THE PEW CHARITABLE TRUSTS

2005 Market Street, Suite 1700
Philadelphia, PA 19103-7077
215.575.9050 Phone
215.575.4939 Fax

901 E Street NW, 10th Floor
Washington, DC 20004
www.pewtrusts.org
202.552.2000 Phone
202.552.2299 Fax

January 25, 2016

The Honorable Orrin Hatch
Chairman, Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
Co-Chair, Chronic Care Working Group
United States Senate
Washington, DC 20510

The Honorable Mark Warner
Co-Chair, Chronic Care Working Group
United States Senate
Washington, DC 20510

Re: Comments to the Senate Finance Committee's Chronic Care Working Group Policy Options White Paper

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

Thank you for the opportunity to provide comments on the white paper released last month by the Senate Finance Committee's Chronic Care Working Group. The Pew Charitable Trusts is an independent, non-profit research and public policy organization. The Improving End-of-Life Care project seeks to advance policies that help people receive high-quality health care as they near the end of their lives.

We commend the leadership of the Finance Committee and the members of the Working Group for a sustained and in-depth analysis of policies designed to improve the health system for people with chronic care needs. There is a significant overlap between individuals with chronic conditions and those who would benefit from palliative care—the comprehensive care and management of the physical, psychological, emotional, and spiritual needs of patients with chronic, debilitating, or life-threatening illness and their families—and end-of-life care. As the Institute of Medicine noted in its seminal report, "*Dying in America,*" these two populations face many of the same health system barriers: a lack of service coordination, a growing number of risky and repeated transitions across settings and inadequate access to palliative care.[1] In fact, one-quarter of adults in the U.S. have multiple chronic conditions and would benefit from palliative care to help manage their serious illness.[2]

Pew believes the Chronic Care Working Group offers a timely, bipartisan opportunity to improve access to quality palliative and end-of-life care regardless of diagnosis, geography, or care setting. We encourage the Working Group to support the proposed initiative around developing quality measures for chronic conditions, but urge the Working Group to take a cautious approach to including a hospice benefit for Medicare Advantage beneficiaries.

---

[1] "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life." 2014. Consensus report. Washington, D.C.: Institute of Medicine. www.iom.edu/endoflife.

[2] Brian Ward and Jeannine Schiller, "Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010," *Preventing Chronic Disease Public Health Research, Practice, and Policy* 10, no. Special Topic (April 25, 2013), http://www.cdc.gov/pcd/issues/2013/pdf/12_0203.pdf.

Developing Quality Measures for Chronic Conditions

Quality measurement is essential to improve the care patients receive, especially as they near the end of their lives. Currently, Medicare lacks consistent and comparable performance indicators for physicians, hospitals, nursing facilities, home health agencies and other providers involved in end-of-life care. The dearth of quality metrics for palliative and end-of-life care creates a lack of transparency and of accountability for palliative care programs, large health systems, and even accountable care organizations.[3]

In 2015 Congress passed the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),* which requires the Secretary of Health and Human Services to create a comprehensive plan for developing quality metrics for the physician payment system; the legislation also provides funding for measure development to execute the plan. The Chronic Care Working Group is considering requiring the Centers for Medicare and Medicaid Services (CMS) to include measures that focus on health care outcomes for individuals with chronic conditions in that plan. We commend the Working Group for specifically listing hospice and end-of-life care as priority areas for CMS.

Physician quality reporting presents a key opportunity to expand the use of measures for palliative and end-of-life care. The current Physician Quality Reporting System (PQRS) contain a limited number of measures on palliative and end-of-life care including a single measure on the physical symptoms of care around pain and advance care planning measures focused on documentation. There are many areas that need increased quality reporting for clinicians, both for physical symptoms, as well as for the holistic treatment of the individual. These include biopsychosocial care, such as depression or the psychological effects of pain. The Working Group's proposal would increase the number of quality measures available under PQRS to monitor and improve the care received by individuals with chronic illness near the end of life.

Measuring Quality Across the Continuum

Although developing quality measures that are focused on physicians is important, we urge the Chronic Care Working Group to look at measure development in other areas as well. Progress has been made in the use of palliative and end-of-life quality measures, especially in hospice care, but these tools remain underused in a variety of care settings. For example, Long-Term Care Hospitals currently do not have measures that assess the quality of palliative or end-of-life care, despite the high mortality rate of patients in those facilities.[4] Accordingly, we strongly encourage the Chronic Care Working Group to promote the development of quality measures for physicians, acute providers like hospitals and post-acute providers like home health agencies.

Specifically, Pew suggests that the Working Group consider directing CMS to develop measures for the post-acute providers enumerated in the *Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)*. Although that statute requires CMS to develop measures for the post-acute setting, it does not specify that this work should include palliative and end-of-

---

[3] Committee on Approaching Death, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life" (Washington, D.C.: Institute of Medicine, 2014).

