



Improving Care for Patients with Serious Illness: Part Two

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HEALTH CARE COVERAGE AND PAYMENT PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, the Bipartisan Policy Center's Health Care Coverage and Payment Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders, its board of directors, or the Serious Illness Advisory Committee.

Glossary of Acronyms

ACL: Administration for Community Living

ACO: Accountable Care Organization

BBA: Bipartisan Budget Act

CBO: Congressional Budget Office

CHIP: Children's Health Insurance Program

CHRONIC Act: Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017

CHW: Community Health Workers

CMMI: Center for Medicare and Medicaid Innovation

CMS: Center for Medicare and Medicaid Services

eCQM: Electronic Clinical Quality Measure

E&M: Evaluation and Management

FFS: Fee-For-Service

HCBS: Home and Community-Based Services

HHS: U.S. Department of Health and Human Services

LTSS: Long-Term Services and Supports

MA: Medicare Advantage

MSA: Metropolitan Statistical Areas

OPPS: Outpatient Prospective Payment System

PCAs: Personal Care Aides

PFS: Medicare Physician Fee Schedule

QMB: Qualified Medicare Beneficiaries

RAISE Act: Recognize, Assist, Include, Support, and Engage Family Caregivers Act

SLMB: Specified Low-Income Medicare Beneficiaries



6	Forward
6	Executive Summary
7	Improving Access to Care for Patients with Serious Illness: Securing a Stable Workforce
13	Improving Access to Care for Patients with Serious Illness: Support for Family Caregivers
23	Conclusion and Next Steps
24	Appendix
30	Endnotes

Foreword

This is the second report in a two-part series on federal policy options designed to improve care for individuals and families who are coping with serious illness. The first report, [Improving Care for Patients with Serious Illness: Part One](#), focused on changes to Medicare payment and delivery models as well as policy recommendations designed to improve access to care through telehealth. This second report offers analysis and recommendations to improve support for family caregivers and create a more sustainable and viable direct care workforce.

Executive Summary

Americans with serious illness, their families, and caregivers face daunting challenges in the U.S. health care system. Patients with serious illness have conditions that (1) carry a high risk of mortality, (2) limit their ability to live independently, and (3) cause them to rely heavily on caregivers to help them remain at home.¹ These high-needs individuals may have comorbid conditions such as diabetes, chronic obstructive pulmonary disease, and heart disease and may need assistance with common, everyday activities such as bathing, dressing, and preparing meals. In addition to traditional medical services provided in a physician's office or hospital, individuals with serious illness often require other non-medical health-related services that help them with these everyday activities. Examples of these services include transportation, care management, minor home modifications such as grab bars, and medically tailored home-delivered meals. And while those with serious illness span every age, the rapid increase in the number of Americans over age 65 with serious health conditions and functional limitations has spurred researchers and practitioners to focus on and advocate for more effective and person-centered models of payment and delivery of services under Medicare, the primary source of insurance for older Americans.

A study by Discern Health identified key characteristics of payment and care delivery models that result in the highest-quality care for those with serious illness.² Key characteristics include: access to in-home services, including the use of telehealth services; care coordination services; individual care plans based on patient and caregiver needs; and interdisciplinary care teams that communicate regularly and monitor changes in a patient's health or functional status. For patients with complex care needs, research has also shown that the provision of certain social services and supports not typically covered by health insurance can reduce hospital readmissions and emergency department visits.³

Since 2014, the Bipartisan Policy Center, under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, has issued policy recommendations to improve quality and reduce costs for the most vulnerable and most costly individuals in the U.S. health care system.⁴ As mentioned above, this report is the second in a series on serious illness that expands on this previous work. The series focuses on changes to existing reimbursement structures and traditional models of care by addressing the following issues: (1) improve quality and access for those with serious illness in Medicare, (2) improve access to telehealth services, (3) increase the availability of a well-trained direct care workforce, and (4) provide additional support to family caregivers.



Improving Access to Care for Patients with Serious Illness: Securing a Stable Workforce

INTRODUCTION

Americans born between 1946 and 1964, known as baby boomers, are turning 65 at a rate of 10,000 per day and will continue to do so until 2029. By 2034, all the baby boomers will be over age 70.⁵ With a rapidly aging population and the prevalence of older adults with multiple chronic conditions, there is concern among policymakers about the adequacy and availability of a workforce able to care for the frail elderly. This demographic shift will place a significant demand on the health care system, requiring policymakers to rethink care delivery. The demographic shift will also have a significant impact on spending under Social Security, Medicare, and Medicaid.

Historically, states have held the authority to license health care providers to practice medicine. The federal government reimburses providers practicing within the scope of their licenses under the Medicare program. Increasingly, policymakers hear from health plans, advocacy organizations, and provider organizations about the barriers imposed by state scope of practice laws, the impact on access to health care, and cost of care. However, federal policymakers have long been reluctant to interfere in state-level professional licensure. As baby boomers increase in number and the medical workforce ages, and with the increase in hospital consolidations and closures, it has become increasingly important to determine the impact on access to care in federal programs and outlays.

The Medicare and Medicaid programs reimburse a range of providers in a variety of settings, including facilities such as hospitals, nursing homes, rehabilitation facilities, and other inpatient settings. These programs also reimburse providers in outpatient settings, such as in physicians' offices, federally qualified health centers or other clinics, and home or community settings. Medicare and Medicaid reimburse physicians, advance practice nurses, psychologists, licensed clinical social workers, home health agencies, and other providers depending on the type of service. Private insurers cover a similar range of settings and provider types.

Specifically, the Medicaid program reimburses care for a similar range of providers, but because Medicaid covers long-term services and supports (LTSS), Medicaid also covers care provided by direct care workers (known as personal care assistants, caregivers, personal care aides, and community health workers). Agencies that contract directly with insurers can employ these individuals. Personal care aides are generally limited to providing non-medical but health-related services, including arranging transportation to doctors' offices or other outings, housekeeping, and assisting clients with bathing or dressing, and often they also advise families and patients on health-related issues such as nutrition, hygiene, and daily activities. They can be employed directly by a family, an agency, a community-based organization, or an insurer.

For both home health aides (Medicare) and personal care assistants, the median annual wage in 2017 was approximately \$23,000. The Bureau of Labor Statistics projects that employment of home health aides and personal care aides will grow 41 percent from 2016 to 2026, much faster than the average for all occupations. This is in part due to the aging population and the baby-boomer demographic shift, along with the increased demand for the types of non-medical health-related services this direct care workforce provides. In this section of the report, BPC examines opportunities to meet this increased demand by supporting a more viable workforce that can provide patient- and family-centered care in the home and community.



A direct care workforce is necessary to provide non-medical health-related services that patients with serious illness need to remain in their homes. Without a well-trained direct care workforce, public and private insurers struggle to meet the needs of the population.

