

## WHAT DOES A TRUMP PRESIDENCY MEAN FOR PALLIATIVE CARE POLICY?

As America ages, palliative care continues to emerge as one of the most important needs for the U.S. health care system. But how does legislative policy impact – positively or negatively – the implementation of a robust and fairly distributed palliative care model? In a recent article published in the *American Journal of Managed Care*, Sharon Pearce, vice president for public policy at the National Hospice and Palliative Care Organization, explains, “A lag in policy changes has resulted in significant variation across palliative care programs for treating advanced illnesses.” Nevertheless, a recent shift in policy “has allowed small-scale testing of community-based palliative care delivery and some innovations in other delivery systems.”

In light of the great demographic shift underway, “Policymakers, payers, and providers have been exploring models of care that can offer better quality, improve the overall patient experience, and also reduce costs.” Since the passage of the Affordable Care Act (ACA) six years ago, several new approaches have emerged to advance the practice of palliative medicine. Pearce emphasizes the importance of creating interdisciplinary palliative care teams (IDTs), which typically include a physician, registered nurse, social worker, and pastoral/spiritual counselor or chaplain.

Despite the fact that the use of IDTs is widely supported by a growing body of evidence, the policy grounding for such teams has lagged behind. At present, most palliative care is taking place in hospital settings, with the greatest emphasis on clinical or medical aspects of palliative care. “Palliative medicine—in the form of consults from doctors, nurse practitioners, and some social workers—may be covered by the Medicare program; however, many important services, including spiritual counseling, caregiver support, and other essential services, must be financed separately, often through charitable giving. There are similar and even more sizeable policy and financial gaps when it comes to community-based palliative care.”

Despite the fact that the National Consensus Project for Quality Palliative Care laid out clinical practice guidance, no federal policy or regulatory framework has been put together to support this work. This means that there are vastly different practices and standards depending on what health care system one finds oneself in. This hinders access to consistently high-quality, measurable, and standardized palliative care.

Policy progress has also been undermined by the political climate around the ACA. End-of-life consultations were famously panned as “death panels.” Despite the settling down of that particular rhetoric in recent years, the generally gridlocked environment of the federal government has hindered positive forward motion on needed policy reforms that could help expand and improve holistic palliative care programs across the country.

With little chance of sweeping policy changes, palliative care advocates have focused primarily on incremental change. “Recent policy changes, primarily in the ACA, are allowing small-scale testing of community-based palliative care delivery, and for some innovations in other delivery systems. Other administrative changes are slowly increasing

access to Advance Care Planning. While many of these demonstrations are still playing out, some models, including the Medicare Care Choices Model (MCCM), accountable care organizations (ACOs), and the Independence at Home Demonstration, are showing early promise."

Pearce goes on to detail a number of ways in which the policy environment around palliative care has changed in recent years – often benefitting the development of palliative care teams. "The ACA led to the creation of a variety of delivery and payment system reforms that are creating new challenges and opportunities for hospitals, health systems, health plans, and others." Additionally, the Medicare Access and CHIP Reauthorization Act (MACRA) "fundamentally changed the way that physicians are paid under Medicare." It repealed the Sustainable Growth Rate formula and replaced it with a Quality Payment Program. This new program emphasizes the overall value of care rather than volume of procedures performed.

Another advance in end-of-life care is the 2016 Physician Fee Schedule Final Rule, which allows physicians to bill Medicare for advance care planning consultations. Nevertheless, Pearce emphasizes that this positive measure must be taken further. "Significant work must be done to ensure that patients can access comprehensive advance care planning services."

In addition to policy that is already in place, Pearce points to new developments on the horizon that have the potential to further develop palliative care practice. She singles out the Care Planning Act (S. 1549), introduced by Senator Mark Warner (D-VA) and Senator Johnny Isakson (R-GA). The bill would "improve individual care planning and coordination of services for individuals facing advanced and terminal illness."

In the House of Representatives, Congressman Earl Blumenauer (D-OR) and Congressman Phil Roe (R-TN) introduced the Personalize Your Care Act (H.R. 5555). This bill would "establish a new Medicare model that allows individuals receiving conventional therapies to receive concurrent care choices such as hospice care, a functional assessment of the individual, in-home services and supports, 24/7 emergency support, and other palliative care services."

Despite the great need for policy advances to improve palliative care in the United States, Pearce recognizes that the ultimate source of change comes from the grassroots decisions and efforts of practitioners and health networks. Hospice workers require a multi-dimensional skill set, which takes time, attention, and resources to develop. "The Palliative Care and Hospice Education and Training Act16 (H.R. 3119/S. 2748) would address these gaps by supporting programs that provide clinical palliative medicine training in a variety of settings, including hospice, and developing specific measures to evaluate the competency of trainees."

Pearce closes by noting that the election of Donald Trump to the U.S. presidency presents many questions for the future of a palliative care movement that is built so greatly on the Affordable Care Act, a policy foundation that Trump has promised to abolish.

Nevertheless, Republican margins in Congress are small, and it's not clear how these struggles will play out. Speaking in her role as NHPCO staff, Pearce promises that her organization "will endorse policies that promote and protect the Medicare hospice benefit, and will support policies that allow hospice and palliative care providers to innovate and refine patient care services and ensure that all patients with advanced and terminal illness have access to the ... care that they need." ([American Journal of Managed Care](#))