



NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
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The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

The Honorable Johnny Isakson
United States Senate
Washington, D.C. 20510

The Honorable Mark Warner
United States Senate
Washington, D.C. 20510

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

Thank you for the opportunity to provide feedback on the Policy Options Document issued by the Bipartisan Chronic Care Working Group. We applaud the Committee and the Working Group for advancing the consideration of policy changes and innovations that address the ever-increasing population of Medicare beneficiaries with one or more chronic illnesses. With chronic disease now accounting for almost 93 percent of Medicare spending, we agree that the impact of chronic disease on the Medicare program and those it serves is staggering and must be addressed with better chronic disease management.

We strongly support the direction of the Working Group in considering that caring for individuals with chronic illness in their own homes should be a central aim of any policy reforms. Home care presents the best opportunities to provide high quality care while controlling Medicare spending. It is also a quickly scalable way of coping with the fast-

growing population of Medicare beneficiaries as the baby-boomer generation ages.

The National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies and public corporations. They have been enthusiastically participating in demonstrations that test new models of payment and chronic care management, as well as investing in new technologies to improve care transitions and enhance care coordination with physicians. They have also been working with hospitals to reduce readmissions and funding research to analyze Medicare claims data to help find opportunities for improving efficiency and lowering costs. Home-based care is not just the best solution for the future Medicare patient population, it is a comprehensive care management service readily available today across the nation.

NAHC strongly recommends that the Working Group continue its consideration and evaluation of policy options in the following areas set out in the Policy Options Document:

1. Expanding the Independence at Home Model
2. Advancing Team Based Care by Improving Care Management Services
3. Expanding Innovation and Technology through the expanded use of Telehealth
4. Empowering Individuals and Caregivers by encouraging the use of Chronic Care Management Services

With respect to the Policy Option to integrate the Medicare Hospice benefit into Medicare Advantage, NAHC recommends that the Working Group table that concept for further review and study to avoid unintended consequences to a highly vulnerable patient population, only some of whom have a chronic illness that is terminal.

Each of these items is discussed in greater detail below.

A. Expanding the Independence at Home Model and Advancing Team Based Care

As the Working Group has found, the Independence at Home (IAH) pilot program has demonstrated significant promise in controlling acute exacerbations of a patient's chronic

illnesses, improving the quality of care for patients at high risk with their multiple comorbidities, and reducing Medicare spending. With only 17 entities in the program, IAH entities have demonstrated quickly that the model deserves to be expanded both in terms of size and scope. In addition, the Policy Options of the Working Group include “advancing team based care,” a central component to IAH.

IAH is currently limited not just to 17 entities. It is also limited in terms of the Medicare population it serves. While wisely targeting the 5% highest risk patients, it has the potential, with design modifications, to serve a greater patient base in an equally effective way. Building on the successes of IAH in expanding both the sites and scope of the model should be a win-win for patients and Medicare.

In expanding the scope of IAH, the interdisciplinary team can and should be modified. While the high risk patients likely need a physician team leader, patients in the lower strata of risk may not. Accordingly, the team composition and leadership should be flexible, required to be composed in a manner that fits the individual patient.

NAHC recommends that the expansion of IAH be comprehensive in scope with a schedule that addresses both the number of sites and the target populations. For example, in Year 1, the existing pilot could go nationwide without limitations on the number of sites. In Year 2, the target population could be expanded from the existing top 5% at risk to the top 25% at risk. In Year 3, the target population expansion would include the top 50% at risk. Year 4 would be the expansion of the model to all Medicare patients with one or more chronic illness diagnosis. This is just one illustration of a phased-in expansion. The point is that a comprehensive phase-in should be included in the Working Group’s plan.

With respect to modification of the delivery model, NAHC has previously submitted to the Working Group, a design that addresses the value of creating flexibility, particularly in the provider of the services and the makeup of the care management team. The Home Health Agency based Chronic Care Management Model is a patient-centered, evidence-based model with care coordinated and supported across providers, sectors, and time. This model would benefit both homebound post-acute patients and pre-acute chronically ill patients. However, its real promise and greatest source of cost savings lies in keeping chronically ill patients out of inpatient settings. The model is a partnership between home health agencies and patient centered medical homes that more fully treat the “whole” patient. The home health agency shares responsibility for patient outcomes with the primary care provider. The home health agency carries out the physician care plan and orders for guideline-level assessments and therapies (i.e. blood glucose monitoring, lipid analysis, flu and pneumonia vaccines.) The home health provider also conducts in-home health coaching, motivational interviewing and patient education, as well as provides ongoing support and

monitoring.

Over time, the Home-based Chronic Care Management Model has evolved to incorporate new evidence, including a greater focus on patient empowerment and patient-centered care principles and methods to support care transitions. This model is now referred to as the “Integrated Care Model,” (ICM) as best practices are integrated into model tenets and care is integrated across providers and settings.

In a number of ways, the Model builds on the Independence At Home demonstration program. However, it is different in that it takes a broader focus than IAH, which is limited to the top 5% of patient who are risk of hospitalization. Instead, it is a flexible model that sets the direction of an interdisciplinary team based on the specific patient needs allowing it to include the wide range of Medicare beneficiaries with multiple comorbidities rather than a small, high-risk population segment. Its flexibility is in a design that uses a physician-leader approach when appropriate to the specific patient, but employs the leadership of other health professionals and the patients family when such leadership fits best as not all chronic conditions are best managed at all times by physicians alone.

