

# Health Care Reform: Implications for Palliative Care

....Be at the Table or Be on the Menu....

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# Objectives

1. What's wrong with the U.S. health care system?
2. How can it be fixed?
3. Why does participation in influencing policy matter to palliative care?
4. “Be at the table or be on the menu.” What can we do to improve access to quality palliative care?

# Health care in the U.S. (... the Wild West)

- What are the ends of medicine?
  - What should they be?
  - What are they in the U.S.?
- *“To cure sometimes, relieve often, comfort always.”*
- The problem: “The nature of our healthcare system- specifically *its reliance on unregulated fee-for-service and specialty care-* ...explains both increased spending and deterioration in survival.”

Muenning PA, Glied SA. What changes in survival rates tell us about U.S. health care. Health Affairs 2010;11:1-9.

# The Value Equation-1

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

## Numerator problems

- 100,000 deaths/year from medical errors
- Millions harmed by overuse, underuse, and misuse
- Fragmentation
- EBM <50% of the time
- 50 million Americans (1/8<sup>th</sup>) without access
- U.S. ranks 40<sup>th</sup> in quality worldwide

# The Value Equation- 2

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

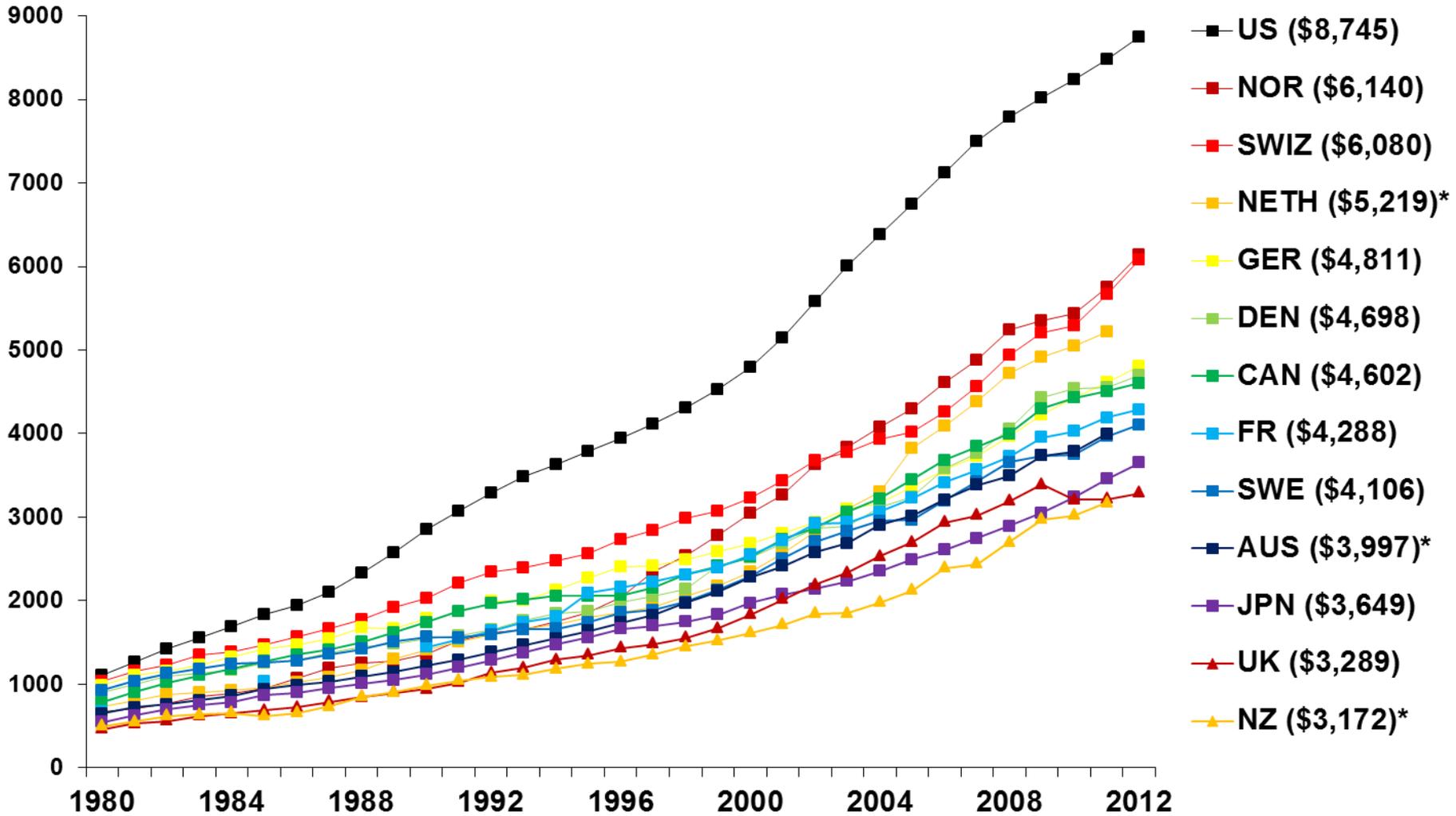
## Denominator problems

- Insurance premiums increased by 131% in the last 10 years.
- U.S. spending 18% GDP, >\$8,400 per capita/yr
- Nearing 50% of total State spending
- Despite high spending, 15% uninsured and 50% underinsured in any given year.
- Lack of health coverage contributes to at least 45,000 preventable deaths/year.
- Health care spending is the primary threat to the American economy and way of life.

# Average Health Care Spending per Capita, 1980–2012

## Adjusted for Differences in Cost of Living

Dollars (\$US)



\* 2011. 6

Source: OECD Health Data 2014.



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# What is this money buying us?

Organization for Economic Cooperation and Development

Among OECD member nations, the United States has the:

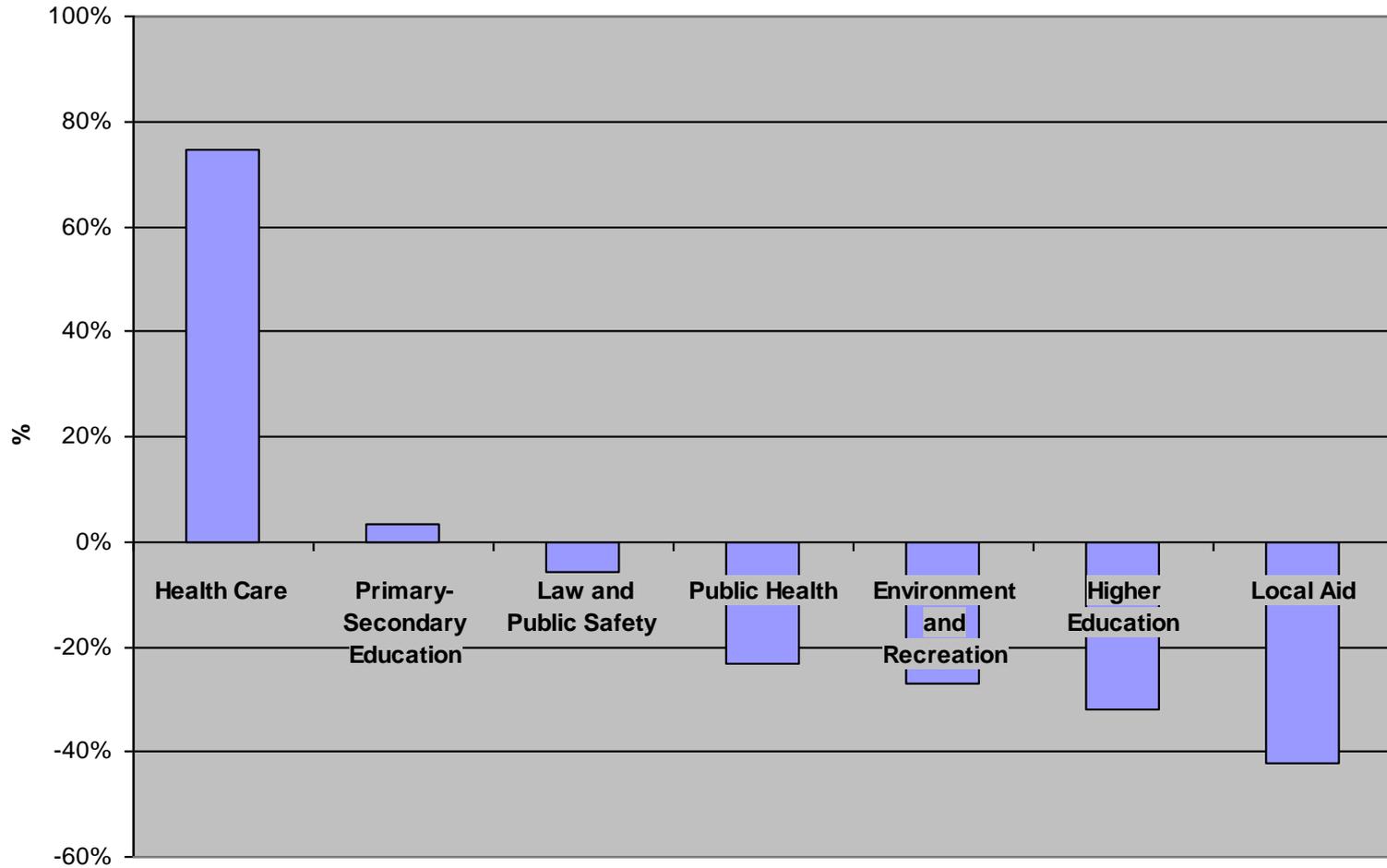
- Lowest life expectancy at birth.
- Highest mortality amenable to health care.

