



Hospice Alliance of Ohio
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TO: Senate Finance Committee
RE: Response to the Bipartisan Chronic Care Working Group Policy Options Document

Senate Finance Committee:

Thank you for the opportunity to comment on the report from the Bipartisan Chronic Care Working Group Sub-Committee (BCCWG). The Hospice Alliance of Ohio is a nonprofit association representing 21 nonprofit hospice providers throughout Ohio. The Association's emphasis is to create an environment that focuses on elevating the standards of practice while fostering person-centered care, providing excellence in care across all the communities we serve.

INTRODUCTION:

At first glance, you may determine that this response is opposing the inclusion of hospice into the "Managed Care" arena. We hope you take the time to consider our comments thoroughly through the lens of community-based nonprofit hospice providers. We believe it is important to appreciate how change affects non-profit providers, who now make up less than 40% of the overall hospice industry.

It is exciting, challenging and frustrating to continually shift to meet the overall goals of a changing healthcare industry. Since the ACA, 2009, the hospice industry has continually made programmatic and infrastructure changes to address over twenty-six legislative and regulatory requirements in this dynamic environment. In the last two Wage Index Updates (2014 and 2015) the industry has been subjected to two significant changes that affect reimbursement. One is related to the penalties heaped on the industry due to technical data entry mistakes with the Notice of Election. The second change is the new reimbursement model that CMS implemented beginning January 1, 2016. Which the effects can only be anticipated at this point due to its newness.

It would be silly at this time to expect the vigorous pace of change to subside as the industry preps for new reporting requirements, continuing scrutiny of claims, and an overall health care industry shift towards a managed care model (ACOs, MA Plans, Managed Care, etc.). A healthcare system that, at the same time, is moving towards patient-centered care (which hospice has provided since its inception), to meet the triple aim, and focus on paying for quality and value.



DEVELOPING QUALITY MEASURES FOR CHRONIC CONDITIONS:

HAO will start our comments in this area of the report as it is an underlying and related critical component to address for hospice and the other chronic care populations you address, as well as the shifting health care environment.

To be in agreement to the report's overall comments in this section is easy but the necessity to address this need is broader than just for "chronic conditions." As the healthcare industry moves towards a "patient-centered care" model, it is essential that quality measures and outcomes be identified and developed that specifically target the unique needs of individuals and the communities in which they live. Of concern is how to include or identify evidence-based strategies that link individual care needs with community-based population health activities and address upstream social determinants of health. Difficulty currently exists in finding a set of metrics that can be used across the health industry to monitor progress and assess outcomes. This may be further hampered in a "managed care" environment where the transparency of data is limited as it becomes "proprietary" property.

The Alliance is in agreement with the bullet point for hospice and end-of-life care. These are the issues that need to be addressed and measured. Other than the family/caregiver experience of care, the work in identifying ways to measure other areas is lacking and not creative or substantial enough to measure an individual's value-based goals or outcomes. While medical measures around end-of-life may be easier to identify, other data, such as what is an appropriate "live discharge rate," is elusive as the industry appears unable to characterize specific elements of appropriateness. The other difficulty with end-of-life measures is that death is an expected outcome while this result is unacceptable for every other area of healthcare. This continues to create an access burden as many healthcare providers excessively treat patients and fail to define appropriate goals of care in a prompt manner. This is noted by the percentage of hospice deaths that occur within seven days or less, 33% since 2010.¹

As payment shifts from volume to quality and value, focusing on patient-centered care and related items such as emotional, biomedical, and spiritual or value needs, as well as having personal choices honored and providing support for families is, as the report acknowledged, obscure. The June 2012 report from the National Quality Forum, we believe supports this notion, as work is still in its infancy.² In a patient-centered and quality value-based health system, these issues should have an elevated priority in determining the appropriate provision of care and measuring outcomes around patient-centered values is essential.

This raises an issue of caution. The Medicare Advantage environment (as well as managed care in general) we believe has yet to identify measures around patient-centered outcomes and practices as well. Many would argue that Medicare Advantage and managed care has little experience in paying for care that addresses social determinates and related outcomes, particularly around family and social supports. As Medicare shifts from a fee-for-service pay structure towards one that pays for value and quality from a population health perspective the significance of addressing social and supportive needs rise as payment for volume of services decreases. Until there are more clearly defined measures and outcomes in these areas, there is concern that removing the Medicare Advantage Carve-Out could disrupt the basket of services



that hospice provides, particularly those services that address the social, emotional and value-based needs of dying individuals.

To that end, we fully agree with your "*Reason for Consideration*" as listed in this section on page 23 of the report. Furthermore, we would argue against your "*Reason for Consideration*" listed under the subject heading of **Providing Medicare Advantage Enrollees with Hospice Benefit** primarily due to insufficient measures. Without the identification of proper measures and outcomes, removing the carve-out threatens the integrity of end-of-life care and could further fragment care during this time as well as return to a system that drives patients towards institutionalization and ICUs.