The Model is also a modern method of providing chronic condition management in that advanced technological tools are incorporated into the care management to achieve greater efficiencies, accelerated care actions, and targeted remedial measures. This technology is boundless in its range of uses, limited only by barriers to innovation. However, current tools that have been employed in trial programs include 24/7 remote monitoring of a patient’s condition, two-way video conferencing for consultations and self-care education, an smartphone technology used by non-professionals to provide front-line review of the patient to detect early signs of clinical deterioration or change that warrants intervention. Personal care aides have been equipped with smartphones that connect to patient-specific assessment questions that do not require a health professional, but are designed to illicit evidence of changes in the patient that might signal clinical concerns. The information obtained is subjected to a risk analysis to trigger the appropriate interdisciplinary team response.

The Model also presents a payment method that fits with the direction of value-based payment and shared risk between provider and payer. Primary to such a payment model is that the provider’s end revenue is dependent upon demonstrating a real financial savings to Medicare. In concept, this payment model is comparable to that used in the IAH pilot program.

The outline of the Model is as follows:

1. Subject beneficiaries must have more than one chronic disease or a dementia along with a chronic disease
2. The individuals subject to the pilot received Medicare-covered home health services within the previous 60 days, but are no longer receiving such covered services
3. It is a pilot program in a least 3 diverse locations subject to expansion by the Secretary of Health and Human Services
4. The home health agency as the provider must meet additional qualifications including the specialized capacity to provide care coordination, patient education and support, telehealth monitoring, and data supported, evidenced-based care management
5. A patient environmental assessment must be conducted with a management and improvement plan related to remediating any environmental barriers to care management, coordination, and success
6. A financial risk-sharing method provides that the participating home health agency receive at least 50% of the Medicare savings achieved through the program conditioned on the requirement that aggregate Medicare expenditures be no greater than would occur without the pilot program
7. Direct reimbursement to the participating providers is limited to per visit reimbursement for face-to-face patient visits by the Case Manager or Clinical Nurse Specialist.

We encourage the Committee to look at integrated care models that include home health care at the center as a way to improve care and reduce costs. Following are several specific homecare agency results from implementing ICM as a care delivery model:

Baptist Health Home Health Network, Little Rock, Arkansas

The ICM program was initially implemented in one HHA in 2007. Specific outcomes in re-hospitalization rates and patient satisfaction were tracked over 2,000 patients. At this agency, re-hospitalization rates declined from 29 percent to 13 percent, and patient satisfaction increased from 93 percent to 97 percent the year following training. The ICCM model's authors have described model focus areas, outcomes data,

and lessons learned in articles published in peer review journals (Suter, et al., 2008; Hennessey, et al., 2010), and this work was highlighted in a Joint Commission Case Study (2009).

Sutter Health

In 2009, Sutter Health developed its Advanced Illness Management (AIM) program using a cross-disciplinary teams that includes physicians, nurses, home health care and hospice personnel and data analysts to improve the integration and management of its home health population. Sutter operates in Northern California. The program, funded partly by a grant from CMS achieved a 59percent reduction in hospitalizations for the enrolled population (approximately 2100 patients), a 19 percent reduction in emergency department use, and a 67 percent reduction in high-cost days in intensive care units. Sutter estimates that over the 3 year grant period it is on track to save Medicare \$118 million.

First Health Home Care, North Carolina

First Health has embedded ICM best practices across a continuum of services in their system, including complex care management and telehomecare. Standardizing the delivery of care for patients with chronic disease led to the development of clinical pathways that incorporate the principles of ICM and also include use of the Patient Activation Measure and specific nutritional and therapy interventions for patients with heart failure, COPD, diabetes and cardiac surgery.

This approach has led to significant improvement in the home health hospitalization rate as well as the home health 30 day hospitalization rate as noted below: (fiscal year 2011, 2012 are October through September; 2013 is year to date October through June)

Home Health Hospitalization Rate (data not risk adjusted)

2011	26.47%
2012	23.87%
2013	20.76%

Home Health 30 day Re-hospitalization Rate (data not risk adjusted)

2011 17.41%
2012 16.92%
2013 10.85%

*White County Medical Center Home Health , Searcy,
Arkansas*

The White County Medical Center Home Health trained all their clinical staff in ICM starting in 2011. They utilize ICM best practices in home care, care transitions, and for care coordination with other team members including physicians, pharmacists, and hospital case managers. Having a chronic care management program and requisite staff competencies has led to significant improvement in their acute care hospitalization (ACH) rates. The risk adjusted ACH rate has improved from 24.4 percent in June 2011 to 12.9 percent in April 2013. The agency is currently in the 1st percentile for the state rankings and 3rd in the nation for preventing acute care hospitalizations.

Atrius Health

Atrius Health is a non-profit alliance of medical groups in Massachusetts. Atrius has integrated home health services and hospice into its operation through the acquisition of the Visiting Nurse Care Network and Hospice to improve communication between physicians and home care personnel, develop a collaborative program and secure comprehensive metrics for care accountability. Using an electronic patient record, Atrius integrates members of a patient-centered team and includes staff education on palliative care and end-of-life care options. The range of patient care services and patient types is wide with programs directed towards post-joint replacement patients to those with terminal illness.

The care focus, coordination, and interdisciplinary team integration includes telehealth care, video visits between physicians, nurses, and patients. The most significant difference from traditional care is that the programs focus on care management, not medical management.

The emerging program results show decreased hospital readmissions through the increased use of home health services, fall and depression risk assessments, and patient communications regarding medicines, pain management, and home safety.

Visiting Nurse Service of New York

VNSNY uses a population health management model with a primary focus on care coordination. It is a program based on patient-centered goals and care plans, nurse-conducted assessment and care coordination, health coaching and support, collaboration with primary care medical providers, clinical and financial outcomes reporting and measurement, and predictive analytics and risk stratification.

