

Incentivizing Cost Reduction through POLST

*NCBC Letter to the Secretaries of
HHS and the VA*

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Dear Secretaries Price and Shulkin:

The National Catholic Bioethics Center wishes to respond to the call of the Pew Charitable Trusts, with fourteen co-signing organizations, for the utilization of Physician Orders for Life-Sustaining Treatment (POLST) as a tool to accomplish end-of-life care planning. The proposal contained in their letter dated February 17, 2017, violates the very informed consent purported to be advocated. Furthermore, evidence suggests that such approaches have more to do with cost saving than the protection of informed consent. In fact, the very means by which costs will be saved is the premature death of a patient through the denial of basic care.

The National Catholic Bioethics Center (NCBC) is a nonprofit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences, including biomedical research. The NCBC serves numerous health care agencies in their development and analysis of policies and protocols, including protocols for advanced care planning. The Center has 2,500 members throughout the United States, and provides consultations to hundreds of institutions and individuals seeking its opinion on this

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and other matters as they pertain to the appropriate application of ethical principles in medicine and the life sciences including as they relate to public policy.

Issues pertaining to end-of-life care are the majority of cases in which the guidance of the NCBC is sought. Significantly, families contact us with concerns over health care professionals' refusal to provide proportionally beneficial care to their loved ones, merely because of age or disability, such as dementia. This is particularly true when patients are admitted to hospice, a resource needed by such vulnerable patients and families. Their concerns are not related to futile care, but rather the meeting of basic human needs such as nutrition and hydration, when these can be absorbed and assimilated without negative side-effects, preventing death by dehydration and starvation. False claims of preventing loss of "human dignity" are used to justify this denial of basic humane care. Often, the family is confronted with a document by which the patient has previously given signed consent (if they even signed it at all) to withhold such basic care if they have a terminal diagnosis. In fact, sometimes there is not a terminal diagnosis. As the scenario is probed, it is clear that neither the family nor patient meant to consent to the withholding or withdrawal of proportionately beneficial care, such as assisted nutrition and hydration, insulin to treat diabetes, or an antibiotic to treat a urinary tract infection. We support the principle of true informed consent in advance care planning, including the finalization of an advance directive. However, in reality what is occurring in practice is the rote completion of a prewritten checklist, often resulting in the denial of such basic care. These checklists are completed long before there is evidence of the benefit in relationship to the burden to the patient, effected by the administration of care or treatment. This can be a form of passive euthanasia, allowed and perpetrated on a patient no longer able to speak for himself. This becomes even more dangerous with the use of the federally preferred form of actionable medical orders known as POLST.¹

The most appropriate manner to address advance care planning is the designation of a well-informed surrogate, who knows and respects the will and best interest of the patient, and who can navigate the specific situation faced by the patient in real time. Except in rare circumstances (such as the appropriately reasoned out-of-hospital DNR) POLST violates true informed consent of the patient, since most health care dilemmas require an analysis of facts within a specific situation in order to direct health care decision making.

As can be documented in the historical development of reimbursement for advance care planning, this very provision was withdrawn from the draft of the Affordable Care Act (H.R. 3200) because of concerns similar to those identified herein.² Thus, there is no statutory provision upon which this reimbursement rests.

1. The National Institute of Nursing Research, of the National Institutes for Health, US Department of Health and Human Services, is the lead federal agency in the science of end-of-life care, and advocates for the use of POLST. See National Institute of Nursing Research, *Making a Difference: Part Two—NINR Research Results*, 2003, <https://www.ninr.nih.gov/>.

2. America's Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 1233 (July 14, 2009), which was not enacted, required doctors to promote medical orders called physician

Without a legislative foundation it exceeds the authority of the Centers for Medicare and Medicaid Services, and should have been rejected. The bill also contained physician “quality measures” on the creation of, and adherence to, the advance directive orders. Such “quality measures” constitute a method to force physician compliance with POLST Paradigm with which they might otherwise object. In late 2010, an explicit advance care planning regulation became so controversial that it was withdrawn a few weeks after it became effective.³ Proponents finally achieved Medicare payment for advance care planning consultations in 2016 through an obscure regulatory process. Regulations now contain a “care plan” [previously called Advance Care Plan] quality measure.⁴ Recently, Rep. Steve King, R-Iowa, introduced H.R. 410 to revoke the Medicare regulation.⁵ Rep. King called Medicare payments for advance care planning “yet another life-devaluing policy. . . . Allowing the federal government to marry its need to save dollars with the promotion of end-of-life counseling is not in the interest of millions of Americans who were promised life-sustaining care in their older years.”⁶

These mechanisms can include the completion of POLST, again, the preferred document of the federal government. The very means by which end-of-life care costs will be saved is the premature death of a patient through the denial of basic care. Under this Pew Trusts approach, health care costs are reduced by incentivizing providers to engage patients in advance care planning discussions that research has shown can discourage treatment even if it might be beneficial to them, and to expand hospice services, which ordinarily are reserved for persons with terminal disease and near the end of life, to include persons who are seriously ill but able to be cured. They call for the national substitution of hospice and palliative (pain relief) care for the life-preserving measures, but without advocating for more curative standards of care (which also include pain relief). This approach targets not only patients at the end of life or having terminal illness, but also patients at any age who have what they call “serious illness,” which they define broadly and vaguely, and includes conditions in which a cure may be possible. It also creates a de facto discrimination against persons with disabilities. Therefore, it requires that patient advance care planning documents, some being immediately actionable medical orders, be part of an electronic health care record database that is instantly accessible across the health care system. This sets in stone decisions made in advance of a problem and in the absence of context, which makes it difficult, if not impossible, to alter specific decisions given real-time circumstances. It further calls for the development

orders for life-sustaining treatment (POLST) to limit life-preserving and curative care.

3. Robert Pear, “Obama Returns to End-of-Life Plan That Caused Stir,” *New York Times*, December 25, 2010, <http://www.nytimes.com>; and Robert Pear, “U.S. Alters Rule on Paying for End-of-Life Planning,” *New York Times*, January 4, 2011, <http://www.nytimes.com/>.

4. Centers for Medicare and Medicaid Services, *2016 Physician Quality Reporting System*, ver. 10.0, November 17, 2015, measure 47, <https://www.cms.gov/>.

5. Protecting Life until Natural Death Act, H.R. 410, 115th Cong. (January 10, 2017).

6. JoNel Aleccia, “Docs Bill Medicare for End-of-Life Advice as ‘Death Panel’ Fears Reemerge,” *USA Today*, February 9, 2017, <https://www.usatoday.com/>.

of quality measures of these activities to which providers are held accountable and upon which payment decisions are made. While such an approach may reduce health care costs, it does so by reducing health care treatment to patients who actually may benefit from it, by incentivizing what amounts to patient neglect and then financially rewarding providers for it. Thus, provider bias in favor of withholding treatment is a resulting reality, especially when decisions are made and set in stone in advance of a problem or its context.

The National Catholic Bioethics Center urges the Department to disregard the recommendations provided by the Pew Trusts and the fourteen co-signatories. We would ask the Department to use its offices to promote public understanding of the importance of selecting a surrogate with power of attorney. If a person is unable to designate a surrogate, a living will is an alternative, although we note it does not offer the protections and flexibility of a surrogate. We further ask the Department to support H.R. 410, which would repeal Medicare payment for advance care planning with POLST and to halt any consideration of POLST completion or adherence as a quality metric of informed consent, which it is not.

Sincerely yours,

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President

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June 17, 2017