Older Americans facing serious illness often prefer to receive care in the home and community, rather than in an institution such as a hospital or nursing home. However, health plans, providers, patients, and their families have identified workforce shortages in a variety of areas, especially those

providing direct care. A direct care workforce is necessary to provide non-medical health-related services that patients with serious illness need to remain in their homes. Without a well-trained direct care workforce, public and private insurers struggle to meet the needs of the population. There are several ways in which Americans with serious illness might access these types of non-medical health-related services; however, access to this care is fragmented and provided through a series of differing benefits with their own eligibility requirements and types of providers. They include:

Medicare Home Health

For older Americans in traditional Medicare, non-medical health-related services can be accessed through Medicare's home health benefit, which covers certain core medical and medically related services in the home. To qualify, a physician must certify that a patient is homebound and needs one or more of the following services: intermittent skilled nursing care, physical therapy, occupational therapy, or speech-language pathology services. Once a patient qualifies, *home health aides* may provide some basic health-related services, such as checking a client's pulse, temperature, and respiration rate. They may also help with simple prescribed exercises, with giving medications, or with other medically related tasks such as bandage changes or helping with artificial limbs. With special training, experienced home health aides also may help with durable medical equipment such as ventilators. However, the services a home health aide provides are dependent on the state in which they work and are limited to the Medicare home health benefit, typically employed by a certified home health or hospice agency. They work under the direct supervision of medical professionals and must comply with Medicare regulations.

Palliative Care and Hospice

Palliative care interventions are designed to control the symptoms of serious illness, coordinate care, and improve communication among patients, providers, and families. These interventions improve quality of life, support patients and families, and in many cases, lower costs.⁶ These services are generally unavailable to Medicare beneficiaries unless they are eligible for and enrolled in Medicare's hospice benefit. Hospice requires that patients be certified by a physician as having a terminal illness. The physician must also certify that the patient is not expected to live more than six months. Patients must also forgo curative care or medical treatment for their condition. Not all patients with serious illness are eligible for hospice care, and those who do qualify may be unwilling to stop active treatment.

Medicare Advantage

Many of the social services needed by those with serious illness are provided by local public agencies or non-profit organizations, including faith-based organizations. Today Medicare Advantage (MA) plans and health care providers often refer patients to these community-based organizations, which provide services at no cost or low cost. These organizations often struggle, however, to keep up with the demand for services in their communities because of limited resources.

Medicaid

For those who are low-income, Medicaid may cover the cost of social services and supports provided in the home. The availability of home-based services under Medicaid depends largely on the state in which a patient resides. Medicaid covers some of the cost of non-medical health-related services through state plans or home and community-based waivers; however, those services are available to Medicare beneficiaries only after they exhaust their financial resources. Further, in most cases, they must wait until they have reached a functional level that would require a nursing home level of care. Because home and community-based services (HCBS) are provided through waivers that limit the number of individuals they serve, patients may spend significant time on waiting lists. Where services are available, there is often a shortage of direct care workers to act as paid caregivers. All too often, patients remain in their homes without necessary care, until they have an adverse event that requires hospitalization, rehabilitation, and/or nursing home care.

BPC leaders have advocated for a series of reforms designed to improve the availability of LTSS to improve care for patients and their families. These proposals have included a series of public- and private-sector reforms designed to expand and protect services for low-income individuals and to encourage those with greater resources to invest in private-sector approaches in a reformed long-term care insurance market. Although an expansion of the availability of LTSS is unlikely in the near term, the following recommendations explore actions that policymakers can take to help patients and their families deal with serious illness now.



Breaking Down State Barriers to the Delivery of Care

RECOMMENDATION

Congress should direct the secretary of the Department of Health and Human Services (HHS) to conduct a review of state medical scope of practice laws and their impact on access, quality, and cost of care for federal programs, including Medicare, Medicaid, and private health insurance. By 2021, the secretary should report findings to Congress and make recommendations on the role that scope of practice laws have on federal policies and issue policy options and regulatory actions available to Congress and to the agency to assure access to quality, affordable care.

As part of the review, the secretary should focus on medically underserved areas in both urban and rural areas, state best-practices, and the impact of an aging population, particularly those with multiple chronic conditions, including serious illness. In preparing the study, the secretary should consult with the full scope of providers, consumers, state agencies (including public health and social service agencies), and state medical boards. The report should include information on private sector payment models, state-level best practices, the Department of Veterans Affairs, Medicare, and Medicaid payment models. The report should also include best practices on plans that permit providers to practice at the top of their licenses. The report should discuss how various payment models, such as managed care, deliver services to alleviate the impact of changing demographics on the health system. Recommendations should include best practices that states have used to review licensing restrictions and how the federal government can encourage adoption of those practices.

BACKGROUND

This issue has a significant impact on those with serious illness. Most states do not permit licensed palliative care physicians or other billable providers, such as nurse practitioners and physician's assistants, to deliver care in a patient's home without a hospice or home health license, and without meeting requirements that are associated with those licenses.⁷ For example, if community-based palliative care services are provided and are not within the scope of the hospital's operating certificate, the hospital may be out of compliance with state law.

In many states there is confusion, if not true restrictions, around who can deliver palliative care in the home. California is testing a model that expands current licensing restrictions. Effective January 1, 2018, California allowed a licensed hospice provider to provide palliative care services concurrently with curative treatment to a person who does not have a terminal prognosis or who has not elected to receive hospice services.⁸ This five-year, state-level demonstration requires participating hospices to annually submit data to the California Department of Public Health, which will in turn create a report by January 2022.

To address this issue in the short term, states should review scope of practice requirements that limit hospice providers from delivering palliative care in the home to patients who do not qualify for hospice services. This could expand access to HCBS for patients with discomfort from symptoms of a serious illness or side effects from the treatment of a serious illness. Also, given the new flexibility in targeted MA supplemental benefits and potential demonstrations for payment models for individuals with serious illness, states should review licensure restrictions and potential confusion around hospice providers delivering palliative care services in the home to non-hospice patients, so that these requirements do not negatively impact the ability of a workforce that is already familiar with the needs of this population from delivering care in the home. Allowing workers to also provide these services through other models of care could alleviate the impact of changing demographics on the health system.

Ensuring Career Growth Opportunities and Wage Increases for Direct Care Workers

RECOMMENDATION

Congress should establish a grant program and direct the Administration for Community Living (ACL) and the Health Resources and Services Administration to provide training grants for personal care aides (PCAs) and community health workers (CHWs)—that is, lay leaders and volunteers who focus on integrating the delivery of non-medical health-related services with clinical services.

This training would incorporate health-promotion curricula in addition to personal care services training. The ACL could make grants to community-based organizations (such as area Agencies on Aging, Independent Living Centers, University Centers for Excellence in Developmental Disabilities Education, Research, and Service), and other aging and disability service providers to deliver training to both consumers and direct care workers on basic first aid, the importance of a good diet and exercise, and orientation and mobility skills. The training should include information on how to access ACL-funded nutrition services and transportation services that operate in the region where the patient lives.⁹ This would be in addition to the health-promotion curricula used to train CHWs on how to help people manage their chronic conditions (diabetes, congestive heart failure, chronic obstructive pulmonary disease, etc.). As the direct care workforce acquires these additional skills, a positive wage differential would be warranted for those without formal training opportunities previously.