# Health Care vs Determinants of Health

## Growth in Massachusetts State Budget Spending FY2001 to FY2012

(Inflation adjusted)

Source: Massachusetts Budget & Policy Center Budget Browser





*"It is thornlike in appearance, but I need to order a battery of tests."*

# What can be done?

## Two options to “bend the cost curve.”

1. **Stop paying** for things that add little or no quality— i.e. don’ t help patients at all or enough
  - Determine best yield per dollar via Comparative Effectiveness Research
2. **Capitation** or versions thereof- i.e. set a limit on what we will spend.
  - Accountable care, bundled payments, medical homes, global budgets (e.g. VA,Kaiser)

# Option 1: Paying for Value via Comparative Effectiveness Research

- Requires scientific comparison and willingness to implement the findings
- Means someone loses money
- Political football, labeled “rationing” and “death panels.”
- Death panel caricatures have made this topic politically untouchable.
- *“American political discourse is not yet mature enough to support realistic discussion about difficult subjects.”*

# Option 2: Setting Limits

## Putting our health care system on a budget:

- HMOs in 1990's reduced spending
- Modern “integrated systems” such as VA, Kaiser, Geisinger, Mayo, Cleveland Clinics also get more quality per health care dollar
- Characteristics of success: large delivery system, advanced IT, strong primary care infrastructure, and tight integration between physicians and the organizations.

# ACA Experimentation and the Value Equation

Affordable Care Act tests expansion of new delivery and payment models. All aim to improve the value equation by *setting limits on spending through versions of capitation and global budgeting.*

1. Patient Centered Medical Homes (aka Health Homes, Advanced Primary Care)
2. Bundled payment for an episode of care
3. Accountable Care Organizations

# ACA Experimentation and the Value Equation-2

The ACA also tries to improve the value equation by improving quality:

- By investing in comparative effectiveness research so we get the most out of a dollar spent;
- By increasing penalties for poor quality of care via Value Based Purchasing/Pay for Performance (e.g., 30-day readmissions, hospital mortality, poor satisfaction scores)

# New Models

## Relevance to Palliative Care

**Accountable Care Organizations:** ACOs are groups of providers receiving set fees to deliver *coordinated quality* care to a select group of patients. Sec. 3022 of the ACA (Medicare Shared Savings Program) allows providers organized as ACOs that voluntarily meet quality thresholds to ***share in the cost savings*** they achieve for the Medicare program.

To qualify as an ACO, organizations must agree to be ***fully accountable for the overall care of their Medicare beneficiaries***, have adequate participation of primary care and specialist physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.

