Joint Legislative Hearing on 2016-17 Executive Budget Proposal Health & Medicaid

Written Testimony of the Hospice and Palliative Care Association of New York State

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The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the opportunity to provide comments on the 2016-17 proposed Executive Budget. Hospice and palliative care models embody important components to provide quality and affordable healthcare--case management and patient centered care. They exemplify the State's Triple AIM approach. We support the Governor's vision of constructive partnerships helping to improve health care delivery and outcomes while reversing unsustainable spending trends and urge that hospice and palliative care providers be embraced as collaborative partners.

Hospice

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.

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 is a Medicare benefit for individuals who have a terminal illness of six months or less if the disease runs its normal course. CMS approved a State Plan Amendment to define terminal prognosis for the NYS Medicaid Hospice benefit as 12 months.

While most of the hospice is a covered benefit under Medicare Part A, hospice care can be covered by other payers including private managed care plans, Medicaid Managed Care and Managed Long Term Care Plans. Hospice care is delivered by a multi-disciplinary team which includes a physician (medical director), a nurse, a social worker and spiritual care. It also includes bereavement counseling and respite. It is an excellent example of a clinical team working to care for a patient with a life-limiting illness. Hospice has a proven record of reducing emergency room visits and avoiding re-admissions to hospitals.

In New York State, HPCANYS supports the efforts of Governor Cuomo to reform Medicaid in achieving the Triple Aim (MRT #209 to expand hospice – assure that access to hospice care is incentive within medical health homes and ACOs, and MRT #109, to facilitate access to palliative care). Hospice has been succeeding at the triple aim since the beginning and is an excellent real life example of it. We remain optimistic and encouraged at the acknowledgement of hospice and palliative care by the Medicaid Redesign Team's (MRT) recommendations. We applaud and thank New York State Health Commissioner Dr. Howard Zucker and Jason Helgerson as well DOH staff that work every day to help our members. They have done an excellent job and we very much appreciate their hard work.

As DSRIP continues forward, small community-based providers are being eclipsed by the larger health care providers at the table in most PPSs. According to an analysis by Leading Age New York, community-based providers like hospices "have not received state financial support for the critical infrastructure needed to survive in today's changing health care environment." Most of the funds made available through DSRIP and other programs have instead gone to acute care providers and primary care providers.

We therefore urge the Governor and the Department of Health as well as the Legislature to ensure smaller community-based providers are not only more involved in DSRIP/PPS implementation but also share in the proceeds when such programs prove successful. Hospice already has been shown to save health care payers millions of dollars by keeping patients at the end of life home, in the community and out of hospitals and emergency rooms. Simply by doing what we do best will generate savings to any PPS; however, being compensated and rewarded for playing a key role in the DSRIP goal of reducing unnecessary hospitalizations and emergency room visits is not guaranteed. This is inherently unfair to our members and other community-based providers in New York State. Please help underscore our value and place in the health care system.

Palliative Care

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.

For hospice providers, palliative care is a part and parcel to hospice care. It is considered part of the treatment plan for hospice services and works to help control symptoms and manage pain so the patient is comfortable.

Palliative care is also provided to patients who are not in hospice but need support and pain management. HPCANYS members offer palliative care in non-hospice situations for people with chronic diseases or for people eligible for hospice but not enrolled in a hospice program. Like hospice care, palliative care is usually delivered in the community and generally in the home. Unlike hospice care, palliative care is not directly reimbursed. As palliative care grows in our health care system, reimbursement methods need to be secured and provided. Like hospice, palliative care has shown promising results in reducing the number of hospital admissions and reducing the number of emergency room visits. If people with chronic diseases and pain associated with such chronic disease have access to quality palliative care, people with such illnesses can stay home, remain comfortable and enjoy an active higher quality of life.

DSRIP

We are encouraged that 11 of the 24 PPSs in New York State have chosen to palliative care as a focus area for various pilot projects. Our members in these areas of New York State are participating in these programs and we are excited to be a part of this program. We expect palliative care to contribute to those PPSs goal in reducing emergency room visits and unnecessary hospital admissions. We hope such success will mean all participants will share in the incentive funds and reimbursement models for

palliative care will be created. HPCANYS strongly supports community-based palliative care be reimbursed by all payers, and support efforts to encourage in-patient palliative care providers refer patients to community-based hospice care as soon as possible for end of life care.

ACCESS TO PAIN MEDICATIONS - OPIOIDS

The governor's proposed budget includes an Article VII Part B proposal to require managed care plans to require prior authorization for more than four prescriptions of opioid pain management mediations in a 30 day time period. HPCANYS understands and appreciates efforts by Governor Cuomo and the Legislature in seeking ways to address the stunning and alarming increase in opioid addiction and abuse and the horrific number of heroin overdoses. This proposal, however well-intentioned, may have a serious and negative impact on people suffering from chronic and painful diseases by limiting and delaying access to needed pain management medications. HPCANYS urges serious consideration of this proposal before it is enacted.

SHIP

Transitions of care is a key component of the success of the new State Health Insurance Plan and we urge that hospice and palliative care be recognized as integral to care transitions.

Nursing Homes

Nursing homes promote continued reforms and performance improvement. We continue to urge the Legislature to provide incentives for nursing homes to make hospice care available through contracts with their local hospices. According to 2013 Medicare data, of the 106,042 New Yorkers who received care by a skilled nursing facility, 24,103 died and of those who died, 7,690 received hospice care (32%). This compares to 59% nationally. This is a lost opportunity to reduce Medicaid expenditures for dual eligible since Medicaid saves 5% of the nursing home rate if the resident utilizes the Hospice Medicare benefit.

CONCLUSION

Expanding access to hospice care and palliative care is essential part of our health care system. Last year, HPCANYS discussed the groundbreaking report published in May, 2014 by the Institute of Medicine, *Dying In America*. This report focuses extensively on the needs of individuals with serious and chronic illnesses.

Dying in America, "People who meet the hospice eligibility criteria deserve access to services designed to meet their end-of-life needs." *http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx*.

Additionally, independent studies confirm hospice is a cost-effective component of health care. 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)*

Another 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)*

And, just last week, the Journal of the American Medical Association (JAMA) dedicated an entire issue to end-of-life care. Hospice and palliative care are featured components of a health care system that delivers high-quality, cost-effective and patient-centered end of life care. By any measure, quality of life, quality of care, cost, it is clear hospice

and palliative care providers are best positioned to care for people at the end of life. New York State can do much better too. Hospice utilization under Medicare is 28.7% in New York State compared to the national average of 44.4%. The median length of state in New York State is also below the national average of 24 days. New York's average length of stay is 18 days. Expanding access to hospice and palliative care and ensuring providers are supported and recognized as essential and valued components of our health care system and must remain a priority in New York State as our health care system changes.

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