Specially trained RN population care managers lead interdisciplinary teams that include Nurse Practitioners, psychiatric Nurse Practitioners, pharmacists, hospital liaisons, social workers, and health coaches who provide both coaching and care navigation.

Overall, the home care community has stepped up with innovation and investment to develop new models of care for the chronic care population with one common result—higher quality of care and lower health care spending. The home care platform is proving itself to be a wise and sensible starting point with its focus on the whole patient, its scalability, and its modern, technology supported care. Still, there are limits to what providers can do absent systemic change in programs such as Medicare.

An expansion of IAH, both in terms of sites and scope, along with modifications in the design to fit a broader chronic care population meets all three of the Working Group's goals:

1. It increases coordination of care in that it involves a multidisciplinary care team charged with integrating all care needed in the community setting while working to avoid costly institutional and hospital care.
2. It incentivizes the appropriate level of care through a shared risk payment model.
3. It reduces Medicare spending through reductions in costly hospitalizations and other services through improvements in care quality, coordination, patient outcomes.

B. Advancing Team Based Care: Providing Medicare Advantage Enrollees with Hospice Benefits

Under the Policy Options Document category of Advancing Team Based Care, the

Bipartisan Chronic Care Working Group has indicated it is considering requiring Medicare Advantage (MA) plans to offer the hospice benefit provided under traditional Medicare as part of the MA benefit package. Currently, when a patient is diagnosed as terminally ill and decides to elect hospice care, responsibility for Medicare-covered services reverts to the fee-for-service program. The MA plan remains responsible for supplemental benefits and any drugs that would still be covered under Part D (if drug coverage is included in the MA plan). The Policy Options document indicates that this change is under consideration because “current coverage options lead to either a disruption in care or fragmented care delivery”.

A primary goal of the Working Group’s efforts is to improve care for individuals managing chronic illness, and to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic health conditions. In some cases the line between living with multiple chronic health conditions and approaching the end of life can be a subtle one, so we appreciate the Working Group’s interest in incorporating for public comment some stakeholders’ recommendation that hospice benefits be brought under the MA benefit package. We also appreciate the opportunity to provide our comment on the proposal, and look forward to continued dialogue with the Working Group on this and other important end of life issues as your deliberative process continues.

As a trade association that represents both hospices and home health agencies, we have had numerous discussions through the years with home health providers and have in-depth knowledge of some of the challenges associated with providing appropriate, effective, and high quality health care in the home as a contractor of some MA plans. Our comments reflect this experience as well as issues related to the unique Medicare benefit that is hospice care, and our concerns over the negative impact this change would have on hospice beneficiaries, hospice programs, and the Medicare hospice benefit.

MA/Structural Issues

We acknowledge that there are some private plans that have done an exemplary job in developing innovative and effective palliative and end-of-life care programs. These programs are the product of significant investment and effort on the part of the plans and involvement of experts in the field of hospice and palliative care; these plans are to be commended for their important work. The vast majority of MA plans do not provide care directly, nor do they invest significant resources required to closely coordinate and monitor quality of care. They have no experience with the complexities of end-of-life care for the Medicare population. For the most part, these plans contract with a sufficient number of providers to meet established standards for access to care. While the plans are required to offer an “actuarially equivalent” package of Medicare services to their enrollees, they have the freedom to make alternative determinations relative to beneficiary cost sharing and to act as gatekeepers relative to care access.

As the Medicare hospice benefit is a home-based, bundled package of services, some of the issues that have arisen under home health serve as a cautionary note to consideration of bringing hospice under the MA benefit package. Under fee-for-service, home health benefits are offered on an episodic basis (60 days per episode) to homebound individuals requiring skilled, intermittent care. Most MA plans, however, do not offer home health benefits on an episodic basis – rather, they contract with providers on a per-visit basis and permit only a small number of pre-approved visits at a time. As a result, the home health agency must await approval and go through the process of having to communicate with the MA case manager (sometimes a prolonged period of time). Additionally, administrative costs are increased for home health agencies since they include costs for negotiating contracts, securing prior authorization for services, and -- once care has been provided -- efforts to collect payment from the plans (which can be considerable). Some of these “hurdles” create fragmentation of services and beneficiary confusion as providers wait for approval of additional visits or of a change in the plan of care.

It should be noted that the hospice benefit is much more complex than the home health benefit in terms of what is contained in the bundle of services, and certain services must be provided under explicit rules (for example, requirements related to providing core services directly). Hospices are required to provide services that are not reimbursed by Medicare (such as volunteer and bereavement services) as well as an additional array of services (such as massage and music therapies) than are required by Medicare because these services have proven therapeutic value. This is not a structure or array of services that MA plans are likely to recognize or consider as they contract with hospice service providers.

It should also be noted that while hospice care is paid on a per diem basis (depending on the level of care provided) under fee-for-service Medicare, additional services (such as hospice physician services) are paid separately by Medicare but included in total expenditures for purposes of the hospice aggregate cap calculation. Under the hospice Conditions of Participation (CoPs), the hospice physician must provide medical services in all cases when the patient’s attending physician is unavailable to provide them. It is unclear how requirements like this one – which are unique to hospice care – would be handled by MA plans.