# What does an ACO need to do?

- Manage *quality outcomes and overall cost for a defined population*, across a ‘continuum of care’
- Prospectively plan and administer budgets, organize resources, and distribute payments
- Be responsible for comprehensive, valid and reliable performance measures for at least 5,000 Medicare beneficiaries

# Medical Spending in the U.S. \$3.06 trillion in 2014

- **The costliest 5% account for 50% of all healthcare spending**

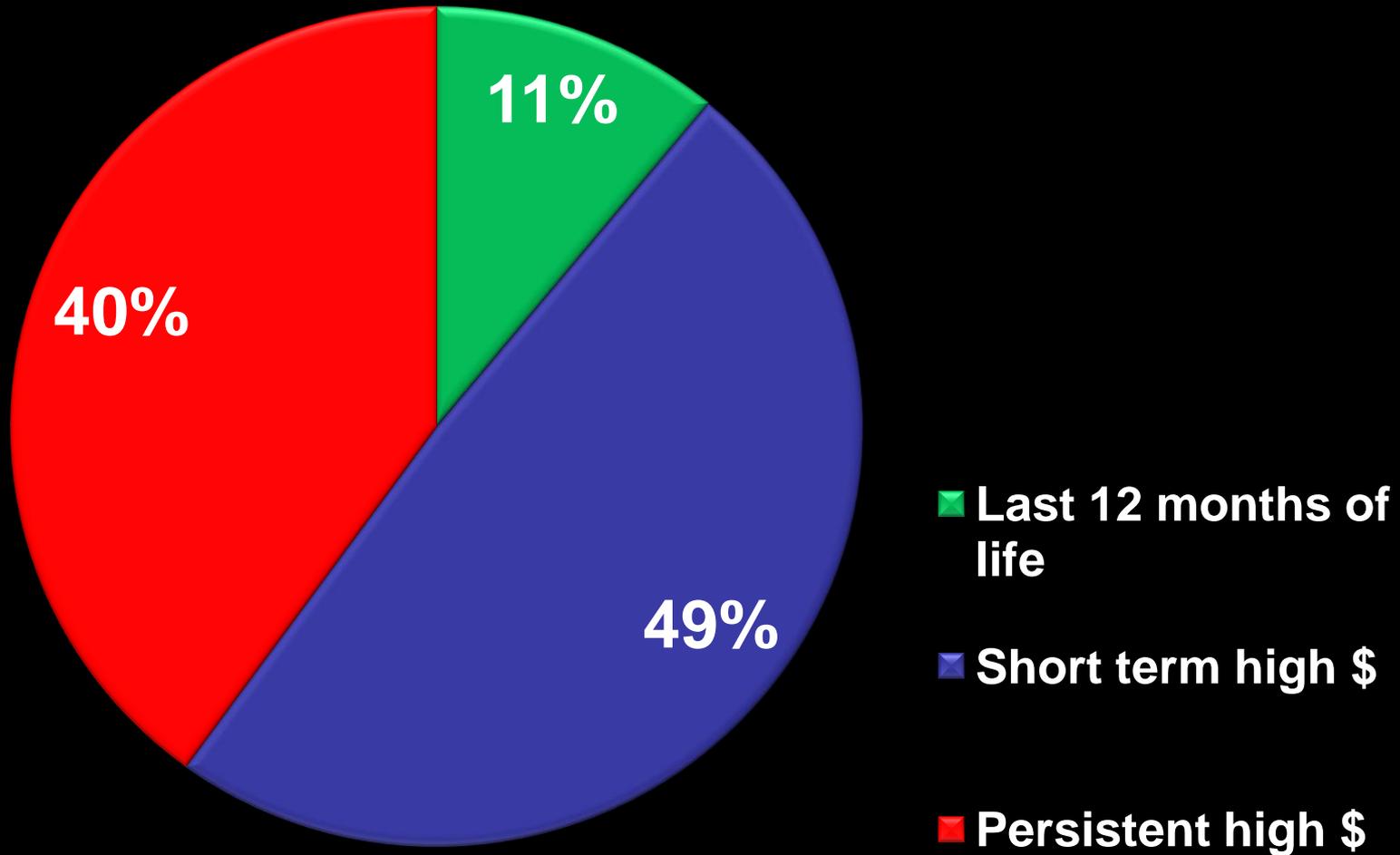
Medicare Payment Policy: Report to Congress. Medpac 2009 [www.medpac.gov](http://www.medpac.gov)

Health Affairs 2005;24:903-14.

