Home Care & Hospice Association of NJ

The Catalyst for Excellence in Home Care & Hospice

January 26, 2016

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 Senate Finance Committee's Bipartisan Chronic Care Working Group.

The Policy Options Document includes a recommendation requiring Medicare Advantage (MA) plans to offer hospice services as part of the MA benefit package. This change would threaten patient/family choice of care provider in their final days of life and reduce the value of the hospice benefit to patients and their loved ones. Therefore, we strongly encourage the Committee to not move forward on this recommendation, and for the reasons below.

The working group's rationale for considering this change is that the current structure for MA enrollees electing hospice care leads to either a disruption in care or fragmented care delivery. This recommendation raises significant concerns for hospice providers and beneficiary advocates; among them are the following:

- Medicare beneficiaries enrolled in MA that elect hospice will no longer have a choice of the hospice provider that will care for them in their final days of life as MA plans are accustomed to contracting with select providers. Because MA plans are not accustomed to managing end-of-life care, it is likely that they will contract with only the lowest cost hospice providers or perhaps limit the number of hospice providers to a very small number. This is especially of concern for residents in nursing facilities. These residents have the right to choose hospice care and must choose from the hospice providers contracted with their nursing facility. If the MA plans are to include hospice care in their package, there would undoubtedly be cases where the nursing facility is not contracted with an MA-approved hospice forcing the resident to either transfer out of the facility (unlikely as terminal patients typically don't choose to make living arrangement changes) or not receive hospice care;

- Hospices currently provide a wide array of services to patients and their loved ones – a number of which are not reimbursed by Medicare. It is anticipated that in most cases MA plans will contract with Medicare certified providers to supply hospice services. In an effort to keep contracted rates low, MA plans may be incentivized to limit the services they contract with the hospices to provide, or may attempt to contract for hospice care on different terms and/or at significantly reduced rates. As a result, beneficiaries may not receive a hospice benefit equivalent to that which they would receive under fee-for-service;

- Similarly, many hospices provide additional services beyond the scope of the hospice benefit (such as massage, music, and other therapies) because they have proven value in improving the quality of life for many patients on hospice. Continuing availability of these services may be at risk if hospice services are provided by way of MA plans;

- Medicare hospice eligibility rules require that a patient be determined to be terminally ill with a prognosis of six months or less if the disease follows its normal course. Tensions could arise between the MA plans and a contracted hospices relative to whether a patient does or does not meet Medicare's eligibility requirements;

- Additionally, the hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the comfort and palliation of the terminal illness and related conditions. Financial incentives may lead MA plans to shift responsibility for unrelated services to a contracted hospice provider; and

- The Medicare Hospice Benefit is currently undergoing significant change. Starting on January 1, 2016, hospices are paid one of two payment rates for RHC depending on how long the patient has been on hospice care. There remain uncertainties about the impact of these changes on the delivery of hospice care, as well as about potential additional changes in the hospice program. These uncertainties will impact hospices' willingness to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs.

As stated above, we recommend the Committee not move toward incorporating hospice as part of the MA benefit package. If inclusion of hospice under MA is to be considered, thorough analysis of the impact of such a change should first be conducted. If and when Congress contemplates inclusion of hospice under the MA benefit package, it should include the following safeguards:

- MA beneficiaries that are determined to be terminally ill and eligible for the hospice benefit should be given the option of immediately disenrolling from MA so that they may elect hospice from the provider of their choice;

- MA plans should be required to contract with Medicare-certified hospices based on fee-for-service benefit and payment terms and levels;

- The hospice inter-disciplinary group (IDG) and the patient's attending physician (if applicable) should be the ultimate authority on hospice eligibility, the hospice plan of care, and determinations of which conditions are related to the terminal diagnosis. Likewise, the IDG and attending physician (if applicable) should determine the conditions that are not related to the terminal and related conditions that should be covered by the MA plan; and

- The quality and coordination of care as patient's transition to end-of-life care should be closely assessed as part of the MA plan satisfaction ratings and there

> should be palliative and end-of-life quality measures incorporated into the MA 5-Start Rating and the Medicare Shared Savings Program. The National Quality Forum (NQF) has endorsed measures and has others under consideration that are directly related to quality of care at the end-of-life. Many of these are used in other areas of healthcare but are applicable to hospice or palliative care patients. These include:

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.

Numerous studies have underscored the need for advance care planning and this has been embraced by policy makers as evidenced by the approval of advance care planning codes payable as part of the Medicare Physician Fee Schedule and the consideration of an advance care planning measure by NQF and HHS. 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 especially important to us as team-based care that is coordinated results in greater patient satisfaction. 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.

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).

We further encourage the Committee to continue evaluation of the following policy options:

- Expanding the Independence at Home Model
- Advancing Team Based Care by Improving Care Management Services
- Expanding Innovation and Technology through the Expanded Use of Telehealth which has proven great success in reducing hospital readmissions in New Jersey
- Empowering Individuals and Caregivers by Encouraging the Use of Chronic Care Management Services

The greatest impact that can be made on improving the quality of care for chronically, seriously, and terminally ill individuals and their caregivers and reducing the cost of care to these populations is to minimize the encounters this population has with hospitals and other inpatient settings. Achieving this requires patient-centered well-coordinated care. There are many innovative programs being piloted at the national and local levels. We urge the Committee to further study these models for best practices and increase the transparency at the CMMI, as indicated in the

Document. Further study should include the input of experts in the fields of advance care planning, care coordination, home care, hospice and palliative care. The Home Care & Hospice Association of New Jersey stands ready to assist the Committee in these efforts by networking with innovative providers in our state and sharing lessons learned for best practices.

Again, we deeply appreciate the opportunity to provide feedback on the policy recommendations.

Sincerely,

Chrissy Buteas

Chrissy Buteas
President & CEO