BACKGROUND

The direct care workforce provides many of the LTSS that allow the seriously ill to remain in the home, yet there is limited potential for career growth and wage increases through further training. Traditional models for increasing wages for direct care workers involve training programs to acquire medical skills most needed in clinical or institutional settings. A direct care worker would traditionally enroll in a training course, such as a nurse's aide certification program, which is often a requirement for working in a nursing home or other institutional setting. Further certification for the health care workforce is clinically focused, including licensed practical nurses and registered nurses. Given the strong patient preferences for how personal care tasks are preformed and by whom, current training models do not support workers who want to acquire the skills necessary to providing these often intimate non-medical health-related services in the home.

Creating training opportunities that allow the direct care workforce, such as PCAs and CHWs, to acquire additional skills and continue to work in the community is necessary to provide new incentives that promote the growth of the community-based workforce necessary to meet the increased demand associated with patient preferences and demographics.

PCAs and CHWs are familiar with the home environment of their patients and their presence in the home allows them to support patients with their diet, access nutrition services, increase mobility through exercise, and arrange nonemergency medical transportation. Also, this workforce is well positioned to monitor the status of durable medical equipment and perform routine maintenance to enhance the performance of equipment that enables movement and community engagement. These skills could allow the direct care worker to receive a wage differential (increased hourly rate of pay) for their work promoting healthy living and assistance in the coordination of care.

For patients living with functional impairments and certain chronic health conditions, the direct care workers could facilitate disease-management programs to improve the patient's health status and quality of life, as well as help navigate non-emergent medical transportation services to reach medical appointments. Functional impairments may hamper the ability of the patient to participate in disease-management programs, and research suggests a correlation between functional impairment and cancelled non-emergent medical transportation.¹⁰ A direct care worker who aids with functional needs could support the patient's participation in disease-management programs. These grants could establish a formal mechanism



for direct care workers to support patients participating in chronic-disease-management programs, which could result in increased adherence to disease-management protocols. Direct care workers could facilitate the availability of non-emergent medical transportation services to help ensure that patients with serious illness never miss needed clinical care appointments,¹¹ though it is unclear how many Medicare fee-for-service (FFS) patients currently have access to non-emergent medical transportation services.

Ultimately, patients with complex needs could achieve better quality of life and possibly improved health outcomes in the community.

Enabling Home Care Services

RECOMMENDATION

The HHS secretary should use existing authority to waive the requirement that providers who are working under direct physician supervision be in the same location when providing home-based evaluation and management (E&M) and palliative care services to patients with serious illness.

Today, physician and non-physician providers must be present at the same location where services are being furnished. Given this, a review by the secretary regarding the utilization, diffusion, and impact of important E&M and palliative care services furnished in the home is warranted.

BACKGROUND

In examining broader physician payment codes that could benefit individuals with serious illness, the availability of services from doctors and other clinicians (as opposed to simply providing the Medicare Home Health Care benefit) could be valuable for this population. While Medicare FFS provides explicit coverage for home-based E&M services and a variety of other home-based clinical care services, such as palliative care, furnished by physicians, the Medicare direct-supervision requirement and payment levels relative to the resources needed to operate a home-visit program make home-based clinical care nonviable for most physician practices.

Given the apparent need and potential health outcomes value of home-based clinical care, the Medicare program has experimented with payment models like the Independence at Home Demonstration, which center around home-based clinical care visits by a primary care physician who leads a multidisciplinary care team and assumes financial responsibility for a patient's care costs.¹² The Independence at Home model, and other home-based clinical care models, like the Hospital at Home model,¹³ have demonstrated that improved health outcomes and reduced acute care spending^{14,15} can be achieved through home-based clinical care. However, it can be difficult to scale these types of payment models. In 2017 (the second performance year of the Independence at Home demonstration), there were 10,484 beneficiaries enrolled in the 15 participating practices.¹⁶ In examining broader E&M codes that could benefit individuals with serious illness, the availability of services from doctors and other clinicians (as opposed to simply providing the Medicare Home Health Care benefit) could be valuable for this population.

While Medicare FFS provides explicit coverage from home-based E&M services and a variety of other home-based clinical care services furnished by physicians, such as palliative care, the Medicare payment levels relative to the resources needed to run a home-visit program make home-based clinical care nonviable for most physician practices. Given this, a review by the secretary regarding the utilization, diffusion, and impact of important E&M and palliative care services furnished in the home is warranted. It is important to note that the secretary has waived the direct supervision rule in other instances, including a waiver for in-home treatment following a hospital discharge when certain conditions are met.¹⁷

In 2016 there were only roughly 1.7 million in-home E&M service claims billed to Medicare, compared with 227 million hospital outpatient and physician office E&M claims.¹⁸ Analysis conducted for this report examined the extent to which E&M services for home-based care vary by state in

order to determine whether states with restrictive scope of practice laws for advanced practitioners differ from those that have more liberal scope of practice laws (see Appendix). There were not major differences in the provision of home-based E&M services between states with either strict or more flexible scope of practice laws, with respect to average number of services per beneficiary, indicating that scope of practice laws are not a barrier to the furnishing of home-based E&M services.

One potential overarching barrier for improved use of in-home clinical care services is Medicare's "direct supervision" requirement for in-home E&M services and other in-home clinical care services. Under this requirement, a nurse or other non-physician practitioner may perform the service on behalf of the physician billing Medicare, but the physician must be physically present to supervise the nurse's activity. In 2016, the Center for Medicare and Medicaid Services (CMS) provided flexibility for accountable care organizations (ACOs) in the NextGen ACO program, by waiving the direct supervision requirement¹⁹ for in-home clinical care services provided to patients following hospital discharge. In an analysis examining whether beneficiaries in ACO counties receive more services on average than beneficiaries in non-ACO counties, beneficiaries generally received more services in ACO counties, with the most notable differences found in home visits for established patients, psychiatric services, and chronic care management codes. However, overall, there were not major differences in beneficiary utilization at home and in the physician's office between ACO and non-ACO counties.²⁰ To further determine the impact of the direct supervision rule, policymakers could review the utilization and outcomes, as well as fiscal feasibility, of waiving the direct supervision rule in Medicare FFS for E&M codes provided in the home that are most impactful for those with serious illness, which today requires physician and non-physician providers to be present at the same location where services are being furnished. Factors should include:

- patient safety;
- availability of health professionals in medically underserved areas (both urban and rural);
- population(s) or current procedural terminology codes for which rule should be waived; and
- federal budgetary impact.



Improving Access to Care for Patients with Serious Illness: Support for Family Caregivers

INTRODUCTION

In addition to examining the workforce needs of delivering care to older adults with serious illness, this report examines the impact on family caregivers. Family caregivers play a central role in any effort to improve the delivery of care to individuals with serious illness. The Family Caregiver Alliance defines a family caregiver as “any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition.”²¹ Family caregivers may or may not live with the person whom they are caring for, and they may serve in a primary or secondary role to paid care providers.

Historically, family caregivers have played a central role for individuals with serious illness, typically performing household tasks and providing personal care. As the health care system has taken steps to reduce expensive institutional services, increasing responsibility has been shifted to family caregivers causing them to take on additional tasks. These include:

- care coordination;
- supporting decision making;
- communicating with health and social service professionals;
- managing medications;
- providing wound care;
- preparing food for special diets;
- operating specialized medical equipment; and
- assisting with activities of daily living and instrumental activities of daily living.