CBO May 2009 High Cost Medicare Beneficiaries [www.cbo.gov](http://www.cbo.gov)

[nchc.org/facts/cost.shtml](http://nchc.org/facts/cost.shtml)

# Costliest 5% of Patients



# Palliative Care is Central to Improving the Value Equation

→ Because our patient population is driving most of the spending

# New Delivery and Payment Models Need Palliative Care

Delivery models targeted to the highest-cost, highest-risk populations are key to improving quality and reducing cost.

Palliative care has demonstrated quality and cost impact for this population.

**Policy Goal: Add palliative care to the eligibility/specifications/metrics for medical homes, accountable care organizations, and bundling strategies.**

# Why is Health Policy Reform Important for Palliative Care?

# Policy Change: Why Do We Need It?

## Workforce

- GME dollars for training
- Loan forgiveness
- Career development incentives
- Adequate compensation

## Evidence

- NIH/AHRQ/VA investment in building the evidence base

## Access

- Financial incentives to deliver palliative care
- Regulations requirements for palliative care
- Threats to Medicare Hospice Benefit

# Policies to Improve Access

1. **Financial incentives** train in and provide palliative care: (Example UK payment schema for primary care)
2. **Financial incentives to hospitals/NHs** that provide specialized palliative care, penalties for those that don't. (Example- preferred provider status criteria, VBP).
3. **Accreditation, regulation, and Condition of Participation** requirements

# Policies to Improve Quality

1. **Care is high quality:** Palliative care programs *meeting quality standards* are a *required* condition of preferred provider status/accreditation/participation/payment. Quality measures are included in VBP.
2. **Workforce is trained:** Faculty to teach workforce exist; loan forgiveness; CDAs; GME funding.
3. **Evidence exists:** Research is funded.

# Palliative Care is in the Sweet Spot

- Improved quality
- Longer life
- Reduced costs
- Improved value...
- So why aren't we on everybody's dance card?

**We are...**

**WE KNOW WHAT TO DO**

# How do we start doing it?

# Strategies

1. Leverage ascent of risk-bearing models and the fact that better quality leads to lower cost.
2. Develop quality standards to protect against undertreatment.
3. Organize
  - Coalition building and participation
  - Common voice and asks

# Rapid Privatization of Medicare and Medicaid is now the Primary Driver of Palliative Care

# *Health Care Law Recasts Insurers as Obama Allies*

By ROBERT PEAR NOV. 17, 2014

“Our government business is growing along multiple fronts” and accounted for about 45 percent of the company’s consolidated operating revenues, said Joseph R. Swedish, the chief executive of WellPoint.

Aetna, in reporting its third-quarter results, said many people thought 2014 would “spell the death of our industry.” But, the company said, it is having “a very good year,” thanks in part to “excellent performance in our government business, which now represents more than 40 percent of our health premiums.”

# *Health Care Law Recasts Insurers as Obama Allies*

By ROBERT PEAR NOV. 17, 2014

One insurer, Humana, derives about 65 percent of its revenue from its Medicare Advantage plans. Enrollment in these plans climbed 17.5 percent, to 2.9 million, in the year that ended Sept. 30, the company said.

At UnitedHealth Group, Medicaid and Medicare Advantage together are expected to provide more than \$60 billion in revenue, or slightly less than half of the company's total, this year. United expects to participate in insurance exchanges in 23 states next year, up from four this year.

"The government, as a benefit sponsor, has been increasingly relying on private sector programs," United said in a document filed with the Securities and Exchange Commission. "We expect this trend to continue."

