TO: Senate Finance Committee
FROM: LeadingAge Ohio
RE: Bipartisan Chronic Care Working Group Policy Options Document

January 26, 2016

Senate Finance Committee:

Thank you for the opportunity to comment on the report from the Bipartisan Chronic Care Working Group Sub-Committee (BCCWG). LeadingAge Ohio is a membership organization representing mission-driven providers committed to advancing solutions for exceptional care and successful living. Our membership is comprised of continuing care retirement communities, affordable housing providers, home health agencies, hospices, skilled nursing facilities, assisted living communities and adult day providers. Our members serve approximately 400,000 Ohioans annually.

LeadingAge Ohio praises the Working Group for undertaking this extensive review process of promising practices in chronic care management. Below, we have outlined portions of the document and LeadingAge Ohio's recommendations.

Expanding the Independence at Home Model of Care
LeadingAge Ohio supports the expansion of the Independence at Home (IAH) model as a positive and cost-effective example of team-based care for individuals with chronic illnesses and conditions. We support care delivery in the individual's place of preference whenever possible, and this home-based model has proven to maintain individuals at home, rather than being shuffled from provider to provider, facility to facility. LeadingAge Ohio agrees that the current IAH demonstration should be expanded into a permanent, nationwide program.

We also support waiving current Medicare requirements for specific skilled services, specifically the home-bound requirement for home health and the 3-day in-patient stay for skilled nursing care. Given that these safeguards were enacted to prevent overuse, and given the IAH model already has built-in accountability for resource use, waiving these requirements make sense.

The Workgroup requested feedback on risk stratification for eligibility using the hierarchical condition categories (HCCs). LeadingAge Ohio is concerned that HCCs do not provide a sufficiently complete picture of patient condition to be used for stratification of risk. We recommend incorporating functional status, as well as diagnoses of Alzheimer's and related dementias, to create a more useful and accurate barometer for high-cost, high-risk populations.

We support the current quality measures. Additional measures that may be useful include advance care planning to ascertain self-determined patient goals, as well as a patient-centered composite measure of quality of life.

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Recommendations:

- LeadingAge Ohio supports the expansion of Independence at Home into a permanent model.
- LeadingAge Ohio encourages lawmakers to waive the home bound requirement for skilled home health and the 3-day stay requirement for skilled nursing facility services.
- LeadingAge Ohio encourages regulators to include function and cognitive impairment in risk assessments.
- LeadingAge Ohio encourages lawmakers to consider additional measures for this program, including advance care planning and quality-of-life measures.

Providing Medicare Advantage with Hospice Benefits

General Comments
The rationale included in this proposal is flawed. It indicates that Medicare Advantage (MA) plans are currently "not required to assume financial risk of their enrollees' hospice care," implying that, by including hospice as a benefit, this dynamic would change. The truth is that hospices have always assumed the risk for their patient population, under a capitated, per diem payment structure. Provided the payment structure under Medicare Advantage also adopts a per-diem model, this will not change. Furthermore, this assumption of risk and care management is the critical piece which makes hospice care so effective for managing the complex end-of-life phase. This is the reason the Medicare hospice benefit has always been carved out of MA plans—because the added layer of management is duplicative and unnecessary, given hospices' willingness to care manage their patients and excellent track record in doing so effectively.

The alternative is, of course, that the MA plan may not reimburse hospices on a per diem basis, but rather set up an alternative fee structure as yet to be determined. While this would certainly shift the risk to the MA plans, it would also shift the decisions and responsiveness away from the patient bedside. LeadingAge Ohio is very concerned that this would impede care delivery, as hospices may be forced to wait for approval, evaluate different contract provisions, or other administrative delays.

And while the proposal indicates that "The full scope of the hospice benefit, including the required care team and written care plan, would be required," if a hospice is forced to frequently authorize the various services it provides, the de facto result will be an unbundling of the benefit. Hospice has long provided the single best model of integrated care in the Medicare program, which addresses the whole individual and family, including psychosocial and spiritual needs. If this policy change is undertaken haphazardly, it could undermine over three decades of progress made to improve the care for America's dying. Finally, LeadingAge Ohio continues to be troubled by the lack of transparency in terms of health outcomes and data available for those beneficiaries served under Medicare Advantage plans. There is a strong public stake in being able to evaluate various Medicare Advantage plans against one another and against traditional Medicare. While we recognize

that health information is valuable to private entities, we believe the public interest should outweigh any proprietary one.