Suggestion around outcome measures:

A suggestion to consider around the development of measures is to more thoroughly examine functional measures and outcomes. The International Classification of Function (ICF), which provides a scientific basis for understanding health and health-related states as well as outcomes, related to both physical as well as social determinants, would be a way to determine appropriate outcomes more quickly. This would provide a common language across the healthcare industry to describe health and health-related states. It would also permit a standard comparison of data, not only across our system but with other countries as it provides a logical coding scheme for medical records.

The ICF provides a systematic process to describe situations around human functioning and related restrictions as well as serving as a framework to organize information. The ICF deals with function and disability and related activity and participation, covering domains from both an individual as well as societal perspective. The ICF also supports the documentation of contextual factors which allow for the measurement of environmental and personal influences which can be translated into understanding the individual's local community and related supports. The components of these categories can be expressed in terms where one could construe a positive or negative outcome depending on the goals of care.

Over time, the ICF model would also provide more detail on indicators around individual risk and related "group" risk to allow CMS to adjust capitation of payments to health plans and protect beneficiaries from selective bias. The ICF model covers issues around personal and environmental aspects more thoroughly than the CMS-HCC Model. In a 2014 Health Value Dashboard study released by the Health Policy Institute of Ohio researchers estimated that factors which influence 80% of one's health are related to behaviors (30%), social and economic factors (40%), and one's physical environment (10%).³ Finally, the ICF's are developed and already integrated into the ICD-10 and ICD-11 taxonomy internationally.

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

HAO believes that furthering the discussion and attention in this area is critical to achieve a system that will appropriately pay for value and quality outcomes as well as meet the triple aim. Your first bullet point regarding plan-level measures that could be used to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care drives directly at the heart



of concerns for hospice providers. To receive high-quality end-of-life care, a hospice has to be able to provide a basket of services that assertively treat and manage symptoms. It must also have the ability to provide care supporting family while addressing social and environmental factors.

Some "goals of care" examples:

- A veteran on hospice wants to travel with the Honor Flight program to Washington DC, to visit the war memorials.
- A dying patient wants to travel from OH to GA and back to visit family and the homestead before dying.
- A mother wants to see her child married before dying.
- Music therapy (art therapy, touch therapy, guided imagery) is needed to sooth a suffering patient.
- The family wants to admit a loved one to hospice immediately to remove them from a hospital setting and spend time in the comfort of their home through the dying process.
- A family is scared as an elderly gentleman falls prey to uncontrolled pain and is suffering and needs to be transferred to an inpatient unit at 2 am, or 2 pm.
- A dying elderly woman, who wants to die at home near her gardens needs fluid removed from one lung to decrease pain and ease breathing.
- A patient on a ventilator wants to be transferred out of the hospital to a more comfortable setting to be with family before being withdrawn from her ventilator.
- A young man, weakened, bed and wheelchair bound, wants to visit his favorite golf course one more time and view life from the 18th tee.

These are typical end-of-life examples that take resources and coordinate care and services to meet these individual goals of care. We believe a system that focuses on patient/family centered outcomes, as well as pays for value and quality, will see the need to support resources to help these individuals meet their dying needs. A system that primarily focuses on paying for medical services through ICD and CPT taxonomy, and hasn't yet developed a way to appreciate how social and environmental factors affect health outcomes, may view the examples as "nice" things to try and do, but may limit resources to help meet these patient-centered goals. The effort to help these individuals meet their goals of care may not be appreciated and thus, the value that hospice brings the dying community will diminish.

When issues like "pre-authorization" for an admission; change in the level of care; accessing care; or support services, takes multiple layers of communications and approval processes it slows the response for patients that are dying. And time is the commodity these patients don't have. In the end-of-life environment, patients have emergent needs that due to their limited existence are framed differently than in a traditional medical environment. This is a philosophical shift in "how to care for" thinking. Those emergent needs are often driven by existential crisis as one attempts to "finish their business." The examples above, some pose a more medical picture while others are driven more by personal needs and activities. However, they are all motivated by a desire to control end-of-life and participate in some last interactions to satisfy individual purposeful needs.



