23

Hospice & Palliative Care Association of New York State

Testimony of
Hospice and Palliative Care Association of New York State
at the Joint Legislative Public Hearing
on the State Fiscal Year 2014-2015 Executive Budget Proposal

Health / Medicaid

February 3, 2014

Introduction

The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the opportunity to provide comments on the 2014-2015 proposed Executive Budget. Hospice and palliative care models embody what many would agree are important components to provide quality and affordable healthcare--case management and patient centered care.

We recognize and appreciate that the State has a responsibility to assure that healthcare funding is provided in the most effective manner. However, we are also keenly aware of the fiscal challenges faced by providers as they attempt to adjust their budgets to accommodate reductions in funding. Hospice Medicare reimbursement has been significantly cut through phase-out of the Budget Neutrality Adjustment Factor (BNAF), productivity cuts, and sequestration. On top of that, a significant number of unfunded mandates have been placed on hospices, including face-to-face encounters, the new Hospice Information Set (HIS), reporting of additional claims data, and electronic prescribing.

Medicaid Redesign and Healthcare Reform

As the State continues to move forward with Medicaid Redesign and implementation of the Federal Patient Protection and Affordable Care Act (ACA), we applaud the Governor and the Legislature for recognizing hospice and palliative care as part of the solution to New York's healthcare challenges, both in Medicaid as well as ACA implementation. We especially want to thank the Legislature for including in last year's budget the provision allowing individuals enrolled in the Managed Long Term Care Program (MLTCP) to access their hospice benefit without dis-enrolling from MLTCP.

We await the Centers for Medicare & Medicaid Services' (CMS's) decision regarding the State's proposal to change the definition of terminal prognosis for Medicaid hospice patients from 6 months to 12 months (MRT # 209 and the Hospice Modernization Act, passed and signed into law in 2011).

HPCANYS is strongly committed to working collaboratively with managed care organizations (MCOs) and facilitating relationships between hospice and palliative care providers and MCOs. We have devoted considerable resources to these efforts. Our Innovations/Managed Care Task Force developed a Managed Care Tool Kit to help promote hospice-MCO relationships. We continue to work on this effort, and education programs, a Return on Investment (ROI) template, and other tools are in development. In addition, we have been and will continue to work closely with the New York State Department of Health to facilitate the smooth transition of hospice being provided concurrently with MLTCP and the carve-in of hospice into Medicaid Mainstream Managed Care (10-01-13)

As you deliberate the Executive Budget proposal I urge you to continue to support implementation of the Medicaid Redesign Team's recommendations regarding hospice and palliative care--MRT #209 to expand hospice and MRT #109 to facilitate access to palliative care. We urge you to:

- Work with the Governor to reauthorize funding for the Palliative Care Education and Training Act, which was appropriated by the Legislature in 2007. The Palliative Care Education and Training Council has worked diligently to carry out the provisions of the Act. The majority of the dollars were intended to fund grants to palliative care certified medical schools and residency programs. The Palliative Care Education and Training grants are a wise, capacity building, cost-effective investment in the future of New York's health care system, and they also support the intent of MRT #109 to facilitate access to palliative care, the Palliative Care Access Act and the Palliative Care Information Act.
- Assure that hospice and palliative care play a strong role in medical homes and ACOs (also in MRT # 209, expand hospice).

Fully Integrated Duals Advantage (FIDA)

With a scheduled implementation date of January 1, 2015, FIDA readiness is being tested, and

the benefits, structure and processes are being finalized. It is imperative that duals have full, seamless access to their Medicare hospice benefit, and we ask that the Legislature make this a priority.

- We urge you to pay special attention to hospice in the nursing home and to assure that there are no "disincentives" for nursing home residents accessing their Medicare hospice benefit.
- As FIDA's new Interdisciplinary Team (IDT) is developed and implemented we urge the New York State Department of Health and CMS to assess and determine how the beneficiary and FIDA IDT will collaborate with hospices' Interdisciplinary Team (also IDT) (which includes physicians, nurses, social workers, hospice aides, therapists, counselors, pastoral care and bereavement staff) in advocating for the beneficiary's right to appropriate end-of-life care provided by hospice.

Wage Parity

Requirements under the Home Care Worker Wage Parity Law apply to any aide providing care to a patient whose care is being paid for (in whole or in part) by Medicaid within the counties of New York, Kings, Bronx, Queens, Richmond, Nassau, Suffolk and Westchester. While we recognize that the proposed budget would direct the Commissioner of Health to adjust Medicaid rates for payment for services provided by CHHAs and Long Term Home Health Care Programs (LTHHCPs) for cost increases stemming from wage increases under the parity law, we are greatly concerned with the negative impact home health aide parity requirements will have on hospices in the eight affected counties.