Family caregivers help loved ones make difficult decisions and provide support navigating a complicated health care and LTSS system. This requires caregivers to communicate with a wide range of providers across a fragmented array of primary care, specialty care, and social services. Over three-quarters of caregivers (77 percent) helped with health systems interactions; many also assisted with making appointments (67 percent), speaking to doctors (60 percent), ordering medications (55 percent), adding or changing insurance (29 percent), or handling other insurance issues (39 percent).²²

Reconciling intra-family dynamics, which may include conflicting goals among caregivers or between caregivers and the person needing care, can be difficult. The National Study of Caregiving, a survey of people who help or have helped older family members and friends in their daily activities, found that that one-fifth of caregivers (20.6 percent) reported that family members “very much” or “somewhat” disagreed about the details of the individual’s care. The percentages were higher for caregivers providing high-intensity care—defined as helping with two or more self-care needs (26.9 percent).²³

Conflicts arise from differing views about the boundaries for caregiving, the nature and seriousness of the care recipient’s condition, failure to appreciate the demands of caregiving and to then provide adequate help or support, concerns about the quality of care, and disagreements over financial matters regarding the care recipient.²⁴

While family caregivers have substantial responsibilities, they frequently do not have the education, training, or supports that they need. Family caregivers report feeling unprepared to provide care, have inadequate knowledge to deliver proper care, and receive little guidance from formal health care providers.²⁵ Most caregivers said that they received little or no training to perform these medical and nursing tasks.²⁶

A survey of adult caregivers age 50 or older revealed the following:

- one in five (19 percent) caregivers have been trained but seek additional resources;
- 26 percent of caregivers who received training for medical and/or nursing tasks were trained by a family member or friend, while 60 percent learned from health care staff;
- 84 percent of caregivers reported needing more help and information on caregiving; and
- the top three topics of concern to caregivers were: keeping their loved one safe (42 percent), managing their own stress (42 percent), and making end-of-life decisions (22 percent).^{27,28}

Family members form the backbone of the health care and LTSS delivery system in the United States, representing the largest single source of care for older adults. About 40 million family caregivers in the United States provided an estimated 37 billion hours of care to an adult with limitations in daily activities in 2013.²⁹ Nearly 18 million individuals in the United States are family caregivers of someone age 65 or older.³⁰

In 2013, the estimated economic value of their unpaid contributions was approximately \$470 billion.³¹ Caregivers must balance these activities with their other responsibilities. Sixty percent of individual caregivers worked at some point in the year that they reported providing care. Among those who reported being employed, over half worked full time (56 percent) while 16 percent worked between 30 and 39 hours per week.³² Individuals providing care to an elder who is age 65 or older were on average 63 years old themselves and also caring for a spouse.³³

Caregiving can be stressful and lead to poorer health outcomes for both the individuals being cared for and for the caregivers themselves. Family caregivers of older adults have higher rates of depressive symptoms, anxiety, stress, and emotional difficulties. Evidence also suggests that caregivers have lower self-ratings of physical health, higher rates of chronic disease, and impaired health behaviors.³⁴ And there is evidence that caregiver strain can lead to increased institutionalization of care recipients.³⁵



Even in cases of demonstrated effectiveness, there has been limited adoption of promising interventions and few caregivers have access to supports services designed to meet their needs.

Interventions that support family caregivers offer the potential to improve the quality of care, as well as the well-being and quality of life, for caregivers and care recipients. Even in cases of demonstrated effectiveness, there has been limited adoption of promising interventions and few caregivers have access to supports services designed to meet their needs. Barriers to integration of family caregivers include payment rules that discourage providers from spending time to communicate with caregivers, misinterpretations of privacy regulations, and reimbursement models oriented to individual coverage.³⁶

Effective caregiver interventions share several characteristics including:

- assessments of caregiver risks and needs;
- tailored interventions that address multiple areas of risk or caregiver need; and
- preferences and active involvement of caregivers in skills training.³⁷



WHAT WOULD HELP FAMILY CAREGIVERS?

- Information on how to navigate the health and social-supports system
- Education and training to develop the skills necessary to manage care on a day-to-day basis
- Assessment to understand the needs of the person being cared for and an understanding of the caregiver's own capacity and competence to deliver those needs

Caregiver supports that are frequently provided include:

- care planning, coaching, and management;
- training on direct care skills;
- information about chronic health conditions;
- behavioral management skills;
- counseling;
- short-term therapy groups that target coping and decision-making skills;
- family meetings;
- in-person and online support groups; and
- respite care.

Prior BPC work has included recommendations to expand access to respite care through Medicare. While state and federal policymakers have taken steps to help provide short-term relief to primary caregivers or respite care, because of concerns about cost and overutilization, respite care is available in very limited circumstances through the Medicare and Medicaid programs. Medicare's respite care is available only to individuals enrolled in Medicare's hospice benefit. To be eligible for hospice care, Medicare beneficiaries must have been diagnosed with a terminal illness and, in the opinion of their health care provider, expected to live six months or less. For those enrolled in hospice, Medicare will cover up to five consecutive days of care in a hospital or nursing facility; however, respite care is not available in the home. While there is no limit to the number of five-day periods, excess utilization may trigger a federal audit of the hospice agency, which serves as a deterrent to hospice agencies.

For qualifying low-income patients with serious illness, Medicaid covers Medicare cost-sharing and premiums, medical services not covered by Medicare, and LTSS. Although federal law does fund respite care as a Medicaid-covered service, the majority of states have been able to obtain approval for coverage of respite care through state plan amendments under section 1915(i), home and community-based waivers under section 1915(c), or more global demonstration waivers under section 1115 of the Social Security Act.

Although respite care is not a covered service under Medicaid, the majority of states cover respite care through one or more HCBS waivers. While most states provide respite care through HCBS waivers, not all HCBS waivers provide respite care. States often use waivers to target services and populations, and they may set conditions on eligibility for specific services. As a result, not all individuals enrolled in HCBS waivers have access to respite services.³⁸

Additional federal funding authorized through the Older Americans Act is available through the National Family Caregiver Support Program, which provides information to caregivers about available services and assistance in obtaining services, individual counseling, organization of support groups, caregiver training, respite care, and, on a limited basis, supplemental services. The following recommendations address both improvements to workforce shortages, as well as support for family caregivers, for patients with serious illness.

Including Family Caregivers in the Care Plan

RECOMMENDATION

The HHS secretary should issue guidelines and require engagement of family caregivers, where appropriate, for individuals receiving LTSS through Medicaid state plan amendments and through home and community-based service waivers.

In developing the guidelines, the secretary should conduct a survey of states to determine best practices in managed LTSS and HCBS for involving and training family caregivers as part of a care plan. The survey should include information on training provided to family caregivers and an assessment of the cost-effectiveness of providing stipends to family caregivers who reside with the eligible enrollee to remain in the home and to provide personal care and coordination services as part of a self-directed care model. Based on that survey, the secretary should issue guidelines for engagement of family caregiving to be included in state plan amendments or waivers.