Competing Pressures

LeadingAge Ohio is concerned that the incorporation of a hospice benefit into Medicare Advantage may be premature, and may hinder, rather than expand access to this critical, team-based model of care. The hospice benefit has undergone significant changes in recent years, with over twenty-six legislative and regulatory requirements in this dynamic environment. In the last two wage index rules, the industry underwent two major changes: first, penalties dealt out to address data entry mistakes and the Notice of Election, and second, the new two-tiered reimbursement coupled with a "service intensity add-on", which took effect January 1. Given that the latest change just occurred, it is premature to determine its full effect.

Further, there is no sign that the pace of change will slow anytime soon. New measures are currently being developed to amplify the Hospice Item Set (HIS) are anticipated to be reviewed this year, the industry is undergoing significant consolidation and realignment, and hospices are struggling to keep pace with other industry shifts, such as the movement towards accountable care organizations (ACOs), Medicaid managed care changes.

Hospice Measurement

Beyond all this, however, is the simple fact that at this point in time, hospice measurement is in its infancy. Those measures that are currently in broad use by hospices are few: a family-reported experience of care instrument (Hospice CAHPS), a small subset of process measures captured on the Hospice Item Set, and various measures—as of yet un-validated—which may be derived from data captured in hospice claims.

These measures have just begun to be collected. Not one of them has more than two years running in the hospice industry. It is yet unclear whether any of them, much less which ones, will be suitable for public reporting.

Finally, hospice measurement diverges characteristically from those measures which Medicare Advantage plans have traditionally used. Because there is no presumption of improvement in end of life care (death is the point, after all), hospice makes an ill fit with the HEDIS (Healthcare Effectiveness Data and Information Set) measures that typically focus on improvement.

The panacea of hospice measurement is, of course, to capture the degree to which the care provided matched the patient's self-determined goals of care, as articulated earlier in the care process. But goals of care at end-of-life are diverse and largely qualitative in nature—ranging from as simple as "having no pain" or "dying at home" to goals that are more challenging to capture, such as "travelling out of state, to visit my childhood home." To date, we have no strategy for capturing these highly personal goals in a way that can be aggregated at the agency level. This is the level of measurement sophistication we are seeking, however, so it should not go unmentioned.

A better approach may be to consider a set of end of life measures which, while not captured within the hospice benefit, touch on the MA plan's ability to promptly identify and guide those beneficiaries which are approaching end of life. Possible measures that would drive appropriate and patient-centered end of life care include: the percentage of beneficiaries who have had advance care planning discussions identifying their care goals, the percentage of individuals who, upon being given a life-limiting diagnosis, have a palliative care consultation; the rate of ICU utilization in the last months of life; the rate of hospice utilization in the last months of life. Because these measures capture processes that fall outside of the hospice benefit, any of these measures could be implemented now, without having to make the policy change of bringing hospice into Medicare Advantage.

Recommendations

- LeadingAge Ohio encourages lawmakers to suspend its interest in incorporating hospice into the Medicare Advantage program **at this time**.

- LeadingAge Ohio encourages lawmakers to work with MA plans to identify measures which capture the whole picture of end of life care, including advance care planning processes, palliative care utilization, and utilization of hospice near the end of life.

- LeadingAge Ohio encourages lawmakers to monitor the progress of the hospice CAHPS, as that metric seems the only currently existent data set that would be appropriate for incorporation into plan-level measurement, if this policy option is pursued at a future date.

- LeadingAge Ohio encourages regulators to facilitate transparency in health data and outcomes under Medicare Advantage.

LeadingAge Ohio thanks you for the opportunity to provide input on this important work. Any questions regarding this document may be directed to Nisha Hammel, Director of Advocacy at nhammel@leadingageohio.org.

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