Hospices are paid on a per diem basis—approximately $189 in the metro-New York Area. This per diem rate must cover physician, nursing, social work, home health aide, therapies, medication, and durable medical equipment. Despite the fact that the majority of hospice patients are Medicare patients, wage parity requirements will place hospices in an untenable position—LHCSAs may decline to provide aides for Medicare hospice patients, since they will be paid less, or hospices will be forced to pay the higher $20.60 rate, which will mean that 4 hour of aide services will cost 43% of the per diem rate, leaving a little over $100 to cover physician services, nursing, social work, therapies, medication and durable medical equipment. Hospices will need a managed care rate sufficient to pay for parity in the downstate counties, which is $20.06 per hour. We recommend that wage parity be repealed. However, if it remains in place, there are several options to be considered:

1) DOH should require this rate for a minimum of one year and should monitor the rates paid by adding a schedule to the Medicaid Managed Care Cost Report (MMCCR) that collects the rate paid to each LHCSA; or
2) Require that DOH specifically include hospice patients' needs in the "high hour/high need" pool to be accessed by MLTC plans.

Recruitment, Training & Retention

The much needed HCRA support for recruitment, training and retention (RTR) rate adjustments would be repealed under the proposed budget. Hospices are already struggling to maintain the well trained staff they need to deliver quality end of life care to your constituents. Many have increased the amount of training for their aides, creating "Hospice Aides," who are skilled at caring for clients at the end of life. Although the budget memorandum indicates that existing RTR funding levels would be maintained within providers' base rates and MLTC premiums, it is not explicit in the bill. We urge the Legislature to maintain HCRA funding for RTR for hospice.

Without the HCRA funding employer-based training programs will not have sufficient funding to continue operations. The proposed managed long-term care rates do not include money for training, and the 1115 waiver proposal would also incorporate workforce training into the plan capitation rates. We are concerned that these changes will actually lead to less aide training at a time when more training is needed to assure availability of a skilled workforce.

Regional Health Improvement Collaboratives

HPCANYS supports the provision in the proposed budget that would support eleven Regional Health Improvement Collaboratives (RHICs). The RHIs will convene key health care stakeholders to identify regional health care challenges and implement recommended solutions, and it is critical that hospice and palliative care providers be included in these endeavors.

Emergency Preparedness

In addition to the various emergency preparedness initiatives included in the proposed budget, we ask that a provision be added to give "Essential Personnel" status to home care and hospice providers working to assist patients during emergencies. During Hurricane Sandy hospice workers faced many challenges in reaching their patients, a situation that could have been avoided had they been designated "Essential Personnel."

Improved Information Technology

In funding improved information technology required to implement a statewide electronic medical records (EMR) system, we ask that you recognize the need to invest in making EMR software compatible with electronic prescribing software. Without the ability to interface, health care providers will be forced to work with ineffective, cumbersome systems that will require manual updating—an inefficient use of limited staff resources.

Certificate of Need (CON) Redesign

HPCANYS has been supportive of CON streamlining and has worked closely with the New York State Department of Health relative to the CON need methodology for Hospice. In 2012-2013 the Association established a CON Task Force and worked with Hospice Analytics to develop a draft proposal to revise New York State's Hospice Need Methodology. The draft proposal supports increased hospice utilization and sustainability of the state's hospice providers.

We thank the Legislature and the Governor for passing and signing into law last year a bill that addressed several hospice residence issues. However, there remain several other issues related to CON redesign and hospice residences that we would like to bring to your attention. As part of CON redesign, we ask that the Public Health and Health Planning Council address:

- Allowing hospice providers that have a residential model which combines dedicated inpatient beds with residential beds to "swing" inpatient beds to residential level of care (regardless of the size of the number of dedicated residential beds they operate) until a residential level bed becomes available for those patients who require it;
- Increasing the number of swing beds allowed in all Hospice residences that meet the requirements to provide general inpatient level of care (and have not exceeded the number of inpatient beds allowed in a given community as dictated by the needs methodology formula).
- Moving forward, any new applications for the establishment of hospice residences should be allowed to be co-located in the same building with a licensed Article 28 entity as long as the hospice residence is architecturally, operationally and functionally distinct from the operations of the Article 28 entity.

Global Cap Shared Savings Reinvestment

HPCANYS supports the proposed initiative to reinvest savings achieved under the global cap back into the health care system.

Hospice in Nursing Facilities

As always, we urge the Legislature to provide incentives for nursing homes to make hospice care available through contracts with their local hospices. In 2009, only 27% of Medicare beneficiaries who died in a nursing home in New York had been admitted to hospice, compared to 54% nationally (Hospice Analytics Market Report). This is a lost opportunity to reduce Medicaid expenditures since Medicaid saves 5% of the nursing home rate if the resident is on the Hospice Medicare benefit.

Affordable Care Act (ACA) – Health Care Exchange and Essential Benefits Package

The proposed budget includes funding to move forward with implementation of the ACA. HPCANYS supports the establishment of a Basic Health Program, as authorized under the ACA, and creation of the Basic Health Program Trust Fund. As guidelines for the Basic Health Plan are developed, we ask that you include hospice and palliative care.