Two options that could be explored in greater depth are the provision of respite care through HCBS waivers and state use of family caregivers as paid personal care providers.

A number of policy ideas have been considered to expand the availability of respite care at the state level. Questions arise as to the political viability of state mandates. While developing the report, BPC considered options to make respite care an optional service under Medicaid, which will require additional federal resources as well as state funding at a time when federal policymakers are seeking to slow cost-growth in Medicaid. Likewise, requiring states to cover respite care as part of all HCBS waivers could have unintended consequences. For example, if states are forced to provide respite care as a condition of approval, adding services could make it more challenging to demonstrate to the secretary that changes proposed by the state will result in no additional federal spending and, as a result, could mean fewer individuals would be covered under the waiver.

States can allow payment to relatives, including legally responsible relatives (spouses and parents of minor children), for personal care services under a range of other Medicaid programs including the home and community-based optional waiver program 1915(c), the “cash and counseling” benefit 1915(j), and the “community first choice attendant care benefit” 1915(k). Generally, to be a paid personal care provider, a legally responsible relative has to be providing the types of services that a parent or spouse would not ordinarily have to provide for a non-disabled spouse or minor child—for example, feeding a 15-year-old child or bathing a spouse.³⁹ In assessing the cost-effectiveness of providing stipends to family caregivers, the secretary should also look at other concerns that have been identified, including the quality of care, substitution of paid help for unpaid help, and interaction with labor laws.⁴⁰

BACKGROUND

The needs and capabilities of family caregivers are not adequately considered in developing care planning for individuals with serious illness. Additional systematic information is needed to support implementation of best practices through managed LTSS and home- and community-based waivers. States seeking additional flexibility may apply for waivers of some Medicaid statutory requirements to explore alternative approaches to program operation, service delivery, and payment. HCBS waivers, Section 1915c of the Social Security Act, authorize states to provide HCBS as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The statute identifies services that may be considered HCBS, including case management, homemaker/home health aide, personal care, adult day programs, habilitation, and respite care services.

Major policy changes in Medicaid under the current congressional and agency leadership have trended toward giving states greater autonomy, rather than adding additional requirements. The proposed survey would gather information from states on how existing waiver authority has been used to support family caregivers to better assess best practices. This information would support states in developing new waivers and supporting the development of payment models that support family caregivers (discussed below).



Creating Medicaid Incentives to Engage Family Caregivers

RECOMMENDATION

The HHS secretary should require that states include within their Medicaid Managed Care Quality Rating Systems a quality measure that assesses the extent to which the managed care plan determines the presence of a caregiver residing with the enrollee and the extent to which a family caregiver could be supported under a care plan.

To assess the degree to which the family caregiver could be supported, a caregiver assessment would need to be completed. One component of the managed care measure could be the proportion of family caregivers who have been assessed. The CMS guidance should be sensitive to the notion that there are circumstances in which a family caregiver is not present or the individual in care does not wish them to be involved in care planning. To avoid penalizing plans where family caregiver assessment is contraindicated, the measure should be limited to households in which a caregiver assessment is appropriate. The measure should also assess the extent to which the caregiver's needs are addressed in the care plan.

BACKGROUND

While family caregivers may share common characteristics and experiences, individual caregiver's roles are unique to the specific circumstances of the person they are caring for and their own capacity and willingness to assume responsibility. Thus, providers cannot develop an individualized care plan for older adults—if a caregiver's help is needed—without assessing or knowing who the primary caregiver is and what his or her capabilities are. Only one in three caregivers (32 percent) reported that a health care provider, such as a doctor, nurse, or social worker, has asked them about what they needed to care for their recipient. And just half as many caregivers said a health care provider asked them what they need to take care of themselves (16 percent).⁴¹

Including this measure in the quality rating system would provide incentives to managed care providers to involve family caregivers in care planning and coordination. As the largest provider of LTSS services, Medicaid can help lead the field in building family caregiver assessments into a coordinated care plan. The National Academies of Sciences, Engineering, and Medicine's report *Families Caring for an Aging America* found that the most effective caregiver interventions begin with an assessment of caregivers' risks, needs, strengths, and preferences.

Supporting Transitions Between Care Settings in Medicare

RECOMMENDATION

The HHS secretary should direct an independent standards-setting body, such as the National Quality Forum, to develop a quality measure for interacting with family caregivers (where available) to smooth transitions from inpatient hospitals to home or post-acute settings. The measures should be developed and implemented in a manner consistent with existing Hospital Inpatient Quality Reporting requirements.

Transitions could be improved for individuals with serious illness through increased understanding of the roles that caregivers can perform and how they should be engaged. This requires:

- identification of caregivers;
- documenting when older adults need a family caregiver to enact a care plan;
- collection of caregivers' contact information as part of the medical record; and
- development and adoption of caregiver assessment tools that can be used in practice.

The existing Hospital Inpatient Quality Reporting systems could be leveraged to support this recommendation. During the 2019 payment determination/calendar year 2017 reporting period, hospitals must report on at least four of the 15 electronic clinical quality measures (eCQMs) for one self-selected quarter of data; eCQMs use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure the quality of health care provided. One of the eCQMs is *Home Management Plan of Care Document Given to Patient/Caregiver*. This optional quality measure could be made mandatory as one of the four required for reporting.

BACKGROUND

There are insufficient incentives for Medicare providers to support family caregivers in transitions from hospitals to home or post-acute settings.

There is ample evidence of the importance of care transitions to improve outcomes and avoid costly hospital readmissions. Caregivers can help ensure that critical information is transmitted correctly to new providers and care settings during transitions, monitor the appropriate delivery of services, inform providers of symptoms or problems that arise, and assist in managing medications.

A metaanalysis of discharge planning interventions, which included caregiver integration, resulted in lower readmission rates and were associated with 25 percent fewer readmissions at 90 days and 24 percent fewer readmissions at 180 days as well as lower costs for post-discharge care.⁴² Encouraging the development of quality measures that integrate and support family caregivers is critical to the transformation toward value-based services.

Understanding Caregiver Needs in Transitioning Patients from Non-Hospital Settings

RECOMMENDATION

Congress should direct the HHS secretary to assess alternatives for other non-hospital providers to support family caregivers, including analysis of how payment rates should be adjusted to reflect the costs of providing caregiver training. While there is support for including caregivers in quality measurement schemes, additional work is required to develop, validate, and obtain endorsement of the measures.

BACKGROUND

Additional work is needed to understand best practices to engage and support family caregivers in non-hospital transitions. This information is the first step in determining how reimbursement rates or quality measures can be amended in a manner that would incentivize the engagement of family caregivers in evidence-based models.

Additional information is needed on how best to support family caregivers in transitions from non-hospital settings.



This recommendation builds on the broader health care system's move toward value-based reimbursement. Encouraging the development of quality measures that integrate and support family caregivers is critical to the transformation toward value-based services.

Paying for Caregiver Coordination

RECOMMENDATION

The HHS secretary should examine budget-neutral revisions to Medicare's Outpatient Prospective Payment System (OPPS) payment weights and Medicare Physician Fee Schedule (PFS) to support family caregivers.