[4] Proclamation No. 224, 80 Fed. Reg. 72724, (Nov. 20, 2015).

life measures. Adding those specific areas to the law's current requirements will ensure that CMS implements measures on advanced illness and end-of-life quality for all post-acute providers.

Community-Level Measurement of End-of-Life

Communities have an important role in normalizing conversations surrounding dying and care near the end of life. Health care systems can play an integral role in community education and should be encouraged to promote advance care planning. The best known community effort for ensuring quality end-of-life care is the Respecting Choices program created by Gundersen Health System in LaCrosse, Wisconsin. A study found that after only two years in operation, 85 percent of residents who died had written advance care plans that were nearly always in their medical records.[5]

The Chronic Care Working Group is considering requesting that the Government Accountability Office (GAO) conduct a report on community-level measures related to chronic care management. Pew strongly urges that any report requested from GAO on community-level measures examine access to and utilization of hospice and advance care planning documentation.

Providing Medicare Advantage Enrollees with Hospice Benefits

Hospice is an essential component of end-of-life care in our system in terms of psychosocial and palliative care needs of beneficiaries. In Medicare, nearly 47 percent of beneficiaries who died in 2013 utilized the hospice benefit.[6] This is a significant increase from a decade ago. Yet we know that there continues to be concerns about the hospice program, both in terms of the inappropriate patterns of utilization, potential cost shifting from the hospice benefit to Medicare Part B and, in a small number of cases, lack of skilled care provided to patients in the final days of life.[7] We continue to be interested in new models of care and financing that address these important issues through an evidence-based approach.

Under the current Medicare rules, Medicare Advantage (MA) beneficiaries who desire hospice must either switch to traditional Medicare or remain enrolled in MA but have traditional Medicare reimburse their hospice services. This creates a complex set of coverage rules that can disrupt patient continuity of care.

The Chronic Care Working group is considering requiring MA plans to offer a hospice benefit that would contain the full scope of the traditional Medicare benefit, including an interdisciplinary care team and written care plan. On several occasions, the Medicare Payment Advisory Commission (MedPAC) has raised concerns about the way hospice is carved-out from the MA program, concluding that current coverage rules "fragment financial responsibility and

---

[5] Bernard J. Hammes and Brenda L. Rooney, "Death and End-of-Life Planning in One Midwestern Community," *Archives of Internal Medicine* 158 (February 23, 1998): 383–90.

[6] "March 2015 Report to the Congress: Medicare Payment Policy: Chapter 12 Hospice Services" (The Medicare Payment Advisory Commission, March 13, 2015), http://www.medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf?sfvrsn=0.

[7] Berthelot, Mary T. "Re: CM-1629-P." Letter to Centers for Medicare and Medicaid Services. 23 June 2015. MS. Centers for Medicare Advocacy, Inc.

accountability for care."[8] MedPAC recommended that Congress include the Medicare hospice benefit in the MA benefits package.

In addition to alleviating fragmentation, MedPAC recognized that consolidating financial responsibility for the continuum of care could lead to the development of innovative models of advanced illness and end-of-life care. Although we share MedPAC's optimism for the potential innovation that could flow from hospice inclusion in MA, we are also concerned about unintended consequences of changing the current benefit structure for this extremely vulnerable population without significant protections and first demonstrating the merits of this idea on a smaller scale.

To address this concern, Pew encourages the Chronic Care Working Group to consider a demonstration of an MA hospice benefit that would preserve patient autonomy to elect (or not) hospice care, ensure the availability of the full spectrum of hospice services, support patient choice of hospices and evaluate the quality of services. A successful demonstration project should from the beginning include all relevant stakeholders in the design of the demonstration project, particularly for such a vulnerable population.

Conclusion

Ensuring all beneficiaries of Medicare have access to consistent, coordinated, palliative and end-of-life care is essential to improving medical services for individuals with chronic conditions near the end of life. Improving quality palliative and end-of-life measures across settings and providers will help evaluate and improve these services. Adding a hospice benefit to Medicare Advantage may help care coordination for those with chronic, terminal illness. However, it is important to advance carefully with a demonstration model first and ensure beneficiary protections are in place before making such a significant change to MA beneficiaries care.

Thank you for considering Pew's comments. Should you have any questions or if we can be of assistance, please contact Lee Goldberg at lgoldberg@pewtrusts.org or 202-552-2127.

Sincerely,

Lee Goldberg
Director, Improving End-of-Life Care Project
The Pew Charitable Trusts

---

[8] "March 2014 Report to the Congress: Medicare Payment Policy: Chapter 13 The Medicare Advantage Program: Status Report" (The Medicare Payment Advisory Commission, March 14, 2014). http://www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-(march-2015-report).pdf?sfvrsn=0.