# Payers Get It

Examples of private sector approaches to community-based palliative care



# Keeping Patients Out of Hospitals: A Private-Sector Approach to Health Reform

By Adam Wolfberg

*Hospitalization alone costs \$3,000 to \$4,000 per day. By aligning incentives, a California practice is thriving, saving money, and keeping people in their homes and community.*



[www.theatlantic.com](http://www.theatlantic.com) 02.25.13 MA Full Risk PMPM contract with HealthCare Partners/DaVita 15%+margin. >700K patients **“Now instead of 30-40 patients/day, Dr. Dougher sees 6-8.”**

# Payers Bringing Palliative Care Home

## Highmark Introduces Advanced Illness Services Program

Beginning Jan. 1, 2011, Highmark will offer the Advanced Illness Services (AIS) program as part of its Medicare Advantage plans. The program will provide 100 percent coverage for as many as 10 outpatient care visits by AIS network hospice and/or palliative care providers to promote quality of care for members with noncurative, life-limiting illness.



Aetna Compassionate Care SM Program

Health & Wellness

Products & Services

How the Program Works | [Support for You](#) | [Important Documents](#) | [End of Life Care](#)



## Public Service Announcements on End-of-Life Care Earn Bronze Telly



Leading collaboration and innovation in health care quality and safety



Home > Publications > Quality Update > Spring 2010

QUALITY UPDATE

35

## RURAL PALLIATIVE CARE EMERGENCY



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FOLLOW US

HOME THE HEALTH LAW MEDICARE MEDICAID STATES COST & QUALITY HEALTH INDUSTRY INSURANCE

## Insurer Begins Huge Palliative Care Program

By Marissa Evans | June 17, 2014





*“[Reading case managers’ notes] dramatically illustrates the need for assistance, the too common absence of such assistance, and the almost desperate gratitude this engenders. We have dedicated ourselves to providing this help.”*

Randall Krakauer, MD. *Invictus: Increasing Patient Choice in Advanced Illness and End of-Life Care. Frontiers of Health Services Management.* Spring 2011.

*“If there is an opportunity to impact at the intersection of quality and cost, this is the mother lode.”*

Randall Krakauer, MD; Director of Medical Strategy, Aetna. *Wall Street Journal*, February 23, 2014.



## Compassionate Care program

1% of all Medicare Advantage members enrolled:

- 82% hospice election rate;
- 81% ↓ in acute days;
- 86% ↓ in ICU days;
- High member and family satisfaction
- Total cost reduction of over \$12,000 per member

# How can we help families help patients stay home?

Partner with payers or providers accepting risk.

# Innovative Payer (+ACO) Toolkit

[www.capc.org/payers/palliative-care-payer-provider-toolkit/](http://www.capc.org/payers/palliative-care-payer-provider-toolkit/)



- Talk to your payers!
- But first, read this:
- Predictors of successful payer-ACO-provider initiatives
- Case studies
- Checklists
- Worksheets
- Resources

# Ensure Quality, Prevent Stinting

AGING & HEALTH

By Bruce Leff, Charlotte M. Carlson, Debra Saliba, and Christine Ritchie

**AGING & HEALTH**

## **The Invisible Homebound: Setting Quality-Of-Care Standards For Home-Based Primary And Palliative Care**

**DOI:** 10.1377/hlthaff.2014.1008  
HEALTH AFFAIRS 34,  
NO. 1 (2015): 21-29  
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The People-to-People Health  
Foundation, Inc.

# Organize

The change we need requires a fundamentally political process of persistent, long-term advocacy.

# Predictors of Effective Advocacy

According to folks on the Hill and in the executive (regulatory) branch:

- *Repetition of a consistent message by all stakeholders*
- Large representative coalition(s)
- No circular firing squads!

# 3 Key Elements of Stakeholder Effectiveness

→ Stories

→ BIG coalition, aligned “asks”

→ Legislative champions with juice

# Stories

# Fighting to Honor a Father's Last Wish: To Die at Home

By NINA BERNSTEIN SEPT. 25, 2014



Maureen Stefanides at NewYork-Presbyterian Hospital with her father, Joseph Andrey, waiting to move to a nursing home despite their efforts to arrange for 24-hour care at his apartment.

Victor J. Blue for The New York Times

# Rising Outrage

## **1069 COMMENTS**

Readers shared their thoughts on this article.

The comments section is closed. To send a letter to the editor, please write to [letters@nytimes.com](mailto:letters@nytimes.com).