BACKGROUND

Medicare payment systems do not account for the costs of involving family caregivers in care planning and coordination. Medicare's OPPS payment weights and Medicare PFS relative values for services are determined by the secretary. These values require coordination between family caregivers and physicians or hospital providers, including through designations via status indicators or payment modifiers, as appropriate, to ensure that the resources required for providers in leading that care coordination with caregivers is adequately accounted for in reimbursement. The secretary should develop payment mechanisms that incentivize providers to engage family caregivers and hold providers accountable for caregiver engagement, training, and support in accessing health care.

Providing Regulatory Flexibility for Non-Medical Health-Related Benefits

RECOMMENDATION

The HHS secretary should permit plans to use newly created authority within MA to support family caregivers with respite care services.

BACKGROUND

The Bipartisan Budget Act (BBA) of 2018 includes important changes to the Medicare program for individuals with multiple chronic conditions. The changes were designed to improve quality of care and lower Medicare costs for patients who may also need help with day-to-day activities such as bathing or dressing. Under the BBA, MA (Medicare's managed care plans) may provide additional or supplemental services to those with complex care needs. This new flexibility for health plans has significant potential to provide access to non-medical health-related benefits, including respite care, which in turn has the potential to keep patients in their homes by supporting their caregivers.

In issuing regulations to implement the MA "uniform benefit" changes per the BBA, CMS should ensure that the flexibility provided to MA plans under the regulations extends to allow MA plans the ability to target respite care benefits for enrollees who: (1) have a designated family caregiver, and (2) meet the definition of "chronically ill enrollee" under section 1853(a)(3)(D) of the Social Security Act, as added by the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. The secretary should issue regulations implementing the CHRONIC Care Act to give MA plans the flexibility to target a respite care benefit to high-need, high-cost Medicare beneficiaries.

MA plans need regulatory flexibility to target respite care and other non-medical health-related benefits to support family caregivers. Respite care benefits help keep individuals with serious illness in their homes, improve caregiver's health, and can support caregivers from declining physically or emotionally. Caregiver strain can lead to increased institutionalization of care recipients. MA plans can use the additional authority provided in the CHRONIC Care Act and the existing MA infrastructure to increase consumer access to respite care benefits.

Creating a Comprehensive, Coordinated Strategy to Address the Needs of Caregivers

RECOMMENDATION

Congress should appropriate funds to support implementation of the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act's National Family Caregiving Strategy. This strategy should consider payment model changes that would support family caregivers.

BACKGROUND

The RAISE Act, signed into law in January 2018, directs an advisory committee, created by the act, to develop recommendations, including ways “to improve and better coordinate Federal programs and activities to recognize and support family caregivers, as well as opportunities to improve the coordination of such Federal programs and activities with State programs.”⁴³ The recommendations are to specifically address the following:⁴⁴

- promoting greater adoption of person- and family-centered care in all health and LTSS settings, with the person receiving services and supports and the family caregiver (as appropriate) at the center of care teams;
- assessment and service planning (including care transitions and coordination) involving family caregivers and care recipients;
- information, education and training supports, referral, and care coordination, including hospice care, palliative care, and advance planning services;
- respite options; and
- delivering services based on the performance, mission, and purpose of a program while eliminating redundancies.

While there is strong evidence of the importance of supporting family caregivers, there is not a coordinated strategy to identify effective mechanisms to address their needs in a comprehensive manner. The National Caregiving Strategy would provide a mechanism at the federal level to identify and address caregiver needs in a consistent and comprehensive manner across programs and funding streams. The public process supporting the development of the strategy should engage a broad array of experts on payment policy, including the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, to examine ways to incentivize support of family caregiving.

This effort should examine managed care and FFS quality measures to support person- and family-centered care, including assessment and care planning. The movement toward value-based reimbursement should include incentives to integrate family caregivers into the delivery system.

However, the RAISE Act does not provide adequate resources to support its own implementation. Section 5 of the act specifies: “No additional funds are authorized to be appropriated to carry out this Act. This Act shall be carried out using funds otherwise authorized.” Given the construction of the language, it is unclear if HHS will have the resources to support the work of the act. The RAISE Act requires the HHS secretary to convene a Family Caregiving Advisory Council, including at least nine members who are representatives of federal departments or agencies and up to 15 members



who are not. The council would meet quarterly during the first year after enactment of the bill and at least three times in each subsequent year. The Congressional Budget Office estimates that implementing the law would cost \$1 million over the 2017 to 2021 period; such spending would be subject to the availability of appropriated funds. Those costs would stem mostly from new staff to coordinate the national strategy and to support the council and from travel and per-diem costs for the council.

The agency designated to implement the act, the ACL, appropriated funds to administer its responsibilities generally under authorities provided in the Older Americans Act. The ACL's appropriation authority does not extend to the RAISE Act, which is stand-alone legislation not linked to the Older American's Act or to other funds available to the HHS secretary. It is not clear that there are existing authorities available to fund these activities without legislative action. This may have been a technical oversight on the part of the bill's drafters.

Assess Reimbursement Practices for Support of Caregiver Training

RECOMMENDATION

Direct CMS and the Center for Medicare and Medicaid Innovation (CMMI) to identify and evaluate caregiver training models, focused on specific chronic illnesses, to determine under what circumstances they are successful and how they might be scaled. CMS should examine ways to improve the assessment of individual and caregiver needs and ways to adjust payments to reflect costs.

BACKGROUND

The CMMI demonstrations should be designed to evaluate interventions under conditions that would assess the feasibility of operating within existing regulatory and payment schemes. The demonstrations would also rigorously assess the costs and savings of model implementation and determine under what conditions they might improve care, lower costs, and better align payment systems to support patient-centered practices. The results of the CMMI analysis would support the recommendation to develop budget-neutral revisions to Medicare's OPPS payment weights and Medicare PFS to support family caregivers. The Institute of Medicine report *Families Caring for an Aging America* identified several limitations in evaluations of caregiver support models:⁴⁵

- not evaluated in real-world delivery settings subject to Medicare, Medicaid, or other payment rules;
- too complex;
- staff required training to implement the intervention;
- limited to caregivers' needs at one point in time (not addressing changing needs over time);
- limited outcome data on cost, health care usage, financial distress, and physical health; and
- limited evidence for subgroups of caregivers (e.g., men, minority populations, rural caregivers, long-distance caregivers, multiple caregivers)

Although many caregiver interventions show improvement in caregiver outcomes, such as health and well-being, relatively few assess the economic impacts of these interventions, such as health care savings associated with reduced formal health care usage by the care recipient. These might include savings associated with delayed nursing home placement and fewer hospitalizations and emergency room visits. Most intervention studies also fail to quantify the cost of delivering the intervention, such as the costs of training the interventionists and the time, travel, and monitoring costs of delivering the intervention.