Specific to the related hospice questions in the report:

1. The Report asks for feedback on specific plan-level measures that could be used to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care:

- As we stated previously, the highest priority is to identify quality measures focused on patient-centered care and individualized goals of care.
- There should be a system that openly reports, by all payors/providers, outcomes related to items addressing emotional, biomedical, and spiritual or value needs, as well as having personal choices honored and providing support for families.
- Standardize processes from any payor, MACs to MA plans, as much as possible;
 - This increases care coordination among providers, and from one provider to another;
 - Streamlines policy and payment systems and reduces errors;
 - Facilitates interpretation of policy and delivery of care; and
 - Increases program efficiencies and contributes to the most effort being focused on the beneficiary and not the administration of policy.
- Identified standardized data elements to report quarterly. This should incorporate the PEPPER Report elements, family satisfaction scores, as well as other defined elements.
- Maintaining access to the current data collected by CMS.
 - For example - data elements such as readmission rates, live discharge rates, Average Length Of Stay, Medium Length Of Stay, etc.
 - DATA needs to be robust, transparent and reported timely (Quarterly).

2. The working group is soliciting feedback on other safeguards that should be in place to ensure MA enrollees have access to high-quality hospice services.

- Billing and payment timeframes need to be standardized, and deadlines to report should be identified:
 - Standardized definition of what a clean claim is and the process to determine a clean claim;
 - Report timeliness of paid claims; and
 - Report percent of claims submitted, claims in processing and related timeframe, and denied claims.
- Partner with highly functioning hospice providers that also support robust community programming from bereavement care to education;
- Partner hospice programs that provide the full realm of hospice services and consistently exceed industry quality standards;
- Align with hospice programs that maintain appropriately credentialed and qualified staff from employed physicians to the hospice aide;
- Align the responsibility to meet the measures and criteria expected for End-of-Life care to both the providers and MA Plans. Making sure the PLAN and provider are expected to meet the same criteria in specific areas quickly aligns expectations and processes;
- Lastly, because of the significance of and transformation of caring for individuals at end-of-life, all major health related associations have statements regarding care at the end-of-



life. MA and managed care plans should identify their philosophy around the significance of and meeting care needs at the end of life.

Other identified opportunities for a relationship between managed care and hospice providers.

- Coordination of care across the continuum;
- Appropriate and timely identification of terminally ill patients;
- Earlier and more robust conversations around "goals of care";
- Engage with community palliative care providers that focusing on management of serious chronic conditions
- Increased assistance to keep the patient in the environment of their choice; and
- Decreasing the utilization of high-cost resources to terminally ill patients.

ADDITIONAL COMMENT:

A National POLST:

An additional point HAO would like to identify is in regard towards the rationale provided in the introduction. At the bottom of page 3, the report outlines three overall efforts that the policy's strives to meet. In reviewing these and the overall report we were somewhat surprised there isn't more effort to identify Advance Care Planning and determining Goals of Care measures with this population, in this report. While we appreciate all the effort by CMS around Advance Care Planning, we can't miss the opportunity to emphasize the importance of discussing goals of care in the chronically ill population. HAO strongly encourages the health care community to have clear discussions around advance directives and goals of care with this population as it would go a long way towards care coordination. Additionally, a national POLST (Physician's Orders for Life-Sustaining Treatment) could allow for coordination to occur across settings, from home to hospital, from nursing facilities to first responders. We believe your final recommendations should include dialog and identified actions promoting this interaction.

IN CONCLUSION:

On January 11, 2016, an article in the Pittsburgh Post-Gazette reported that Highmark, a leading health plan across Pennsylvania, ended contracts with ten nursing facilities and eight home care agencies. A representative stated, ***"This is an example of Highmark beginning to act differently, as an integrated care and financing system."*** One of the home health agencies who had worked with Highmark for decades was terminated from the contract. A representative of a nursing facility dropped from the network stated, ***"We've worked hard to reach that four-star rating and then, here you go, we're tossed out. It is kind of mind-boggling to me."***

HAO is not aware of the specific circumstances regarding the removal of these providers from Highmark and we are not specifically critical of Highmark. In fact, we expect a narrowing of the choice of providers to occur as the healthcare arena transitions. Rather, it is our request that the evaluation of Plans and Providers move forward in a way that the highest quality providers raise to the top. As new payors begin to shape the changing face of Medicare and Medicaid in the future, those payors should be incentivized to identify quality providers and partners. This again underscores the need to have clear guidance and identified measures evaluating outcomes and services that meet the triple aim as well as patient-centered goals of care.



Thank you again for the opportunity to participate in responding to the Report and for your thoughtful work and efforts. The Hospice Alliance of Ohio is proud to contribute to your efforts, and we are available to discuss further our comments if desired.

1. The Centers for Medicare and Medicaid Services; 2010 - 2014. Downloads/reports/HospiceData. Accessed/Cushman, January 22, 2016.

2. National Quality Forum. *Performance Measurement Coordination Strategy for Hospice and Palliative Care, FINAL REPORT JUNE 2012*. Washington, DC. National Quality Forum; 2012.

3. Health Policy Institute of Ohio. *2014 Health Value Dashboard*. Columbus, OH. Health Policy Institute of Ohio; 2014.