**All** 1069

**Readers' Picks** 809

**NYT Picks** 31

# Rising outrage: NYT reader's comments

- “It is outrageous that Medicare will pay for expensive hospital care but not lower cost, better care, at home!”
- “My heart broke reading this story and it brought me to tears.”
- “This is horrific. The entire time I was reading this I was saying to myself, “This is America? This is freedom?””
- “My mother died...from the poor care I had promised her she wouldn't have to undergo. I will feel guilty and traumatized until the end of my life because I couldn't stand up to them...”
- “Everybody profits from our for profit health care system except the frail elderly citizens it is supposed to serve.”
- “Turn a light on the disdain for agedness that is an equally guilty party here.”

# Best Sellers

October 26, 2014

[◀ Oct 19, 2014](#)
[Nov 02, 2014 ▶](#)

## OVERVIEW

### PRINT & E-BOOKS

Fiction

Nonfiction

### HARDCOVER

Fiction

Nonfiction

### PAPERBACK

Trade Fiction

Mass-Market Fiction

Nonfiction

### E-BOOKS

Fiction

Nonfiction

### ADVICE & MISC.

Combined

48

### CHILDREN'S

THIS  
WEEKLAST  
WEEK

## HARDCOVER NONFICTION

WEEKS  
ON LIST

1

1

**KILLING PATTON**, by Bill O'Reilly and Martin Dugard. (Holt.) The host of "The O'Reilly Factor" recounts the death of Gen. George S. Patton in December 1945.

3

[▶ Buy](#)

2

2

**NOT THAT KIND OF GIRL**, by Lena Dunham. (Random House.) A collection of revealing and often humorous personal essays from the creator and star of "Girls."

2

[▶ Buy](#)

3

**BEING MORTAL**, by Atul Gawande. (Metropolitan/ Holt.) The surgeon and New Yorker writer considers how doctors fail patients at the end of life, and how they can do better.

1

# Coalitions





# Patient Quality of Life Coalition

ABOUT PQLC

MEMBERS

COALITION ACTIVITY

RESOURCES

CONTACT



**ADVANCING THE INTERESTS OF PATIENTS AND FAMILIES FACING SERIOUS ILLNESS BY PROMOTING PUBLIC POLICY TO IMPROVE AND EXPAND ACCESS TO HIGH-QUALITY PALLIATIVE CARE.**



MEMBERS

The Patient Quality of Life Coalition is comprised of organizations representing a variety of stakeholders in palliative care in the US. Click on each member logo to find out more.



# Home

## Welcome!



AMERICAN ACADEMY OF  
HOSPICE AND PALLIATIVE MEDICINE



Center to  
Advance  
Palliative Care



National Hospice and Palliative Care  
Organization



Welcome to the home of the National Coalition for Hospice and Palliative Care! The NCHPC, formerly known as the Hospice and Palliative Care Coalition (HPCCC), was founded in 2001 by the American Academy of Hospice and Palliative Medicine, the Hospice and Palliative Nurses Association and the National Hospice and Palliative Care Organization to create a mutually beneficial framework for shared organizational activities. With the addition of the Association of Professional Chaplains, Center to Advance Palliative Care (CAPC), the National Palliative Care Research Center (NCPRC), and the Social Work Hospice and Palliative Care Network (SWHPN), the NCHPC is designed to focus on common goals while recognizing that each organization has its own unique goals that it may choose to pursue independently. (use the About Us page for information on each member organization, and links to their respective website)

Home	Who We Are »	What We Do »	What Is Advanced Illness?	Key Documents	Contact Us »
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## C-TAC Featured in Bipartisa...

"In today's health care system, patients and their families have great difficulty getting the help they need at this very difficult time in their lives," said Bill Novelli, Co-Chair of the Coalition to Transform Advanced Care (C-TAC), professor at Georgetown's McDonough School of Business and former CEO of AARP.

[Read More](#)

### Members

We are a diverse alliance of patient and consumer advocacy groups, health care professionals and providers, private sector stakeholders, faith-based organizations, and health care payers with the shared mission to help provide all Americans, especially the sickest and most vulnerable, with comprehensive, high quality, person- and family- centered care that is consistent with their goals and values and honors their dignity.

