**To: Members and Staff of the Senate Finance Committee Chronic Care Working Group**

**Subject: Comments from RTI International on the CCCWG Options Paper**

**Date: January 26, 2016**

RTI International is one of the world's leading research institutes, dedicated to improving the human condition by turning knowledge into practice. Our staff of more than 3,700 provides research and technical services to governments and businesses in more than 75 countries in the areas of health and pharmaceuticals, education and training, surveys and statistics, advanced technology, international development, economic and social policy, energy and the environment, and laboratory testing and chemical analysis.

RTI is presently working under separate contracts with CMS on both the **Independence At Home Demonstration** and the **Hospice Quality Reporting Program.**

Comments follow on each of these topics as referenced in the Chronic Care Working Group options paper. We appreciate the opportunity to inform the CCWG objectives of improving how Medicare treats beneficiaries with multiple complex chronic illnesses, and would welcome the opportunity to expand on these comments if members or staff wish further discussion.

**Independence at Home (IAH) Demonstration:**

As the implementation support contractor for the Independence At Home Demonstration we have detailed knowledge of how the demonstration operates.

We agree that the first year results are promising and it may be desirable to develop an IAH-like program as a permanent part of the Medicare program. We are engaged in analyses and will be convening technical expert panels designed to inform future directions for IAH.

We strongly recommend that the committee **defer actions on any specific recommendations** pending the results of the planned analyses and technical expert panel meetings that are being conducted in 2016 and 2017.

These activities will examine the key tenets of the IAH program design: how to best identify the target population, what criteria should be required for a medical practice to be accepted as an IAH practice, and how future IAH-like practices should be reimbursed to provide the desired results and minimize the risk of Medicare fraud.

We also recommend that it would be prudent to **wait for at least one more year of the IAH demonstration results** before designing a benefit as part of the Medicare program. The Year 1 results were highly variable across practices, with only half the practices achieving savings. Further work to identify the right patients and the characteristics of the practices is important.

Ideally, the committee would await results of the mandated **Report to Congress** to provide the full evaluation results based on the first three demonstration years and meaningful data for further action.

**Hospice Quality Reporting Program (HQRP):**

RTI's work on HQRP includes developing and implementing quality measures and the patient-level data collection required to assess care provided for patients and caregivers receiving hospice services.

Based on our analysis of the scientific reliability and validity of the quality measures currently implemented in the Hospice Quality Reporting Program, we will begin public reporting of quality measure data, enabling consumers and other stakeholders to assess and compare hospice performance.

Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice. Hospice care is palliative care provided through a well-established program for patients with a prognosis of six months or less if the terminal illness runs its usual course. As delineated within the Medicare Hospice Benefit, these services can be provided in the home, nursing home, residential facility, or on an inpatient unit. Under current rules and capitated payment, patients enrolled in Medicare Advantage (MA) plans that elect hospice care revert to traditional Medicare coverage. Thus, MA plans are incentivized to encourage hospice-eligible patients to elect hospice; this ends the MA plan'sclinical and financial responsibility for the patients. This "carve-out" can result in fragmented care for patients nearing end of life.

We support **ending the MA carve-out** because it could result in improvements in care coordination for vulnerable patients. However, some unintended consequences on quality of care could result. RTI wishes to comment on strategies to monitor and mitigate these unintended consequences and protect patients at the end of life.

**First,** we strongly recommend the continued inclusion of MA plan beneficiaries in the HQRP. The current HQRP and its national patient-level data collection includes all hospice patients, regardless of payer.

Gathering hospice quality information, regardless of payer or setting of care, incentivizes all hospice care providers to provide high-quality care and allows for monitoring of any potential unintended consequences ending the carve-out might have on quality of care.

**Second,** because the ending the carve-out and keeping MA beneficiaries who elect hospice care in their MA plans would incentivize increased care coordination, use of palliative care, and earlier use of hospice care for patients, we also strongly recommend a focus on developing quality measures for MA plans. These quality measures should capture important domains of high-quality palliative care and care coordination at the end of life across the continuum of care.

Currently, there are no nationally implemented quality measures for palliative care. Development and implementation of measures to capture quality of palliative care should be a priority and would provide an opportunity to better understand the relationships between management of advanced illness, palliative care, and hospice care.