the beneficiary from being confused about what they are being billed for since they will not actually be present for all of the physician consultations.

## **Expanding Innovation and Technology**

### **Maintaining ACO Flexibility to Provide Supplemental Services**

The Working Group is considering clarifying that Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) may furnish a social service for which payment is not made under FFS Medicare. It also is considering whether Medicare should allow MSSP ACOs to furnish a remote patient monitoring service for which payment is not made under FFS Medicare. The Working Group notes that this would be a clarification of existing policy that ACOs are permitted to provide services not covered by Medicare if the ACO does not submit a claim to Medicare.

The Coalition supports allowing the MSSP ACOs to provide beneficiaries with supplemental services. In addition to the supplemental services described by the Working Group (social services or transportation services), we urge that the policy provide for sufficient flexibility to allow ACOs to provide palliative care services, including those services provided by non-physician providers, which may not be directly reimbursed under the Medicare program. In conjunction with this policy, the Working Group and subsequent legislation developed by the Senate Finance Committee may want to direct CMMI to evaluate the extent to which ACOs are providing these services and determine what, if any, cost savings are attributable to the use of these services by non-physician providers. Moreover, CMMI should determine whether it may be possible to scale these services to the broader Medicare FFS population.

## **Identifying the Chronically Ill Population and Ways to Improve Quality**

### **Developing Quality Measures for Chronic Conditions**

The Coalition supports the policy under consideration by the Working Group under which the Centers for Medicare and Medicaid Services (CMS) would be required to develop quality measures that focus on the health care outcomes for individuals with chronic disease. The Working Group is considering several topic areas for measures related to chronic conditions, involving patient and family engagement, shared decision-making, care coordination, hospice and end-of-life care, Alzheimer's and dementia and community-level measures.

We agree with the Working Group's assessment that there currently are insufficient quality measures to address the needs of individuals with multiple chronic conditions. Measures that work for the broader population may not be appropriate for evaluating the quality of care provided to individuals with multiple chronic conditions because of their unique health care needs. For the same reason it is particularly challenging to develop appropriate, evidence-based quality measures for this population. Therefore, the Coalition believes that it is important for CMS to encourage and fund development of measures that are specific to, and appropriate for, assessing the care delivered to individuals with chronic conditions.

In particular, we recommend that as part of this policy, CMS specifically should be directed to identify and support development of measures related to palliative care, which is a critical component of care for the chronically ill population. As discussed earlier, not only do patients with chronic illness who receive palliative care consultations have better quality of life, research also indicates that by closely matching treatments with a patient's goals, palliative care can provide substantial cost reductions. Requiring the development of related quality measures would enable objective assessment of the

extent to which patients' needs for palliative care are being met. It is important to note that outcomes measures related to palliative care for the chronically ill population are difficult to develop because the nature of chronic conditions means that patient goals regarding outcome may change over time. Therefore, measure development also should support creation of evidence-based process of care measures of palliative care, appropriate for the chronically ill population.

The Coalition further recommends that CMS be directed to take advantage of ongoing efforts to identify and promote evidence-based measures of palliative care. These include the Measuring What Matters project spearheaded by the American Academy of Hospice and Palliative Medicine, the Hospice and Palliative Nurses Association, and other organizations. In particular, CMS should also consider the work of the National Quality Forum (NQF) Palliative and End of Life Care Project, which was announced in October 2015, and is supported under a contract provided by the Department of Health and Human Services. The purpose of the project is to identify and endorse performance measures that address palliative and end-of-life care. Under the project, a call for new measure submissions is currently underway. These will be reviewed and considered for NQF endorsement by a standing committee, which will also re-evaluate previously-endorsed palliative and end-of-life care measures.

#### **Empowering Individuals & Caregivers in Care Delivery**

The Coalition is pleased with the attention given by the Working Group to empowering individuals and caregivers in care delivery. We are strongly supportive of, and provide additional comments on several of the policies under consideration.

#### **Encouraging Beneficiary Use of Chronic Care Management Services**

In its calendar year 2015 Medicare Physician Fee Schedule final rule, CMS finalized a policy to create a new code to provide reimbursement for the management of chronic care services for Medicare beneficiaries. This code was designed to pay separately for non-face-to-face care coordination services. This service can be billed on a per calendar month basis when at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional is provided and certain other conditions are met, such as the patient has to have multiple (two or more) chronic conditions expected to last 12 months, or until the death of the patient. CMS reimburses an average of \$42 for the code, and beneficiaries are responsible for a 20 percent co-payment of approximately \$8.