While the Centers for Medicare & Medicaid Services (CMS) and others have made considerable advances with the Hospice Quality Reporting Program (HQRP) in recent years, hospices quality measures are not yet publicly reported. As a result there is no single, reliable publicly-available means for comparing the quality of or satisfaction with an individual hospice provider’s care. This gives MA plans little to go on when judging which hospice provider(s) to contract with for services other than low bids by hospice providers. The Medicare Payment Advisory Commission (MedPAC) and others have found that lower cost hospices as a general rule are those that admit patients for significantly longer lengths of stay – an area of particular concern to policymakers and one that significant efforts are focused on curbing. Yet these are

the hospice providers who will be most able to offer low bids to MA plans.

Beneficiary Issues

We acknowledge that the coverage rules that are applicable when a MA enrollee elects hospice care are somewhat more complex than would otherwise be the case if hospice were provided as part of the MA benefit package. However, the benefits that would be gained by streamlining the process are more than negated by the additional challenges that would be faced by beneficiaries in the final stages of life and their informal caregivers. Descriptions of some of those challenges follow.

Beneficiary Choice: Given the current provider contracting approach of most MA plans relative to choice of provider of services, it is anticipated that MA plans would contract with a single or very limited number of hospice providers, giving a beneficiary or family little or no choice of hospice provider. As a general rule, the current population of individuals entering Medicare is healthier than was the case in previous generations and has a greater familiarity with private plan approaches to care coverage. For these young-old individuals, a MA plan may be a very attractive option. The biggest considerations for a Medicare beneficiary in selecting a private plan will focus on current needs – wellness, preventive and curative care; supplemental benefits provided at limited or no charge; and prescription drug coverage (if offered as part of the plan). Most relatively healthy beneficiaries would not make a private plan decision based on their anticipation of end-of-life care needs. Issues change considerably when a beneficiary is faced with a terminal prognosis of six months or less. The choice to transition to end-of-life care -- and the provider that will supply that care – are deeply personal ones. Choice of an end-of-life care provider is most often based on the recommendations and experience of family members, the beneficiary’s priest or spiritual adviser, or other trusted sources. Under an MA plan, a beneficiary no longer retains choice of provider for end of life care – that right is essentially waived when entering an MA plan.

Under the hospice benefit, a beneficiary has the right to change hospice providers once in a benefit period. If a patient has already changed hospice providers but wishes to change hospice providers again, the beneficiary may revoke hospice care and begin a new hospice benefit period under the care of a third hospice provider, with no loss of care. It is unclear how this current right of provider choice would be preserved under MA – and whether MA plans would have sufficient options among hospice providers in an area to ensure this right to its enrolled patients.

Additional choice concerns arise relative to patients that reside in nursing facilities (NFs). In NFs where hospice care is available, it is based on the facility’s choice of hospice providers with which to contract. In cases where a NF patient is on MA, there is no guarantee that the NF and MA-contracted hospice provider(s) will be the same – in fact, there is a very high probability that they will not have agreements with the same hospice(s). Under such contracting limitations,

a MA-enrolled patient requiring NF care may not have an option to access hospice care, even if it is offered in his/her facility.

Cost Sharing. While some limited beneficiary cost sharing is permitted under the hospice benefit, most hospice providers do not charge copayments for services. MA plans have the freedom to charge beneficiaries different coinsurances from those charged under fee-for-service as long as the package of benefits is actuarially equivalent to what is offered under fee-for-service. This could result in significantly increased beneficiary/family liability relative to hospice services.

Benefits, Coverage, and Continuity of Care. Under hospice, providers are paid on a per diem basis with the expectation that they will supply all care that is reasonable and necessary for the palliation and management of care related to the terminal diagnosis and any conditions determined to be related to the terminal diagnosis. This constellation of diagnoses is what the hospice physician considers as part of his determination that a patient has a six-month prognosis if the patient's disease runs a normal course. It is widely recognized that prognosis is not an exact science and that each patient must be assessed comprehensively to make a clear determination of what conditions are expected to lead to his ultimate demise, as well as to establish responsibility for care and develop an effective treatment plan. This is a hallmark of the hospice benefit. Hospices must assess a patient's needs each time there is a change in his condition, but no less frequently than every 15 days. Hospices must be prepared to change the treatment plan in very short order based on the patient's need. Many MA plans' contracting practices and requirements for prior approval of care or a change in service will create serious conflicts for hospice providers as they may result in delays in (or denials of) the provision of care that is needed by dying individuals.

With great frequency MA plans separately authorize distinct portions of Medicare benefits otherwise offered as a bundle under fee-for-service. This practice, applied in hospice, will lead to conflicts that will arise between the patient's hospice physician/interdisciplinary team and the MA plan over the comprehensive plan of care and appropriateness/approval of distinct services, in addition to delays in approval for services. These threaten the autonomy of the hospice team, but also have the potential to impact timeliness and quality of care, as well as overall effectiveness of the hospice benefit.

As noted previously, the vast majority of hospices provide the hospice benefit as structured under fee-for-service (including some services that are not reimbursed by Medicare) as well as an array of additional services neither explicitly covered nor reimbursed by Medicare, but that have proven therapeutic for patients in the final stages of life. These are services that hospices currently finance through their financial margins under fee for service as well as through other means – such as through donations or profits from fundraising enterprises such as thrift stores. MA plans may not consider the full scope of benefits that current hospice

beneficiaries receive when they contract with providers; as a result, hospices that contract with MA plans may no longer be able to provide this full range of benefits. Consequently, the full benefit of hospice care may no longer be accessible to MA-enrolled terminally ill individuals and their caregivers.

The hospice benefit is the only benefit under Medicare that requires a beneficiary to waive his or her right to a set of services (in this case, curative services related to the terminal illness or related conditions). Beneficiaries DO retain the right, under statute, to access Medicare benefits for curative services targeted at conditions that are not related to the terminal illness. Determinations of relatedness (and unrelatedness) are complex and require intense familiarity with terminal illness processes and the combined impact of multiple advanced illnesses. Disagreements between MA plans and hospice providers over a patient's right to curative care for non-related conditions will invariably arise; when they do, service delays will diminish patients' comfort and well-being, and could hasten death.