A meta-analysis of caregiver decision making found that caregivers had unmet needs for information, discussions of values and needs, and decision support, which led to negative sentiments after decision making. The study concluded that there were insufficient quantitative evaluations of interventions to involve caregivers in decision making with seniors and that the evaluations that do exist found few clinically significant effects. The analysis recommended that more rigorously evaluated interventions were needed to help caregivers become more involved in decision making with seniors.⁴⁶

Filling Knowledge Gaps to Address Caregiver Needs

RECOMMENDATION

Expand the data-collection infrastructures within HHS, the U.S. Department of Labor, and the U.S. Department of Veterans Affairs to facilitate monitoring, tracking, and reporting on the experience of family caregivers to better design policies that address their needs.

In addition to providing a baseline and time-series analysis on key characteristics, activities, and outcomes of family caregivers to help guide policy, federal research should evaluate health policy with consideration of the family caregiver in mind. While HHS and other federal agencies conduct valuable research into innovations in health care delivery and payment through a number of organizations—including the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, CMS, the Patient-Centered Outcomes Research Institute, the National Institutes of Health—these efforts do not typically assess the role of family caregivers.

BACKGROUND

There are significant gaps in the knowledge base needed to effectively address the needs of family caregivers. An Institute of Medicine ad hoc committee on family caregiving for older adults identified significant gaps in the knowledge base needed to inform policymaking for supporting caregivers. The committee found that existing data collections do not capture information on caregivers' characteristics or the outcomes of their caregiving activities. It recommended development of a robust surveillance system of routine, longitudinal, population surveys to assess family caregivers and be sufficiently large enough to support analyses of important subgroups of caregivers.⁴⁷



Conclusion and Next Steps

In the workforce arena, a number of reports have been issued to stress the importance of allowing non-physician providers to practice to the full extent of their licenses. Increasing the scope of individuals who can safely provide services to patients with serious illness will improve the availability of HCBS, which can make a significant difference in the quality of life for someone with serious illness. Research suggests that one option to improve the availability of care in the home would be to revise Medicare rules that serve as a barrier to the provision of services in the home for those with serious illness.

Additionally, the diversity of need among those with complex conditions includes Alzheimer's and dementia, intellectual and other developmental disabilities, behavioral health conditions, and traumatic brain injury. The skills needed to successfully support individuals living with these disabilities varies significantly. Developing specific training that prepares the direct care workforce to care for individuals living with these conditions requires additional research that should be done in conjunction with stakeholders who advocate for these populations and the organizations that develop training programs for this workforce.

At the same time, there is a lack of a comprehensive system of supports for family and friends of loved ones with serious illness. While there are innovative approaches to family involvement, there is not sufficient information to develop proactive policy solutions and to understand both the political state and federal budgetary impact of policies designed to address that burden. Over the years, many policymakers have tried to improve the availability of LTSS for those who need care, but comprehensive LTSS reform has been elusive. Having more information available will help researchers and policymakers better understand how to resolve this difficult problem. In the meantime, BPC's recommended steps will improve the availability of support for family caregivers.

Collectively, BPC's leaders believe that the steps recommended in this report can help advance care for those with serious illness and their families. At the same time, BPC leaders agree that more can and should be done to improve quality of care and to respect the wishes and values of those with serious illness. In future work, BPC will continue to explore policy options to improve care for individuals with significant frailty and multiple chronic conditions.

Appendix

BPC explored policy options that would improve care for Medicare beneficiaries with significant frailty and multiple chronic conditions. This analysis from the Moran Company examined whether and to what extent direct supervision requirements in Medicare are a barrier to improved home-based care.

Project 1 examined the extent to which E&M services for home-based care vary by state in order to determine whether states with restrictive scope of practice laws for nurses differ from those that have more liberal scope of practice laws. Additionally, BPC was interested in understanding whether differences in service usage exist between Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) compared with beneficiaries not receiving cost-sharing assistance.

HIGHLIGHTS

Project 1

Overall, there were no major differences between strict and liberal scope of practice states with respect to the average number of services per beneficiary. Researchers did find that among psychiatric visit codes and chronic care management services, beneficiaries in states with liberal policies tend to receive more services.

- Scope of practice laws seem to affect more highly discretionary services rather than standard home-visit codes.
- QMBs and SLMBs are more likely to receive home care services overall compared with other beneficiaries without cost-sharing assistance.
- Home visits for established patients, psychiatric services, and chronic care management services have higher utilization among the QMB and SLMB population.

Project 2

Project 2 explored how beneficiaries' use of home-based services in next-generation accountable care organizations (NextGen ACOs) might differ from those not in an ACO. Additionally, researchers investigated home- and office-based services from 2015 to 2016 to examine whether there was an increase in home-based services and a corresponding decline in office-based E&M services.

HIGHLIGHTS

Due to limitations with the ACO variables in the data, the Moran Company mapped beneficiaries to ACOs based on counties located within metropolitan statistical areas (MSAs) that ACOs service.

- Beneficiaries in ACO counties receive more services on average than beneficiaries in non-ACO counties.
- The most notable differences in home visits are for established patients, psychiatric services, and chronic care management codes.
- There were no major differences in beneficiary utilization at home and in physician's offices between ACO and non-ACO counties.
 - Note that the analysis only looked at one year of data on either side of the introduction of ACOs. There may be more distinct differences when more claims data are available.
 - Certain states experienced large variations in average utilization per beneficiary from 2015 to 2016; however, there is no discernable pattern among ACO and non-ACO states.



RESULTS

To understand the differences in service utilization among beneficiaries receiving services in states with strict or liberal scope of practice laws, researchers looked at the average number of services per beneficiary in each state. Then it grouped states together based on the type of practice laws in each state: strict or liberal. As hypothesized, little difference in home-based service utilization occurs in the two groups when all codes are looked at overall. Regardless of the laws in place, beneficiaries received on average just over five home care services in 2016, as shown in Table 1a below.

Table 1a. Total Volume and Per Beneficiary Volume by Code Type And State Type

	Strict States			Liberal States		
Code Type	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume
TOTAL	6,243	5.19	32,410	2,204	5.28	11,641
Home Visit Established Patient	4,745	4.84	22,968	1,540	4.34	6,682
Home Visit New Patient	2,757	1.14	3,135	841	1.15	971
PPS	528	1.00	528	120	1.00	120
Psych	256	12.42	3,180	196	13.77	2,698
TCM	296	1.16	344	140	1.19	167
Chronic Care Management	575	3.92	2,255	120	8.36	1,003

	All Other States			All States Combined		
Code Type	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume
TOTAL	22,781	5.72	130,202	31,130	5.60	174,253
Home Visit Established Patient	17,884	4.99	89,229	24,112	4.93	118,879
Home Visit New Patient	8,229	1.17	9,603	11,801	1.16	13,709
PPS	2,455	1.00	2,455	3,103	1.00	3,103
Psych	909	13.32	12,104	1,361	13.21	17,982
TCM	1,219	1.24	1,510	1,655	1.22	2,021
Chronic Care Management	2,377	6.44	15,301	3,070	6.05	18,559

Data Source: 2016 5% Carrier Standard Analytic File

Date: June 2018

Notes: Liberal States: Colorado, Hawaii, Idaho, Maryland, Massachusetts, Nevada, North Dakota, Rhode Island, and Vermont. Strict States: Florida and Texas

However, when codes are grouped into service categories, beneficiaries receiving services in liberal states are getting noticeably more psychiatric visits, roughly 1.5 more visits, and they are getting approximately four more chronic care management services than beneficiaries in states with stricter laws.

