January 26, 2016

The Honorable Orrin Hatch
Chair
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Committee on Finance
United States Senate

The Honorable Mark Warner
Committee on Finance
United States Senate

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

LeadingAge commends the work of the Finance Committee's Bipartisan Chronic Care Working Group and the Policy Options Document you released last month. The document should provide a strong foundation for policy changes to more effectively manage the health care and other services needed by individuals with chronic diseases and conditions.

The mission of LeadingAge is to expand the world of possibilities for aging. Our membership has a service footprint of 4.5 million people. Our community of 6,000 members provides the full range of services to elders and people with disabilities, including nursing home care, home- and community-based services, affordable housing, assisted living and continuing care retirement communities. Most of the people our members serve have at least one chronic health condition, and the majority of the population has multiple co-morbid conditions.

We appreciate the opportunity to provide comments on several of the issues on which the working group requested stakeholder input. Our views on home care and hospice services, expanded recourse to technology, and ACOs are below.

Expanding the Independence at Home Model of Care

LeadingAge has been one of the many supporters of the Independence at Home (IAH model) as an example of team-based care for vulnerable beneficiaries built on care delivery where they live, rather than a fragmented system of providers and facilities. We support expanding the current IAH demonstration into a permanent, nationwide program.

The IAH initiative also should waive current Medicare eligibility requirements for specific skilled services; the home-bound requirement for home health care and the three-day hospital in-patient stay requirement for skilled nursing care. The IAH model includes close oversight by the provider team and accountability for resource use as part of the performance measures. The home-bound and three-day stay requirements therefore are not needed to prevent over-use and they do not allow the necessary flexibility to serve beneficiaries “at the right place, with the right services, for the right amount of time,” which is the IAH goal.

The working group requested feedback on risk stratification for eligibility using the hierarchical condition categories (HCCs). HCCs have long been used to identify and rank disease burden and predict costs by managed care plans and the Program of All-inclusive Care for the Elderly (PACE). However, HCCs do not capture risk, based on the functional status of the individual served. Furthermore, because of failure to diagnose, document or code, Alzheimer’s and other dementias are often not identified. New criteria are needed to further identify the high-risk, high-cost population who would benefit from the team-based home care of the IAH program.

We support the current quality measures, and would offer that additional measures to explore could include expanded advance care planning to capture the individual’s goals and preferences for care beyond typical end-of-life interventions; for example, CPR or ventilator use. We would also support the inclusion of a composite measure of quality of life, focusing on the beneficiary’s experience, rather than merely measuring the processes and outcomes defined by the providers.

Recommendations:

Support IAH expansion into a permanent model with waivers of the homebound status requirement for home health services and of the 3-day acute hospital stay requirement for skilled nursing services.

- **Waive the home bound requirement for skilled home health and the 3-day stay requirement for skilled nursing home services.**
- **Expand the risk assessment criteria beyond HHCs, to include function and cognitive impairment**
- **Expand quality measures to include goal-based advance care planning and quality-of-life measures.**

Providing Hospice Coverage under Medicare Advantage

LeadingAge understands the chronic care working group’s concern that beneficiaries enrolled in Medicare Advantage (MA) plans do not have the same access to hospice services that beneficiaries have under traditional Medicare.

However, simply adding hospice to the list of services MA plans must offer would be ill-advised at this time because of the following characteristics of Medicare Advantage and hospice:

- Medicare Advantage's quality programs use HEDIS (Healthcare Effectiveness Data and Information Set) measures. These mainly focus on improvement in the beneficiary's condition, which has limited relevance or value for individuals experiencing advanced illness and end of life.
- Medicare Advantage quality measures were divided into five broad categories, each with an assigned weight determining the level of importance. Patient experience and access each had a weight of only 1.5 compared to weights of 5 for improvement, 3 for outcomes and 3 for intermediate outcomes. The levels of importance used in Medicare Advantage measures do not align with the hospice benefit in which the patient's and family's experience are the main components of a successful hospice program.
- We currently lack publicly reported data on hospice quality. The Affordable Care Act required hospices to begin reporting quality measures in 2013. Since July 2014, hospices have submitted quality data for seven process measures, including measures related to screening and assessment of pain and assessment and treatment of shortness of breath.
- In 2015, hospices began participating in a Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care Survey. The survey goes to the informal caregiver, typically a family member, of deceased hospice patients. Publicly reported data from these initiatives is not expected before 2017, so there now is no way to analyze hospices' performance on this assessment.
- The Medicare Advantage CAHPS has no questions that are relevant to end-of-life care; questions mainly focus on physician/patient interaction instead of the individual's quality of life.
- The five Medicare health outcomes survey (HOS) measures which are included in the Medicare Advantage Part C plan ratings consist of measurements related to improvement or maintaining physical and mental health, physical activity, bladder control and fall prevention. Even though these areas of care are important for quality of life, the Medicare health outcomes survey (HOS) measures do not have a focus on end of life care.
- The Medicare Hospice Benefit is currently undergoing significant change. Starting on January 1, 2016, hospices receive one of two payment rates for routine home care depending on how long the patient has been on hospice care. The impact of these changes on the delivery of hospice care remains uncertain, and additional changes in the hospice program are possible as well. Because of these uncertainties, hospices may hesitate to enter into contracts with MA plans, particularly if the contracts do not, at a minimum, cover costs.
- Hospice is a capitated Medicare benefit under which the hospice team (including the hospice medical director), attending physician and hospice patient develop and implement the plan of care. Medicare Advantage plans can charge different out-of-pocket costs and have different rules for service delivery. In contrast, the hospice per diem payment rate is intended to cover all care determined to be reasonable and necessary for the beneficiary's comfort and palliation of the terminal illness and related conditions. A hospice carve-in would require major changes to the ways in which both hospice and Medicare Advantage organizations currently operate.

We recognize that 31% of Medicare beneficiaries are enrolled in a Medicare Advantage plan, although enrollment rates vary greatly by state and locale. While it is certainly necessary to begin discussing how these beneficiaries can obtain better coverage of hospice services, the impact of a hospice carve-in on both hospice and Medicare Advantage must be taken into account. We believe it would be premature to implement a carve-in before the related issues for both programs are resolved.

Recommendation: We suggest CMS implement a process for stakeholder input that includes convening a Technical Expert panel to discuss this issue.

Plan-level measures: appropriate and quality hospice services

The working group is soliciting feedback on specific plan-level measures that could be used to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care.

Currently, there are no vetted outcome measures for end of life care. The measures currently in use are process measures, although the hospice CAHPS does measure the patient and family caregiver care experience.

The National Quality Forum (NQF) Measure Applications Partnership (MAP) identified 28 measure concepts that are important for hospice and palliative care. These measure concepts represent areas that must be addressed to ensure access to affordable palliative and hospice services. Measure concepts include the person- and family-centered nature of care, which focuses on individual goal setting and preferences; the team-based aspects of care coordination; and the holistic process of care that emphasizes not only the treatment of physical illness, but also emotional, mental, spiritual, and psychological well-being.

Of the 28 measure concepts, MAP prioritized seven for both hospice and palliative care, three specific to hospice care, and three specific to palliative care. The three priority measure concepts specific to hospice care reflect patients' needs for increased access and communication; the three priority measure concepts specific to palliative care reflect patients' needs for education and care coordination.

Recommendation: Besides the existing seven process measures and the hospice CAHPS, we suggest evaluation of the following outcome measures identified by the National Quality Forum (NQF) Measure Applications Partnership (MAP):

- Physical aspects of care—treatment of pain, dyspnea, constipation, and other symptoms using standardized scale— should be periodically re-evaluated and incorporated into the care plan. Managing physical aspects of care is the logical initial focus for performance measurement as it has the largest evidence base and helps avoid unwanted treatments and hospital or emergency department admissions and readmissions
- Preventing unnecessary hospital and emergency department admissions is an important indicator across the care continuum. If patient needs are adequately met, the result should be reduced admissions and readmissions.

- Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms—is essential to compassionate care of people who are dying. Behavioral changes significantly add to the burden of care and can lead to an unstable care plan, hospital admissions and crisis interventions.
- Timeliness and responsiveness are vital to optimal hospice care as they prevent unnecessary emergency department visits and hospital admissions and readmissions. Given that the average length of stay in hospice is relatively brief, care must be timely to support patients and caregivers, enhance autonomy, prevent unwanted hospital admissions, and improve experience of care. Further, a timeliness factor should be incorporated into other measure concepts such as assessments and care planning.
- Access to the healthcare team on a 24-hour basis is important for hospice patients with complicated healthcare and comfort issues and their caregivers, as it emphasizes the importance of the team being available to assist when needed, to reduce anxiety. Timely intervention improves care coordination and limits unnecessary hospitalizations.
- Avoiding unwanted treatments, when measured, serves as a proxy for appropriate levels of communication and care planning in hospice programs. Unwanted treatments also include unnecessary hospital/ED admissions and readmissions.

Safeguards to ensure MA enrollees have access to high quality hospice services

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

LeadingAge recommends the following:

- The Medicare Advantage measure’s metric category weight for patient experience and access to services needs to be adjusted to provide an incentive, in the form of increased bonus payments and rebates, for Medicare Advantage plans to contract with and adequately reimburse quality hospice providers
- Access to quality hospice services should be a component in the determination of the MA plan’s star rating.

Expanding Supplemental Benefits for Medicare Advantage

Flexible benefit structure based on chronic conditions of individual enrollees
The chronic care working group is considering giving MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual enrollees. Specifically, the chronic care working group is considering allowing MA plans to offer:

- Additional supplemental benefits not currently covered that are related to the treatment of the chronic condition or the prevention of the progression of the chronic disease;
- Reduction in beneficiary cost-sharing for items and services that treat the chronic condition or prevent the progression of the chronic disease;
- Adjustments to provider networks allowing inclusion of more providers and nonclinical professionals to treat the chronic condition or prevent the progression of the chronic disease;
- Care improvement and/or wellness programs specifically tailored for the chronic condition.

The working group also is soliciting feedback on:

- Whether **all** MA plans should be permitted this flexibility, or if a subset of plans based on quality, experience, or other criteria should be eligible.
- The process by which chronic diseases would be identified for which MA plans benefits would be tailored.
- What other requirements MA plans should be required to meet to ensure changes to benefit design improve care for chronically ill beneficiaries and do not disrupt care for beneficiaries who do not have a chronic condition.
- What, if any, changes would need to be made to Special Needs Plans if this policy were implemented.

Recommendation: LeadingAge suggests:

- Only Medicare Advantage organizations that have a proven record of quality, as well as experience with disease-specific care coordination should be allowed the flexibility to offer supplemental benefits not currently allowed, and this flexibility could be targeted to improve outcomes for individuals with specific diseases.
- CMS should consider the past performance results of Disease-Specific Special Needs plans, and the existence of NQF-endorsed measures for outcomes in the treatment and management of a particular disease as part of the process to determine the chronic diseases that will have a more flexible benefit plan.
- In order to determine which diseases should be targeted for a flexible benefit plan, CMS should also consider what diseases have been successfully monitored through the use of telehealth and other remote monitoring technologies.
- Medicare Advantage plans allowed to have a flexible benefit structure based on chronic diseases should be given the approval to offer these benefits for individuals who do not meet the criteria for the flexible benefit structure, disease-specific plan.

<u>Reason for Consideration</u>: Currently, MA plans must offer the same benefit package to all of their enrollees, despite the different health needs of these enrollees. Allowing MA plans to specifically tailor their benefit package to meet the needs of chronically ill individuals will help improve management of chronic diseases and/or prevent the progression of these diseases.