Hospice Provider/Benefit Integrity Issues

In addition to concerns about the challenges associated with integrating the MA structure with the hospice benefit and about the impact this change will have on hospice beneficiaries, this proposed change will also have a significant impact on hospice providers and the integrity of the hospice benefit generally. Many of these issues – MA plan redefinition of the hospice benefit package, the autonomy and authority of the inter-disciplinary team, delays in access to care, disagreement over determinations as to which conditions are related versus unrelated to the conditions that make up the patient's prognosis, the terms under which benefits are provided, additional administrative costs related to contracting and prior authorization of services, to name a few – will also severely impact hospice providers.

In recent years hospice care has undergone a wave of change that has not been experienced since the benefit was initially created. Many of these changes have been implemented with the intent of maintaining the integrity of the hospice benefit, but come at significant cost to hospice providers. In addition, beginning January 1, 2016, CMS implemented a new payment system for hospice Routine Home Care. While the new payment system is designed to redistribute payments so that they better reflect actual costs of care across a patient's length of hospice service, the full impact of these changes is not yet known. Hospice providers may be hesitant to contract with MA plans without a better sense of the impact that payment changes on the fee-for-service side will have on their financial viability. This may particularly be the case for those hospices that, generally, have patients on service for shorter lengths of time before death. Further, given the Congress' and CMS' desire to have hospice payments better reflect the actual costs of care, it is not clear how that goal would be maintained should hospice services be brought under the MA benefit package. These are concerns that policymakers must consider closely in relationship to the change being contemplated.

RECOMMENDATIONS:

Given the aforementioned and other concerns, we do not advocate a move toward inclusion of hospice services under the MA benefit package. With the existing comprehensive approach to care required under hospice, it is not clear that such an action would advance team-based care; instead, we believe that the value of the services provided by the hospice team could be greatly diminished. Further, while some complexities related to current coverage changes would be eliminated, a great many more would ensue.

If Congress does wish to further explore bringing hospice under the MA benefit package, we would advise the following:

- Coverage of hospice under MA should be explored as a demonstration that compares success across the different type of managed care models. This type of demonstration should include utilization of a broad array of quality measures. In all cases, the quality and coordination of care as patients transition to end-of-life care should be closely assessed as part of the MA plan satisfaction ratings. (Additional and more detailed comments on MA and quality measures are provided later in these comments.)
- If Congress determines that it is advisable for hospice to be brought under the MA benefit package, MA beneficiaries should have the right to disenroll from MA at any time so that they may elect hospice care from the provider of their choice.
- MA plans should be required to contract with Medicare-certified hospices based on fee-for-service benefit levels, service delivery model, and payment terms.
- The hospice inter-disciplinary group and the patient's attending physician (if applicable) should remain the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related and unrelated to the patient's terminal prognosis.
- Additional issues related to the current hospice benefit structure and associated requirements must be thoroughly explored to ensure that the integrity of the existing hospice benefit is retained when it is brought under the MA benefit package.

MA, End-of-Life Care and Quality Considerations

As we see the number of individuals living with a chronic, serious, advanced or terminal illness increase (along with lengthening of the average lifespan), the emphasis the health care system places on the cost and quality of care for these individuals becomes ever more important.

Until policymakers are able to thoroughly study all aspects of end-of-life care in the MA environment, hospice care should not be included as part of the MA benefit package. There are simply too many potential negative consequences that could occur without the proper studies to inform decision makers.

Numerous studies have shown that individuals hold quality of life as the most important aspect of end-of-life. Therefore, good measures of quality of care at the end of life are essential. At this time, there are no palliative care-related measures in the MA Five-Star Quality Rating System or the Medicare Shared Savings Program. Therefore, we encourage the Committee to study the models that have implemented palliative care early in the disease trajectory before incorporating palliative care or hospice in the MA benefit package. There are various state programs that could be studied, as well as:

[Aetna's Compassionate Care Program](#)

[Highmark Blue Shield Advanced Illness Management Program](#)

[Sutter Health Advanced Illness Management \(AIM\) Program](#)

[Gunderson Respecting Choices Program](#)

[The Advanced Care Project by the Coalition to Transform Advanced Care](#)

Study should focus not just on containment or reduction in overall costs, but also on development of validated quality measures and best practices. The quality measures should encourage those items that studies have shown to be key to quality end-of-life care:

- Earlier access to palliative care
- Integrated care coordination

Moving toward earlier access and integrated care advances team-based care, which, as the Committee summarizes in its Policy Options document, leads to stronger patient outcomes and reduced overall expenditures.

There are measures being used in other care sectors that could be used as indicators of outcomes achieved when palliative care is employed earlier in a person's serious/chronic illness journey. These include:

- Decreased hospital readmissions
- Reduction in ICU days
- Reduction in number of hospital days
- Reduction in number of hospital stays

- Reduction in ED visits
- Number of hospice referrals
- Number of hospice admissions
- Length of stay on hospice

There are also a number of existing measures endorsed by the National Quality Forum (NQF) or currently under consideration that could be utilized and further developed, including:

Measure 0210 - Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life.

Measure 0211 - Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.

Measure 0213 - Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life.

Measure 0215 - Percentage of patients who died from cancer not admitted to hospice.

Measure 0216 - Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there.