[Read more](#)

### About C-TAC

Our **vision** is that all Americans with advanced illness, especially the sickest and most vulnerable, will receive comprehensive, high-quality, person- and family- centered care that is consistent with their goals and values and honors their dignity.

Our **Mission** is to transform advanced illness care by empowering consumers, changing the healthcare delivery system, improving public and private policies, and enhancing provider capacity.

[Read more](#)

### Workgroups

Our members are organized into four Workgroups. Each Workgroup has a charge in accordance with our Strategic Plan, which encourages integration across Workgroups and individual stakeholders in order to make the biggest impact in the shortest amount of time.

[Read more](#)

## Act: Workgroups

Hear more about our Workgroups and Committees here:

**Clinical Models**, Co-Chairs, Randy Krakauer and Brad Stuart

**Policy Advocacy**, Co-Chairs, Charlie Sabatino and Mark Schoeberl

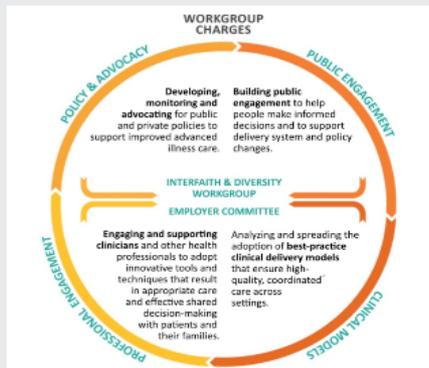
**Professional Engagement**, Co-Chairs, David Longnecker, Cynda Rushton and Marian Grant

**Public Engagement**, Co-Chairs, Bill Novelli and Alexandra Drane

**InterFaith**, Co-Chairs, Rabbi Richard Address, Rev. Tyrone Pitts and Rick de Filippi

To learn more about [advanced illness](#), [our mission & vision](#), [coalition members](#), and [plan](#) to reform advanced care, please [contact us](#).

Share this



## Coalition Updates

- ▶ Statement on IOM "Dying In America" Report
- ▶ California Quality Collaborative's Take Accountability for Ambulatory Care Transitions (TAACT)
- ▶ Topics in Healthcare Symposium
- ▶ C-TAC Featured in Bipartisan Senate Aging Committee Roundtable
- ▶ C-TAC News Bulletin March & April 2014
- ▶ Allina Health LifeCourse Features First Late Life Documentary: Redefining Care

## Archives

Select Month

# Influencing Policy

*“Democracy is the worst form of government except all those other forms that have been tried from time to time.”*

Winston Churchill Nov. 11, 1947 in a speech to the House of Commons

# Importance of Grassroots Advocacy

- Members of Congress rely on input from people like *you* to educate them
- Letters, visits, and phone calls from constituents help staffers and lawmakers develop their positions, decide whether to co-sponsor a bill, and determine how they vote on a particular issue
- *The squeaky wheel gets the grease*

# What you can do

- Join and participate in membership organizations.
- Visit the AAHPM advocacy center at [www.capwiz.com/aahpm](http://www.capwiz.com/aahpm)
- Meet with your own elected representatives.
- When your organization asks you to call, email, send letters, do it.
- It actually matters and makes a difference.

# A skeptic, persuaded

Submit public comments when asked- they are taken extremely seriously in Washington.



# What to do?

## Impact vs. Feasibility

	Low Feasibility	High Feasibility
Low Impact	<ul style="list-style-type: none"> <li>• Why bother</li> </ul>	<ul style="list-style-type: none"> <li>• Whine and complain</li> <li>• Roll your eyes about politics in the U.S.</li> <li>• Talk only with the choir</li> </ul>
High Impact	<ul style="list-style-type: none"> <li>• New legislation</li> <li>• Change in Medicare Conditions of Participation</li> <li>• Sustained public awareness campaign</li> <li>•?</li> </ul>	<ul style="list-style-type: none"> <li>• Join effective coalitions</li> <li>• Write/meet with your representatives</li> <li>• Link your work to IOM recommendations</li> </ul>