



**Testimony of Terry Lacasse, Volunteer Ambassador,  
American Cancer Society Cancer Action Network**

**In Support of LD 1064 “An Act To Advance Palliative Care Utilization in the State”**

**April 1, 2021**

Good afternoon, Senator Claxton, Representative Meyer, and members of the Health and Human Services Committee. My name is Terry Lacasse. I am a resident of Brunswick and a volunteer ambassador with the American Cancer Society Cancer Action Network (ACS CAN). I also represent the American Cancer Society and ACS CAN on the palliative care advisory council. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation’s leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

I would like to thank you for this opportunity to submit the following testimony in support of LD 1064. Palliative care is a growing field of specialized medical care that improves the quality of life of patients and their families by focusing on relief from pain, stress and other often debilitating symptoms of treatment for a serious disease such as cancer. Palliative care is appropriate *at any age and any stage of a serious or chronic illness* and can be provided alongside curative treatment. It is delivered by trained specialists who work together with doctors and nurses in a team-based approach that focuses on the patients’ needs, explains treatment options and gives patients and their families a voice in realizing their treatment goals.

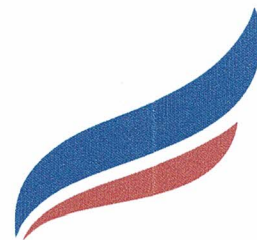
More than 10,000 people will hear the words “you have cancer” this year in Maine.<sup>1</sup> From the moment a patient hears these life changing words, all the way through treatment and beyond, they cope with pain, stress and side effects from treatment. Pain, nausea, worry and other symptoms and side effects of cancer and its treatment are not an inevitable consequence of cancer. They typically can be controlled.

Treating the whole patient—not only the disease but also the physical and psychological consequences of treatment—is the key to both extending life and enhancing the quality of the time gained. Numerous studies have found that palliative care:

- Reduces symptoms and pain
- Improves quality of life

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- Reduces unnecessary emergency department visits, hospitalizations, and time spent in the intensive care unit
- And typically results in overall cost savings <sup>ii,iii,iv,v</sup>

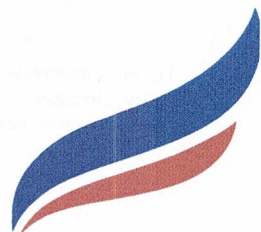
Despite the benefits, thousands of patients who are suffering from the side effects of treatment for chronic disease have no idea that palliative care is available to them and can help relieve their symptoms and help them focus on getting well.

Nationally, only 40 percent of public and sole community provider hospitals reported having a palliative care team in 2019 – these hospitals are often the only option for people lacking health insurance or who are geographically isolated.<sup>vi</sup> Furthermore, only 36 percent of smaller hospitals report having palliative care teams (compared to 72 percent of larger hospitals). These hospitals with fewer than 50 beds are typical in rural areas of the country<sup>vii</sup> – creating a lack of access to palliative care for rural Americans.

Maine ranks average nationally, but the lowest in New England, achieving an “B” grade on access to hospital-based palliative care teams in the most recent evaluation from the Center to Advance Palliative Care and the National Palliative Care Research Center, with 100% of our largest hospitals (300+ beds) and 67% of our smallest hospitals (<50 beds) reporting a palliative care team.<sup>viii</sup> It’s important to note that this report only captures a piece of access to palliative care in that it is based on self-reported data for hospital-based care. The percent of our smallest hospitals reporting a palliative care team has grown over the past few years, but despite the recent growth, significant disparities continue to exist in access to and delivery of concurrent palliative care. For example, Maine’s palliative care advisory council has identified significant gaps in access to palliative care in terms of outpatient care, non-hospital based palliative care, for patients with less advanced disease, for pediatric patients, and for patients that live in certain parts of the state. Moreover, the remarkable increase in the number of palliative care teams in recent years has not been matched by growth in the number of trained clinicians to lead and staff these programs.

Patients and families facing serious illness need to be educated about palliative care so they can find their way to the best choices that minimize symptoms and suffering while fighting disease. While enhancing palliative care information and awareness, we must also enact policies to cultivate and support development of more health care professionals who are trained to provide this multidisciplinary care to meet the growing community need. We must also pass policies to ensure providers who deliver palliative care services are being reimbursed for that care.

LD 1064 begins to take steps in the right direction by addressing some of the areas identified as needing action. By focusing on Mainers with MaineCare coverage and public and provider education, the bill has the potential to help decrease disparities in access to palliative care. For these reasons, we ask you to vote in support of LD 1064.



If this bill moves forward, ACS CAN recommends adding the following language to section 2 of the bill: "All MaineCare enrollees for whom palliative care is appropriate according to evidence-based guidelines, must have access to these services." This language not only ensures that providers are reimbursed for the services, but also that all MaineCare members for which palliative care is clinically appropriate will be eligible to receive such services.