Measure 1625 - Percentage of hospitalized patients who die an expected death from cancer or other terminal illness and who have an implantable cardioverter-defibrillator (ICD) in place at the time of death that was deactivated prior to death or there is documentation why it was not deactivated.

Measure 1626 - Percentage of vulnerable adults admitted to ICU who survive at least 48 hours who have their care preferences documented within 48 hours OR documentation as to why this was not done.

Measure Under Consideration 578: Advance care plan

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

Note for measure under consideration 578: We believe this measure is a good starting point to promoting advance care planning, a necessary component to quality care. We recommend that this measure be added to the quality programs of other provider types

and, eventually, be expanded to include measures assessing provider compliance with patient's advance directive. Consideration should also be given in the future to including in the measure assessment of whether providers inform patients of the availability of advance care planning discussions, and provide referral in cases where the patient indicates an interest, if not directly having the discussion. This would be an especially appropriate measure for all physicians considering the fact that two new physician billing codes for advance care planning were added to the Physician Fee Schedule in 2016.

Numerous studies have underscored the need for advance care planning. As evidenced by development and consideration of an advance care planning measure by NQF and HHS, it is clear that health policy experts see a compelling need for greater progress relative to utilization of advance care planning. We strongly encourage the Committee to promote use of an advance care planning measure in the Physician Quality Reporting System, the MA 5-Star Rating program and the Medicare Shared Savings Program, at minimum; and to further study an advance care planning measure that could be utilized across the care continuum.

The Policy Options document contains several policies that are closely related to advance care planning and would be of great help to better informing individuals (and their representatives) about their health status so that these individuals could make more informed decisions about the plans for their care. These policy options include a one-time visit code post initial diagnosis of Alzheimer's/dementia or other serious or life-threatening illness; improving care management services for individuals with multiple chronic conditions (high severity chronic care management code); and addressing the need for behavioral health among chronically ill beneficiaries. The Advancing Team-Based Care section of the document is of great interest to us as numerous studies have proven that team-based care that is coordinated results in greater patient satisfaction because their wishes are addressed and met as much as possible and also results in better quality outcomes. This approach is the basis of the palliative care philosophy on which hospice care is based.

Practices that would promote earlier access to hospice and palliative care and integrated care coordination include screening tools that would identify individuals that could benefit from hospice and palliative care referral and linking quality measures and incentives to those providers making the referral. By referring more individuals to hospice at the right time and to palliative care services at the right time the following should be minimized: futile care, care that is not reasonable and necessary, ineffective care that increases burden and decreases quality of life. Simultaneously, such referrals will increase quality of life and decrease overall health care costs.

We also note that, in previous comments to the Committee, we have strongly advocated for creation of an effective advance care planning benefit under Medicare that is provided by a multi-disciplinary team. We note that members of the Committee have recommended such as

part of the Care Planning Act, and urge the Committee to explore options for implementing a benefit along these lines. The benefits of this approach for beneficiaries, Medicare and the health system generally cannot be overstated.

Additional Comments:

Establishing a One-Time Visit Code Post Initial Diagnosis of Alzheimer's/Dementia or Other Serious or Life-Threatening Illness

The Committee asked for feedback regarding establishing a one-time visit code post initial diagnosis of Alzheimer's/Dementia or other serious or life-threatening illness. Specifically, the Committee seeks feedback on the scope of diseases that would be considered a serious or life-threatening illness. We believe the types of diseases that would fall into the broad category of serious or life threatening are those that are not curable but require medical supervision of at least two visits per year and an ongoing regimen of treatment. For example, diabetes, multiple sclerosis, congestive heart failure, asthma, Parkinson's, advanced rheumatoid arthritis, Alzheimer's and other dementias. The definition could further include individuals who are mentally incapacitated. Because of the broad scope of such a category, it is not practical to develop criteria for each illness that fits within the scope of serious or life-threatening illness; rather, it is best to develop guidelines applicable to all serious and life-threatening illnesses. It is also important in the definition of a serious or life-threatening illness to differentiate this type of illness from a chronic condition. While a chronic condition can be a serious illness, not all chronic conditions would fall into this category (i.e. osteoarthritis).

C. Improving Care Management Services

A very important policy change that the Working Group could recommend is the removal of any and all barriers to the use of non-physician practitioners in the care of chronically ill Medicare beneficiaries. Non-physician practitioners (NPPs) include Nurse Practitioners, physician assistants, clinical nurse specialists, and nurse midwives. Every year, the shift to NPPs for primary care grows. It is the primary care practitioner who is usually managing the care of people afflicted with multiple chronic illnesses. Yet, antiquated Medicare policies, borne out of the 1960s, still limit Medicare coverage when the patient's primary care practitioner is an NPP.

The out-of-date design of Medicare is highlighted in the longstanding requirement that a physician certify the medical necessity of services and homebound status of a prospective Medicare home health services patient. This forces patients who have been under the direct care of an NPP for years to transition to a physician for the sole purpose of securing the certification. These NPPs can order the care needed under state practice acts. The NPPs know the patient far better than the physician. Yet, Medicare still requires the patient to rely on a physician she may barely know, if at all, to meet Medicare's technical limitations on certification.

Currently pending in the Senate is S. 578, the Home Health Care Planning Improvement Act of 2015, sponsored by Senators Susan Collins and Chuck Schumer along with a combined total of 42 bipartisan cosponsors.

S. 578 fits squarely within the Working Groups goals for policy reforms. It improves care coordination by recognizing the NPP as the primary practitioner for the patient when the patient has made that choice. Further, it would incentivize the appropriate level of care by putting the authority for certifying Medicare coverage in the hands of the practitioner who knows the patient best. Finally, care quality, transitions, efficiencies, and patient outcomes are certain to be improved as the care is under the control of the patient's primary care provider, thereby avoiding the problems occurring when a new practitioner is inserted into the patient's care.