New York's Essential Benefits Package and Health Care Exchange (New York State of Health) under the ACA were established in 2013. When the state's Essential Benefits Package is re-evaluated, we ask that you strongly consider:

- Integrating palliative care into chronic illness management; and
- Eliminating the 210 day limitation placed on the Hospice benefit.

Child Health Plus (CHP)

HPCANYS has a long record of supporting pediatric palliative care and hospice services. We support the provisions in the proposed budget that would eliminate the existing CHP waiting period, permanently extend the authorization for certain CHP income and benefit expansions enacted in 1998, and transition rate setting methodology to the Department of Health.

Additional Comments

In addition we, urge you to:

- Assure New York State's compliance with the Federal Medicaid Manual relative to payment to hospice physicians. Please urge DOH to make the appropriate systems changes/coding

accommodations so that hospices can bill for "...other physicians' services, such as direct patient care services, furnished to individual patients... This reimbursement is in addition to the daily [hospice] rate."

- Consider adding funding to support HPCANYS' Interdisciplinary Pediatric Palliative Care Training Program, Train-the-Trainer program, and web-based "virtual advisor" for pediatric palliative care, designed to expand capacity to care for children under CAH I&II pediatric palliative care services and the Affordable Care Act's concurrent care for children provision.

About Hospice and Palliative Care

Hospice and palliative care offer appropriate, high quality, cost-effective care to patients and their families, and Hospice is one of Medicare's most cost-effective programs:

- According to an independent study conducted at Duke University, hospice saves Medicare an average of $2,300 per patient, or nearly $2 billion a year. *(Taylor, D.H., et al. (2007) 'What Length of Hospice use Maximizes Reduction in Medical Expenditures Near Death in the US Medicare program?' Social Science & Medicine Vol. 65, (7) pg. 1466-1478)*
- A study by Aetna found that "Liberalization of hospice benefits that permits continued curative treatment and removes limits on hospice benefits is a strategy that is financially feasible for health plan sponsors, insurers, and Medicare." *(Spettell, C.M., et al. (2009) 'A Comprehensive Case Management Program to Improve Palliative Care.' Journal of Palliative Medicine Vol. 12, (9) pg. 827-832)*
- Data from the 2008 Dartmouth-Atlas study, "Tracking the Care of Patients with Severe Chronic Illness" demonstrates "...more resources and more care (and more spending) are not necessarily better." *(Wennberg, J.E., Fisher, E.S., Goodman, D.C., Skinner, J.S. (2008) 'Tracking the Care of Patients with Severe Chronic Illness.' The Dartmouth Institute for Health Policy and Clinical Practice.)*
- A study by B.A. McNamara, published in the Journal of Palliative Medicine, found that "Proactive care in the form of timely community-based palliative care assists in preventing vulnerable people at the end of life from being exposed to the stressful ED environment." *(McNamara, B.A., et al. (2013) 'Early Admission to Community-Based Palliative Care Reduces Use In Emergency Days before Death.' Journal of Palliative Medicine Vol. 16, (7) pg. 774-779)*

The Hospice and Palliative Care Association of New York State represents the state's certified hospice providers and palliative care providers, as well as individuals and organizations concerned with care for patients at the end of life. Hospice serves patients at the end of life and provides pain and symptom management, addresses social, emotional and spiritual needs and provides care and support to the bereaved. Hospice services are provided in the home, nursing home, and inpatient facilities. Hospice:

- Embraces all patients coping with advanced illnesses
- Focuses on comfort rather than cure
- Emphasizes quality of life

- Promotes personal choice and individual dignity
- Respects the traditions and wishes of the patient and the patient's family
- Most often provides care in the patient's home, but when necessary, also provides care in the nursing home and inpatient setting
- Utilizes current treatments and medications
- Addresses physical, social, emotional, and spiritual needs
- Provides care and support to the bereaved

Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process. Palliative care seeks to address not only physical pain, but also emotional, social and spiritual pain to achieve the best possible quality of life for patients and their families. A number of hospice programs have added palliative care to their names to reflect the range of care and services they provide, as hospice care and palliative care share the same core values and philosophies.

Conclusion

Hospice and palliative care provide case management and patient centered care—they are the perfect partners to help advance the State's objective of providing quality, cost effective care. Thank you for your ongoing support of expanding Hospice and facilitating access to palliative care. I look forward to working with you in the coming year to ensure that the FY 2014-2015 budget provides the people of New York with access to quality hospice and palliative care.

Submitted by:

Kathy A. McMahon
President and CEO
Hospice and Palliative Care Association of NYS
2 Computer Drive West, Suite 105
Albany, NY 12205
phone: 518/446-1483
fax: 518/446-1484
e-mail: kmcmahon@hpcanys.org

01-24-14