Medical services or other non-medical, social services as additional supplemental benefits
The chronic care working group is considering allowing MA plans to offer a wider array of supplemental benefits than they do today. These additional supplemental benefits could be medical services or other non-medical, social services that improve the overall health of individuals with chronic disease. Any new supplemental benefits would continue to be paid by plans’ rebate dollars.

The working group is soliciting input on:

- The criteria that could be used to determine what new supplemental benefits could be offered by a MA plan.
- Whether safeguards should be put in place so that the offering of new supplemental benefits does not lead to abusive practices and/or inappropriate enrollment.

Recommendation: LeadingAge suggests the criteria used to determine what new supplemental benefits could be offered by a MA plan should include a review of the services currently offered by existing integrated payment and care delivery models, such as the Program of All Inclusive Care for the Elderly (PACE). PACE provides non-emergency transportation, nutritional services and adult day center services based on the individual needs of enrollees. Research on PACE has shown decreases in Medicare costs, reductions in nursing home placement and hospitalizations.

Reason for Consideration: A wide range of non-medical or social factors, such as nutrition, are important contributors to the health and care costs of chronically-ill individuals. Currently, MA plans are able to provide some services not traditionally covered under fee-for-service Medicare. However, there are additional services that may particularly benefit chronically ill beneficiaries that are currently not permitted to be offered by MA plans as supplemental benefits.

Improving care management services for individuals with multiple chronic conditions:

LeadingAge supports a high-severity chronic care management code. However, much of this needed coordination is, and should be, provided by interdisciplinary team members beyond the current "incident to" rules for physician services billing. For example, home health team providers (including nurses, social workers, therapists and pharmacists) are well positioned and skilled in the areas of care coordination for persons with multiple chronic conditions.

We would also support the inclusion of one serious chronic condition and a co-morbid diagnoses of Alzheimer's or a related dementia.

Ensuring Accurate Payment for Chronically Ill-Individuals

LeadingAge supports the proposed changes to the CMS-HCC model. In particular, we are concerned that the current HCCs (and provider coding) fail to capture the risk of both complex care needs and increased costs for those individuals with Alzheimer's and related dementias. We also support the inclusion of functional status measures in the risk-adjustment model, which, when paired with chronic conditions and add further predictive value to expected costs and service needs.

Expanding Innovation and Technology

Increasing Convenience for Medicare Advantage Enrollees through Telehealth

LeadingAge strongly supports permitting MA plans to include certain telehealth services in their annual bid amount. The use of these technologies should not be a substitute for network adequacy requirements.

- The working group is soliciting feedback on whether the telehealth services provided by the plan should be limited to those allowed under the traditional Medicare program.
- The working group is also soliciting feedback on whether additional telehealth services should be permitted and, if so, which ones.

LeadingAge firmly believes that telehealth services provided by the plan **should not** be limited to those allowed under the traditional Medicare program. The following barriers to the use of telehealth services must be removed:

- the restrictions on originating site to include the homes of patients, regardless of geography (i.e., not limited to rural areas);
- the restrictions on real-time two-way video conferencing communications, to include asynchronous biometric as well as behavioral/ activity remote monitoring technologies;
- the restriction of the eligible provider to physicians or physician assistants. Eligible providers should include home health/ home care agencies, nurses, and care/case managers.

The working group is soliciting input on whether safeguards should be put in place so that the offering of new supplemental benefits does not lead to abusive practices and/or inappropriate enrollment. LeadingAge believes that such safeguards should include:

- Eligibility criteria, such as number and types of chronic conditions, hospitalization history, and provider competency.
- Certain requirements such as physician/plan authorization, and periodic review and re-authorization
- Quality measures, such as hospitalizations, hospital readmissions, outcome measures, and patient satisfaction.

Providing ACOs the Ability to Expand Use of Telehealth

LeadingAge strongly supports lifting the originating site requirement entirely for ACOs ***AND*** specifying additional eligible providers.

