



January 25, 2016

Senator Johnny Isakson, Co-Chair
Senator Mark Warner, Co-Chair
Chronic Care Working Group
Senate Committee on Finance
Chronic_care@finance.senate.gov

Dear Senators Isakson and Warner:

Thank you for this opportunity to comment on the Policy Options Document prepared by the Working Group and released in December, 2015. The Illinois HomeCare & Hospice Council (IHHC), the oldest home care association in the United States, is a trade association representing home health agencies, hospices and private duty organizations in Illinois. Our members include not-for-profit, hospital-based, and free-standing for-profit providers, as well as agencies that are based in county health departments. We also represent a number of the organizations that supply and support these home care providers.

IHHC members are most impressed with the scope of the Policy Options Document, and the creativity of many of the options under consideration. The open process used by the Working Group is abundantly evident in the options described. IHHC does, however, have a few concerns about some of the proposals that have been made, and some that have not been included.

Hospice Inclusion in MA Plans

IHHC's most significant concern relates to the proposal to eliminate the managed care carve-out for hospice services (see page 8). Hospice care is by its very definition team-based care, and IHHC hospice members' experience with many managed care organizations indicates a real lack of understanding of the hospice model.

In particular, the typical MA requirement for pre-authorization can be a real problem when hospice services are sought in the final days of life—a quite common occurrence. Though not ideal, delivery of hospice care in only the final days of life can still be a very positive and important experience for a patient and his or her family. Lengthy pre-authorization processes can rob patients and their families of a quality palliative care experience, particularly if the referral is made immediately prior to a weekend. As it stands today, when a patient enrolled in

a MA Plan elects hospice, the hospice organization can move forward with care delivery knowing that the details of coverage will follow an established process designed to enable the prompt delivery of care. This is not necessarily the case within the managed care organization.

IHHC member hospices are also concerned about whether the MA Plans will cover the full range of costs incurred in the delivery of hospice care. Will the Plans' approach to payment and payment amounts support the range of hospice services and personnel—the activities of the Medical Director, chaplain, unlimited nursing visits, aide visits, medical equipment, oxygen and medications? What about respite and inpatient care, the role of volunteers, and time of death visits? Will the MA Plan's approach diminish or replace the value and role of the Interdisciplinary Group? Will MA Plans grasp and support the notion that providing comfort is a central value in hospice, or will it be seen as an expensive extra?

In IHHC's view, the only way in which the provision of hospice services by MA Plans would work would be if the Plans were required to pay hospices on a per diem basis as in the fee-for-service Medicare program and at levels that support the actual cost of delivery of quality hospice care. One of CMS' primary concerns with the hospice industry in recent years has been the infrequency of nursing visits in the last days of life demonstrated by some agencies. While IHHC members will argue that if hospice has done its job the family and patient are prepared for the events in these final days and often prefer to maintain their privacy at this time, we agree that a pattern of few or no visits at this time is potentially problematic. Placing the provision of hospice care into a business model where the primary values are increased efficiency and reduced expenditures seems antithetical to the care delivery goals that CMS and most hospices espouse for end of life care.

Perhaps a better solution to the disruption in care or fragmented care delivery identified by the Work Group would be a better integrated hybrid approach that would allow for a patient's existing health care provider network to be involved with the patient's choice of hospice organization. The current health care system is increasingly fragmented by, among other elements, the contracting practices of the managed care approach. These "in or out" policies present health care consumers with troubling choices on a regular basis and result in many more transitions from provider to provider than used to occur in the lifetime of a consumer. A more reasonable and gradual approach to coverage transitions would assist the provider community in improving the quality of care transitions for patients. The transition into hospice care is a particularly critical time for insuring that the coverage and care provider transitions are smooth and caring.

Use of Telehealth Technology

Many home health providers have been employing telehealth technology in patient's homes for many years in an effort to enhance patient education efforts and increase compliance with medication administration, management of diet, and other factors that influence the wellbeing of patients with chronic illness. IHHC members have found this technology to be of great value in these endeavors as well as in early identification of changes in condition that may signal deterioration leading to re-hospitalization or other disruptive events. With this early warning system, home health organizations can often intervene before deterioration moves into the critical zone. Unfortunately, home health provider organizations have had to implement this extremely useful technology without any support from their biggest payer—the Medicare program.

While IHHC applauds the Work Group's recommendations to employ telehealth technology more fully in the physician's office, our members are greatly disappointed that the Policy Options Document does not promote the inclusion of this tool within the cost structure and coverage options of the Medicare home health benefit. Not only do the Medicare regulations not recognize the use of telehealth technology as a covered service within the home health benefit, the cost of the technology cannot even be included in an agency's cost report. As a result, there is no recognition of the cost of this technology in the payment and rate-setting apparatus.

Telehealth technology is a critical tool for home care providers as they assist physicians in the management of chronic illness. It is a great patient teaching tool and should be viewed as an indispensable monitoring and early warning system for health care professionals and for patients and their families. The involvement of the health care professional in the home setting is another critical component for success—working with the patient in their home environment simply cannot be duplicated in the physician's office, and a visit by a care manager (who may not be a nurse) is not an effective substitute.

It is IHHC's hope that the Chronic Care Working Group will recognize the value of these comments and consider recognition of telehealth services in the Medicare home health benefit among its policy options. IHHC is ready and willing to provide additional information and support if needed.

Again, thank you for the opportunity to comment on the proposed Policy Options. This is a challenging time in the health care industry as providers face the growing population of older Americans, particularly those with chronic illness. The home care industry is skilled in meeting the needs of this population, and is eager to participate as full partners in federal efforts to manage and enhance the care of these individuals.

Sincerely,

Cheryl A. Meyer, MS. RN, PHCNS, BC
IHHC President