This is likely just one example of where Medicare policy reforms can occur that removes the existing barriers to supporting the patient/practitioner relationship. Breaking down those barriers is certain to improve care across the board.

D. Telehealth Risk-Sharing Proposal: Reducing Inpatient Care through Technology

NAHC supports the Group's Policy Option of expanding the use of telehealth services. The broadest expansion possible is best, particularly if such expansion is shielded from Medicare cost increases using such payment models as risk sharing. We believe that the use of telehealth should be a high priority as Congress considers evidence-based reform proposals to advance the nation on the fast track toward a highly functioning, technologically enabled, modernized health care delivery system. When deployed in the home as a service of home health care, remote patient monitoring technologies greatly enhance the cost savings potential. Seniors are able to remain in their homes longer, delaying costly transfers to higher acuity settings, are more engaged with their care and have higher levels of care satisfaction. Providers are able to better manage the care of patients with chronic conditions by monitoring changes in health status with increased frequency and employing advanced analytic tools and data trends to improve service delivery, care coordination and reduce unnecessary emergency room visits

and hospital admissions.

Two specific changes should be made in existing Medicare standards to make telehealth services an optimum value tool in the care of persons with chronic illnesses. First, given the Working Group's commitment to caring for those with chronic illness in their own homes, the "originating site" standard should be revised to include the home. Second, remote monitoring services coverage under Medicare should be extended to care provided by any health care professional. The current limitation to services provided by physicians and certain other practitioners limits the value of telehealth as remote monitoring is effectively and efficiently provided by other health professionals such as nurses, therapists, and others who work collaborative with physicians in coordinated, team-like care of patients in their community.

These changes go beyond the Policy Options set out by the Working Group. The value of telehealth is not limited to the MA Plan or ACO model of care. Patients with chronic illness are more likely to receive care through traditional Medicare rather than an MA Plan or ACO. As such, to maximize the value of telehealth, it should be extended to all Medicare fee for service beneficiaries. If there are concerns about unchecked spending, that can be controlled through payment models that incentivize appropriate use rather than use itself.

The benefits of telehealth have already been demonstrated in a number of home health agencies across the country. When telehomecare interventions for chronically ill Medicaid patients were deployed at Windsor Place Home Health in Windsor, Kansas, for example, hospital readmissions, emergency room visits and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period were approximately \$1.3 million, while the "per patient" cost of the intervention was just \$6 per patient per day. Similarly, at Forrest General Home Care and Hospice in Mississippi, targeted telehomecare interventions for patients with congestive heart failure and chronic obstructive pulmonary disease caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year. Finally, the Veterans Administration telehealth program is a model worthy of replication within Medicare as it has proven to be a tremendous tool in managing individuals with chronic or acute conditions.

We believe that results like those seen in Kansas and Mississippi could be experienced on a large scale if Medicare reimbursement policies supported the targeted use of telehealth in the home for chronically ill patients who would benefit from "pre- acute" homecare.

To that end, we recommend that Congress consider legislation providing authority to CMS to test the value of care models that rely on the use of telehealth in home care settings.

One such bi-partisan legislative proposal is the Fostering Independence through Technology Act of 2013 (S. 596), introduced by Senators Amy Klobuchar and John Thune. It would have provided authority for CMS to implement a shared savings pilot program for home care agencies using remote patient monitoring technology. Under this budget neutral/savings legislation, participating agencies would receive a 75 percent share of the total Medicare cost savings realized over a year relative to a performance target set by the Secretary of HHS. The legislation would have limited payments to the amount that would have otherwise been expended if the pilot project had not been implemented, making this proposal cost-neutral. This integration of telehealth combined with the use of health information technology would greatly modernize the service delivery of home health care and provide for additional cost savings.

E. Maintaining Flexibility to Provide Supplemental Services in ACOs and any Innovative Model

NAHC recommends that the Working Group support the waiver of the Medicare home health services “confined to home” or homebound requirement in innovative care models such as ACOs, post-acute care bundling, Independence at Home, and the recently initiated Complete Joint Replacement (CJR) bundle model. The option of waiving the homebound limitation has been considered by CMS in each of these innovations, but CMS did not permit such in the end standards. The failure to extend that waiver in these innovative programs limits the intended flexibility that is at the heart of these new models. That flexibility is the chief means by which the innovations can bring about improvements in patient outcomes and spending.

With programs that put the provider at risk for unnecessary spending, a waiver of the homebound requirement can do no harm to Medicare. However, it can bring new knowledge regarding how care in the home, regardless of a person’s mobility, can achieve positive results for all stakeholders. Follow-up with a recently discharged inpatient in her own home improves the likelihood of an effective transition, compliance with post-hospital care plans, and reductions in unnecessary readmissions. Transitions in care takes on a more active operation when health care personnel attend to the patients in their own environment. Outpatient care and follow-up visits with the community physician are valuable. However, direct connection to the patient in his/her own home ensures that all support services are in place, medication management is secure, and the impact of the community environment is fully understood and incorporated into continuing care plans.

F. Encouraging Beneficiary Use of Chronic Care Management Services

The Working Group recognizes the importance of care management and coordination to achieve improved patient outcomes in its policy option of encouraging Medicare beneficiaries to use the chronic care management services of physicians. While the Policy Options document focuses on physician care management, the existing Medicare home health benefit provides an opportunity to broaden the scope and delivery of care management services to chronically ill Medicare beneficiaries through a provider community with over a century of experience.