The Coalition is strongly supportive of the Working Group's policy proposal to waive the beneficiary co-payment associated with the current chronic care management code (as well as the proposed high severity chronic care code that is described above). We share the concern of the Working Group that providers find the co-payment confusing for these non-face-to-face encounters, as well as burdensome to collect from patients. We believe patients also are confused about being charged a co-payment for these types of provider encounters. By removing this financial and confusing burden, we believe this will bolster the chronic care code take-up rate by providers.

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

The Working Group is considering requiring that CMS implement a one-time payment to clinicians to recognize the additional time needed to have conversations with beneficiaries who have received a

diagnosis of a serious or life-threatening illness, such as Alzheimer's/Dementia. The purpose of this visit would be to develop a care plan for the patient; and discuss the progression of the disease, treatment options, and availability of other resources that could reduce the patient's health risks and promote self-management.

The Coalition is supportive of this proposal and believes that the current evaluation and management codes are insufficient, and may not be appropriate for the intended purpose of this visit. Separate payment for this service from Medicare under the Physician Fee Schedule would allow providers to have lengthier encounters, develop a detailed patient care plan based on the anticipated progression of the disease, and discuss the availability of community resources for assistance. The one time visit, as described by the Working Group has key components of a typical palliative care initial consult, and the visit could serve as a pre-cursor to a provider's effective use of the chronic care management codes (current and newly proposed) as the services and referrals developed as part of the care plan could be implemented and monitored for their effectiveness.

The Coalition also urges the Working Group to consider other serious or life threatening illnesses (in addition to Alzheimer's and Dementia that are specifically listed) that should be eligible for such a visit post an initial diagnosis of a serious illness. Cancer, heart disease, and many other conditions should fall under this definition. We believe that more clarity should be provided by the Working Group in how "serious or life threatening illness" is defined.

The Coalition also recognizes that more health care providers need to be trained in providing such guidance to patients with a serious life threatening illness, and believe that palliative care could provide such a model. Providers must have adequate skills to be able to have goals of care conversations, and address the needs of patients with multiple chronic conditions. In recognition of this need, we urge the Working Group to consider three policy issues that need to be addressed in order to ensure that Medicare beneficiaries are provided better quality of care through greater access to palliative care services. These three policy issues involve the need to train more physicians, nurses, social workers, and other health professionals in the medical subspecialty of palliative care; the need to educate the public and providers about the availability of palliative care; and the need for a greater investment in evidence-based research specific to palliative care and symptom management. As part of our effort, we continue to actively advocate in support of the Palliative Care and Hospice Education and Training Act, H.R. 3119 (a Senate companion measure is expected to be introduced shortly). We recognize that this legislation is outside the jurisdiction of the Senate Finance Committee, but believe these issues are important to consider in context with establishing a policy for such visits post initial diagnosis of Alzheimer's/Dementia or other serious or life-threatening illness.

### **Expanding Access to Digital Coaching**

The Working Group is considering requiring CMS to provide medically-related information and educational tools on its website to help beneficiaries learn more about their health conditions and help them in the self-management of their own health. The Coalition is supportive of this proposal. We also believe that this would provide an opportunity to provide education about palliative care to beneficiaries so patients know what it is, and how to ask for it. The Coalition would work with CMS to develop a clear definition of palliative care, and the services that could be provided through the care continuum.

**Conclusion**

We look forward to working with you and members of the Working Group as you develop ideas to improve the Medicare program for individuals with chronic conditions. We will reach out to you and your staff to schedule a meeting to further discuss our ideas and concerns. If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition at 202-661-5720 or [Keysha.Brooks-Coley@cancer.org](mailto:Keysha.Brooks-Coley@cancer.org).

Sincerely,

Alzheimer's Association  
American Academy of Hospice and Palliative Medicine  
American Cancer Society Cancer Action Network  
American Heart Association | American Stroke Association  
American Psychosocial Oncology Society  
Association of Oncology Social Work  
Catholic Health Association of the United States  
Center to Advance Palliative Care  
Coalition for Compassionate Care of California  
Colon Cancer Alliance  
CSU Institute for Palliative Care  
Motion Picture & Television Fund  
National Palliative Care Research Center  
Oncology Nursing Society  
Pediatric Palliative Care Coalition