Thank you for the opportunity to provide this testimony. I would be happy to answer any questions.

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<sup>i</sup> American Cancer Society. *Cancer Facts & Figures 2021*. Atlanta: American Cancer Society; 2021.

<sup>ii</sup> Meier, DE, Brawley, OW. Palliative care and the Quality of Life. *J Clin Onc*;20:20:2750-2752 ( 2011).

<sup>iii</sup> Smith TJ, Temin S, et al. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care. *J Clin Onc*. Published online ahead of print on February 6, 2012 as 10.1200/JCO.2011.38.5161

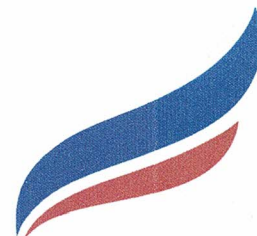
<sup>iv</sup> Temel JS, et al, Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, *N Engl J Med* 363;8 (2010).

<sup>v</sup> McCarthy IM, Robinson C, Huq S, Philastre M, Fine RL, Cost savings from palliative care teams and guidance for a financially viable palliative care program, *Health Serv Res*. 2015 Feb;50(1):217-36, Epub 2014 Jul 15. Morrison RS, Dietrich J, Ladwig S, [Quill T](#), Sacco J, Tangeman J, Meier DE., Palliative care consultation teams cut hospital costs for Medicaid beneficiaries, *Health Aff (Millwood)*. 2011 Mar;30(3):454-63. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE, Cost savings associated with US hospital palliative care consultation programs, *Arch Intern Med*. 2008 Sep 8; 168(16):1783-90.

<sup>vi</sup> Center to Advance Palliative Care. *America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals*, 2019. [www.reportcard.capc.org](http://www.reportcard.capc.org)

<sup>vii</sup> Ibid.

<sup>viii</sup> Ibid.







# Palliative Care: Effect on Cost of Care

The table below lists key studies and review articles that examine the effect that the addition of palliative care has on overall patient costs. While results vary, the addition of palliative care typically either reduces overall costs or is cost neutral.

| Study  | Setting   | Effect of adding palliative care (per patient)  |
|--|---|---|
| Morrison 2011 Health Affairs                         | New York Medicaid hospital patients   | \$6,900 savings, (\$7,563 who die in hospital and \$4,098/patient discharged alive)—Could save NY Medicaid an estimated \$84-\$252 million/year.  |
| McCarthy 2015 Health Services Research               | Hospitals (Texas)   | Palliative care in the first 10 days of admission resulted in \$9,689 savings for patients who died in the hospital, \$2,696 savings for patients discharged alive.   |
| May 2015 JCO   | Inpatient hospital cancer patients in 5 hospitals (OH, NH, NY, VA, PA)        | Intervention within 6 days reduced costs by \$1,312 (14%) compared to no intervention and intervention within 2 days saved \$2,280 (24%).   |
| May 2016 Health Affairs                              | Inpatient hospital patients with advanced cancer in 6 sites in NY, OH, VA, WI | Receipt of a palliative care consultation within 2 days of admission was associated with 22 percent lower costs for patients with a comorbidity score of 2–3 and with 32 percent lower costs for those with a score of 4 or higher. |
| Lustbader 2017 Journal of Palliative Medicine        | Home-based palliative care within an Accountable Care Organization (ACO)      | Cost per patient during the final 3 months of life was \$12,000 lower compared to usual care. Also reduced Medicare Part B spending in final 3 months of life by 37%, and hospital admissions in the last month of life by 34%.     |
| Isenberg 2017 Journal of Oncology Practice           | Inpatient palliative care unit  | The total positive financial impact of the program was \$3,488,863. The program saved the institution \$452 per transfer.   |
| Kyeremanteng 2018 Journal of Intensive Care Medicine | Patients with palliative care consultations in the ICU                        | Demonstrated trend that palliative care consultations reduce length of hospital stays and costs without impacting mortality.  |

### Conclusions of Meta-Analyses

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|--|---|
| Hughes 2014 (review)<br>Annu Rev Public Health | <i>"The benefits of palliative care have now been shown in multiple clinical trials, with increased patient and provider satisfaction, equal or better symptom control, more discernment of and honoring choices about place of death, fewer and less intensive hospital admissions in the last month of life, less anxiety and depression, less caregiver distress, and cost savings."</i> |
| May 2018 JAMA                                  | <i>Hospital costs were lower for patients seen by a palliative care consultation team than for patients who did not receive this care. The estimated association was greater for those with a primary diagnosis of cancer and those with more comorbidities compared with those with a noncancer diagnosis and those with fewer comorbidities.</i>  |

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