Table 1b highlights the differences in service utilization among QMBs and SLMBs. Beneficiaries who receive cost-sharing assistance because they qualify for QMB or SLMB status received more services overall than beneficiaries who were not eligible. QMBs received an average of 6.8 services, while SLMBs received 7.2 services compared with all other beneficiaries who received an average of 5.2 services in 2016. Again, psychiatric and chronic care management services, in addition to home visits for established patients, have higher utilization among QMBs and SLMBs.

Table 1b. Total Volume and Per Beneficiary Volume by Medicare Status And State Type

Code Type	QMB			SLMB		
	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume
TOTAL	6,689	6.78	45,373	736	7.20	5,302
Home Visit Established Patient	5,403	5.92	32,009	590	5.91	3,487
Home Visit New Patient	2,627	1.20	3,148	280	1.19	334
PPS	975	1.00	975	124	1.00	124
Psych	337	15.33	5,166	39	17.77	693
TCM	353	1.37	485	25	1.04	26
Chronic Care Management	724	4.96	3,590	85	7.51	638

Code Type	Neither QMB nor SLMB			All Beneficiaries		
	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume
TOTAL	23,705	5.21	123,578	31,130	5.60	174,253
Home Visit Established Patient	18,119	4.60	83,383	24,112	4.93	118,879
Home Visit New Patient	8,894	1.15	10,227	11,801	1.16	13,709
PPS	2,004	1.00	2,004	3,103	1.00	3,103
Psych	985	12.31	12,123	1,361	13.21	17,982
TCM	1,277	1.18	1,510	1,655	1.22	2,021
Chronic Care Management	2,261	6.34	14,331	3,070	6.05	18,559

Data Source: 2016 5% Carrier Standard Analytic File

Date: June 2018

Notes: QMB beneficiaries were QMB for all 12 months and either QMB only or QMB plus Medicaid. SLMB beneficiaries were SLMB for all 12 months and either SLMB only or SLMB plus Medicaid.



In Project 2, the analysis focused on the difference in service utilization between beneficiaries receiving services in a county with an ACO presence and beneficiaries in counties without an ACO presence. An ACO county is defined as any county located within the MSA the ACO serves. Beneficiaries in a county with an ACO in 2016 received more total home-based E&M services, 5.9, than beneficiaries not in an ACO county, 5.3. As in the previous tables, the difference is greater in the home visit for the established patient, psychiatric visit, and chronic care management code categories.

Table 2a. Total Volume and Per Beneficiary Volume by Code Type And ACO Participation Counties

	Code Type	Number of Beneficiaries Receiving Services	Average Volume per Beneficiary	Total Volume
ACO	TOTAL	12,621	5.89	74,377
	Home Visit Established Patient	9,757	5.13	50,028
	Home Visit New Patient	4,877	1.17	5,710
	PPS	1,138	1.00	1,138
	Psych	619	14.35	8,880
	TCM	674	1.34	903
	Chronic Care Management	1,187	6.50	7,718
Non-ACO	TOTAL	18,702	5.34	99,876
	Home Visit Established Patient	14,477	4.76	68,851
	Home Visit New Patient	6,961	1.15	7,999
	PPS	1,965	1.00	1,965
	Psych	746	12.20	9,102
	TCM	981	1.14	1,118
	Chronic Care Management	1,890	5.74	10,841
Total	TOTAL	31,130	5.60	174,253
	Home Visit Established Patient	24,112	4.93	118,879
	Home Visit New Patient	11,801	1.16	13,709
	PPS	3,103	1.00	3,103
	Psych	1,361	13.21	17,982
	TCM	1,655	1.22	2,021
	Chronic Care Management	3,070	6.05	18,559

Data Source: 2016 5% Carrier Standard Analytic File

Date: June 2018

Notes: ACO is defined as all counties located within the MSA the ACO serves.

The second half of Project 2 analyzed home- and office-based E&M services across 2015 and 2016. Utilization of home health E&M services increased at a similar rate in ACO and non-ACO counties. Office utilization increased at a slower rate for both ACO and non-ACO counties—3 percent and 1 percent, respectively—than home-based services. Because the analysis reflects one year of data on either side of the introduction of ACOs, there may be more distinct differences when more claims data are available.

Table 2b. Differences in Per Beneficiary Volume by ACO Participation Counties and Setting, 2015-2016

	ACO Participation by County	Beneficiary Count		Average Service Count per Beneficiary		
		2015	2016	2015	2016	% Difference
Home	No	18,484	18,702	5.09	5.34	5%
	Yes	12,650	12,621	5.57	5.89	6%
Office	No	227,241	273,423	2.26	2.32	3%
	Yes	85,595	99,761	2.88	2.92	1%

Data Source: 2016 5% Carrier Standard Analytic File, 2015 5% Carrier Standard Analytic File
Date: June 2018

METHODS

Descriptive Analysis

As this is not a statistical analysis and was designed to be descriptive in nature, no tests of significance were performed. Researchers did not account for confounding variables, such as health status, age, race, income, or others; therefore, no causal relationships can be drawn from this analysis.

Data

The entire analysis is limited to 18 E&M codes, which BPC identified, that are frequently billed at home by non-physician medical professionals. Project 1 and the first part of Project 2 use the 2016 5 percent Carrier Standard Analytic File (which provides all physician claims submitted in 2016 for a 5 percent sample of beneficiaries) to pull all beneficiary and claim information for these 18 E&M services performed in the home (place-of-service code 12). For the second part of Project 2, researchers also pulled information for the same 18 services that were performed in the office (place-of-service code 11) and at home in years 2015 and 2016 using the 2015 and the 2016 5 percent Carrier Standard Analytic Files.

States with Strict and Liberal Scope of Practice Laws

States with strict and liberal scope of practice laws were identified by BPC. The strict states are Texas and Florida. States with liberal laws are Colorado, Hawaii, Idaho, Maryland, Massachusetts, Nevada, North Dakota, Rhode Island, and Vermont. States that do not fall into one of these two categories are not included in Table 1a.



QMB/SLMB Status

For a beneficiary to be classified as a QMB or SLMB in the second part of Project 1, their QMB/SLMB status must have remained constant over the full 12-month period in 2016. If a beneficiary was QMB or SLMB for one to 11 months, they are not considered a QMB or a SLMB, and instead, they fall into the “Neither QMB nor SLMB” category along with all other beneficiaries with home-based E&M service billing.

ACO Designation

Due to limitations with the ACO variables in the data, in this analysis, ACO is defined as any county located within the MSA the ACO serves. In the data, it was possible to determine in which county the service was performed. If a service was performed in a county within the same MSA where a NextGen ACO is located, it is considered the service an ACO service. Any service that was performed outside an MSA where NextGen ACOs are located is considered a non-ACO service. Although this is not a precise method to determine ACO services, it allowed an analysis of more data, yielding better results than using the ACO-specific variables with very small numbers.

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Notes



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