In some respects, the administration of the Medicare home health benefit by both Medicare itself and the home health agency providers has been a roadblock to improve care and care outcomes for individuals with chronic illnesses. Part of the problem is the inaccurate assumption that the Medicare home health benefit is a limited, post-acute short term benefit for individuals with an acute condition. However, it is one of the best designed benefits in Medicare, permitting coverage of patients with chronic illnesses in a coordinated and comprehensive manner.

Medicare home health services are covered provided the individual in “confined to the home,” aka homebound, and in need on skilled nursing care on an intermittent basis or physical therapy or speech language pathology, 42 USC 1395f(a)(2)(C) [Part A]; 42 USC 1395l(a)(2) [Part B]. Both Part A and Part B can cover non post-acute care services without a prior hospitalization.

Since the early 1990s, Medicare regulations have specifically indicated that coverage is available without regard to whether the individual has an acute, chronic, or terminal condition. Similarly, the rules permit coverage for care over the long term as well as the short term, dependent only on the existence of a skilled care need. Also, skilled care that is intended to maintain function or slow deterioration is within the Medicare coverage benefit standards. 42 CFR 409.42-409.44.

One particular qualifying skilled nursing services set out in the Medicare rules is worthy of note—skilled management and evaluation of a care plan. 42 CFR 409.44 incorporating 409.33. Specifically, the skilled service is defined as:

“Services that could qualify as either skilled nursing or skilled rehabilitation services—

(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on

the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.”

The care coordination described in the earlier examples of successful home care-based chronic care management is the exact type of care that is embodied in the “overall management and evaluation of care plan” skilled service under current Medicare rules. However, it is rarely applied by home health agencies out of well-reasoned fear that Medicare will retroactively reject payment for the claim.

NAHC recommends that the Committee require CMS to engage in nationwide education of its contractors and home health agency personnel focused on this one basis for coverage. If needed, clarifying or expanded policy guidelines should be issued. In the end, an application of this covered service in home care can create the foundation for significant improvement in patient-centered, community-based chronic care management that benefits Medicare beneficiaries and the Medicare program bottom-line.

This type of action should be considered cost neutral by the Congressional Budget Office as it merely supports the application of existing law. No new policy is created. Still, given CMS’s track record of educating home health agencies and Medicare beneficiaries on coverage standards, it is unlikely that CMS will act without urging from the Senate Finance Committee.

G. Developing Quality Measures for Chronic Conditions

CMS currently posts home health performance data on its Home Health Compare website, deriving HHA-specific performance ratings from data collected through the Outcome Assessment Information Set (OASIS) assessment tool and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. While the OASIS tool collects patient-specific information on outcome, process and potentially avoidable event measures at the point of care, the HHCAHPS survey assesses patient satisfaction through survey responses provided by the patient, a family member or a friend at a later

date. CMS also uses some of the OASIS data in its Star Rating system.

We encourage the Working Group to use the data collected through the OASIS tool as the primary starting point for the new measure development needed to advance any payment reforms. However, we caution that OASIS data is skewed toward patient improvement outcomes that do not universally fit for patients with chronic illness as the goals for those patients may be maintenance or slowed deterioration in their clinical conditions. The Star Rating system totally excludes these types of measures.

Our members have reported that there are some limitations associated with the HHCAHPS survey, as a patient's satisfaction with the care they receive may not reflect the quality of care provided in some instances. Additionally, responses provided by a patient's friend or family member may not provide a true picture of the care received by the patient as many patients may not share complete details regarding their health condition(s) with others. As such, we believe that HHCAHPS results should be a small component of any system that links payment to quality, if at all.

Despite these reporting initiatives, gaps in quality measurement continue to exist. The Measures Application Partnership (MAP), a public-private partnership between the National Quality Forum (NQF) and the Department of Health and Human Services (HHS), identified areas where existing Home Health Compare measures should be updated, as well as six priority areas for new measurement development.

As an initial matter, MAP stakeholders recommended that Home Health Compare measures be updated to align with quality measurement principles being used in other care settings. The MAP advisory committee indicated that existing Home Health Compare measures should be revised to reflect data collected over a period of time rather than a single point in time, and be flexible enough to allow for customization to reflect the unique care provided within the home health care setting. Stakeholders also recommended that existing measures be modified to take into account health disparities, to reflect key structural and cost goals for home health care, and to address the unique care required by specific subpopulations who receive home health in significant numbers (e.g., patients with chronic disease, cancer patients, patients with dementia).

In addition to its examination of existing home health measures, MAP stakeholders also identified six priority areas for new measure development, focusing on those areas where current measures are either insufficient or non-existent, including:

- Function, including an assessment of functional and cognitive status;
- Goal attainment, including the establishment and attainment of patient/family/caregiver goals and advanced care planning and treatment;
- Patient and family engagement, including care experience and shared decision-making;
- Care coordination, including transition planning;
- Safety, including measures related to falls, pressure ulcers, and adverse drug events; and
- Cost/access, including measures examining inappropriate medication use, infection rates, and avoidable readmissions.

Establishing appropriate quality benchmarks is challenging, as the patient population is very heterogeneous even within care settings. In home health, for example, the patient population is split between older individuals struggling with chronic disease and other patients who are recovering from a single acute episode. Although the same measures might be used to evaluate the quality of care provided to both of these patient groups, the use of same benchmarks or targets may not be appropriate given the diverse health needs of the two groups.

In closing, we appreciate the opportunity to submit our comments as you consider ways to improve care for Medicare patients with chronic illness. If you have any questions or need any further information, please do not hesitate to contact us.

Sincerely,

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