LeadingAge firmly believes that the following barriers should be removed:

- the restrictions on the originating site to include the homes of patients, regardless of geography (i.e., not limited to rural areas);
- the restrictions on real-time two-way video conferencing communications, to include asynchronous biometric as well as behavioral/activity remote monitoring technologies;
- the restriction of the eligible provider to physicians or physician assistants. Eligible providers should include home health/home care agencies, nurses, and care/case managers, who play a significant role and reduce the burden and cost of chronic care management.

LeadingAge believes that lifting these restrictions only for two-sided risk ACOs will protect against the risks of abuse and over utilization. We recommend considering this for all ACO types and suggest considering the following potential safeguards to prevent abuse:

- Instituting eligibility criteria, such as number and types of chronic conditions, hospitalization history, and provider competency
- Certain requirements such as physician authorization, and periodic review and re-authorization

- Quality measures, such as hospitalizations, hospital readmissions, outcome measures, utilization cost, and patient satisfaction.

Expanding Use of Telehealth for Individuals with Stroke

LeadingAge also strongly supports eliminating originating site geographic restriction for the narrow purpose of promptly identifying and diagnosing strokes. This would provide every Medicare beneficiary the ability to receive an evaluation critical to diagnosis of an acute stroke via telehealth from a neurologist not on-site.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization

The chronic care working group is considering recommending that ACOs in MSSP Track One be given the choice as to whether their beneficiaries are assigned prospectively or retrospectively.

For care coordination purposes, it makes sense to allow ACOs to choose the beneficiary assignment methodology that best matches with their care model. With ACOs bearing responsibility and risk for the beneficiaries under their care, the organizations should be allowed to optimize their service delivery system with choice of assignment method.

A beneficiary who voluntarily elects to be assigned to an ACO should be allowed to receive services from providers that are not participating in the ACO. As ACOs are now structured, beneficiaries retain their freedom of choice for service providers. Even with the voluntary election to be assigned to an ACO as a beneficiary, that participation does not equate to joining a managed care plan, and beneficiaries should retain their freedom of choice. One might assume a beneficiary who voluntarily elects assignment to an ACO would be savvy enough to proactively avoid seeking out unnecessary or extraneous care.

A beneficiary who voluntarily elects to be assigned to an ACO should maintain the same provider freedom of choice that is allowed all other ACO participants.

The work group has asked whether ACOs that are assigned beneficiaries prospectively or in which beneficiaries volunteer to participate should receive an upfront, collective payment for all services provided to the beneficiaries in the ACO.

As ACO models become more closely aligned with managed health plan models, beneficiary protections and financial regulations should also be aligned. And when ACOs become responsible for upfront prospective payments, safeguards that exist in the health plan world should be applied to these ACOs. For example, regulations related to reinsurance, financial stability and reserves should be present as the level of risk assumption increases. Beneficiary protections that safeguard against underutilization and unethical selection practices such as seeking out healthier less costly beneficiaries and limiting service to complex high utilizers should be mandated.

Again, we greatly appreciate this chance for input into the chronic care issues now under consideration by the working group. We commend the working group's focus on several issues we outlined in our original comments submitted in June, including better coverage of home care and the promise of applied technology as a means of increasing care efficiency and enabling individuals to live independently.

We would just note that many other issues must be addressed for the achievement of a healthy, ethical and affordable system of services for people with chronic health conditions. In our earlier comments, we discussed the importance of affordable housing, the special needs of people dually eligible for Medicare and Medicaid, the need for strategies to improve service delivery in frontier and rural areas, and the savings that could accrue from better coverage of low-cost, non-medical interventions that can help prevent falls, malnutrition and other illnesses and injuries that are expensive to treat.

We would also reiterate that since many or most of the services people with chronic health conditions require are provided outside of doctors' offices and hospitals, post-acute care providers must be seen as equal partners in chronic care. Nursing homes, home care agencies, and other post-acute care providers have substantial expertise in managing chronic care, and they must have a seat at the table when decisions about these services are being made.

We look forward to a continued collaboration with the working group and the Finance Committee on the development of a better system of services for people with chronic health needs.

Sincerely,

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