



**Written Testimony of
Hospice and Palliative Care Association of New York State
to the Joint Health Legislative Budget Hearing**

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Submitted to:

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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.

The Hospice and Palliative Care Association of New York State (“HPCANYS”) appreciates the opportunity to provide comments on the State Fiscal Year 2020-2021 proposed Executive Budget: Making Progress Happen. Hospice and palliative care providers serve an important role in health care. However, the current health care system does not support these benefits. The Hospice and Palliative Care Association of New York State respectfully offers the following recommendations to the Executive Budget which could increase access to hospice while also ensuring hospices can effectively provide care to those in need and contributing to decreased Medicaid expense.

**Hospice Care in New York’s Healthcare System – High Quality, Cost Effective
Coordinated Patient Care**

New York State’s population is aging. 3.2 million (or 1 in 6) residents of the state are over age 65. Hospice services are also ‘greying’ with the majority of hospice patients aged 85 and older. As we approach the aging of the baby boomers, hospice must be a key player in caring for the dying.

High costs in long term care are highly correlated to hospital stays and rehospitalizations as well as nursing home placements. **Hospice has a 1-2% rehospitalization rate compared to the hospital 30-day unplanned all-cause readmissions of 16% in 2017.** According to a 2017

Kaiser Health News study, New York hospitals have one of the highest readmission rates in the nation with 90% of New York hospitals penalized by Medicare for their readmission rates. When you consider Medicaid only patients, and those who have both Medicare and Medicaid, the avoidable cost to the Medicaid system for care or coinsurance can be significant. Considering the low rehospitalization rate of hospice care, as this is a cornerstone of hospice care, leveraging hospice care could dramatically impact New York's high rate of admissions and readmissions.

In addition, individuals want to die at home. One survey listed 80% would prefer to die at home, yet 60% of us will die in a hospital and 20% in a nursing home. Only 20% will die at home according to national studies. In New York, only 30% of Medicare decedents are on hospice at the time of their death compared to 49.8% nationally.

Now more than ever we need an increased focus on ensuring people diagnosed with a terminal illness and/or chronic disease or condition have access to hospice and palliative care that provides for the needs of the patient and caregivers in a more cost-effective approach.

Hospice in New York State

- Hospice and Palliative Care offers high quality, patient centered care to patients and their families
- Hospice is one of Medicare's most cost-effective programs
- When Governor Cuomo established the first Medicaid Redesign Team ("MRT"), two proposals were advanced by the MRT -- greater access to Hospice in MRT#209 and to Palliative Care in MRT#109. **And yet, many years later, hospice utilization and length of stay are still extremely low and few DSRIPS chose palliative care as a project.**

Hospice: A Model for Quality Health Care

Since its inception, hospice has been ahead of its time, focusing on delivering high-quality, holistic care to patients and families, with features that are only recently being adopted by the rest of the healthcare system. National attention is increasingly focused on patient-centered care, social determinants of care and improved care coordination, which have always been key tenets of hospice. National and state policies now aim to reduce unplanned hospital readmissions, excessive emergency visits, and overuse of services – all of which contribute to a

sharp rise in healthcare costs and all of which have been shown to be dramatically reduced by hospice.

As the U.S. healthcare system continues to evolve, the understating, integration, and acceptance of hospice care is both morally and fiscally good policy. For four decades, hospice has been a model of a holistic patient and family-centered approach to caring for people at the end-of-life.

- **Person-Centric, Holistic Care.** A plan of care is based on the patient's needs and wishes. This plan is re-visited bi-weekly by the patient and his or her interdisciplinary hospice team. Grief support is an important aspect of the services offered by hospice. After the death, the family is offered bereavement support for at least one year. Such follow-up is not available even in trauma response facilities, where families who have experienced tragedies are sent home with little or no support toward emotional recovery.
- **Comfort-Based.** Hospice puts an emphasis on managing pain and other quality of life symptoms. Quality of life is the guiding goal, and hospices address pain and discomfort on the physical, psychological, social, and spiritual levels using both medical and non-medical interventions, often more effective and cost-efficient than traditional curative healthcare models.
- **Interdisciplinary.** Hospice is required by Medicare to be delivered by an interdisciplinary team, which includes nurses, doctors, health aides, social workers trained volunteers and clergy, and may also include occupational, speech, and physical therapists, and dieticians. The patient and family are the center of the team.
- **"Home"-Based.** In the United States, hospice has evolved to a home-based model. Most hospice patients are cared for at home, where studies have shown most patient prefer to be cared for at the end-of-life. A patient's home may be wherever he or she is living - their private home, a nursing home, or an assisted living facility. When it is not possible for hospice patients to die in what is thought of as their traditional home, they can receive inpatient hospice care in special inpatient units or hospice-contracted beds in hospitals or nursing homes.
- **Efficient, high-quality healthcare.** Hospice patients are supported in a way that reduces emergency room visits and unplanned hospital admissions. While pain management is not a central focus in the health care system at large, hospice clinicians have considerable

expertise in managing pain. Hospice contributes to better care, as its presence in nursing homes has been shown to correlate with better performance in pain management compared with nursing homes that do not partner with hospice providers. Patients with a terminal illness who die in hospitals have been found to have a poorer quality of life compared with patients who die at home with hospice care and support for them and their loved ones.

- **Ongoing involvement.** Medicare requires that bereavement support be made available to hospice family members for up to a year after a death. Some hospices go even further by offering support groups to the whole community, sponsoring grief camps, and training grief professionals.
- **Cost Effective Care-** not only does hospice enjoy high levels of consumer satisfaction as measured by the publicly available CAHPS surveys on the Medicare Hospice Compare website, hospice care has been proven to bend the cost curve at end of life by the avoidance of the hospital level of care and other ineffective treatments. Specifically, there was one ACO in NY state who told their local hospice program that for every hospice patient, the ACO showed an \$11,000 cost savings compared to other patients with the same diagnosis who did not have hospice care. For those who are dually eligible, hospice is a way to provide high quality care while maximizing Medicare reimbursement relieving the burden on the Medicaid system for costly and ineffective treatment coinsurance dollars. Further, hospices with residences provide a living option under Medicaid that saves the state Medicaid long term care dollars at a lesser fee than a nursing facility.

Making Progress Happen: Ensuring Quality Health Care for All New Yorkers

HPCANYS urges New York state to recognize the important role of hospices and palliative care in the health care system. By removing current barriers to hospice and palliative care, utilization of hospice and palliative care services would increase. Since the majority of patients in hospice are on Medicare, the state would not only help NY state residents access services, but could also decrease Medicaid expenses.

1. Create a Responsibility or Role as Hospice Expert Liaison at Department of Health

Rationale: The lack of a Hospice Liaison within the Department of Health is perhaps the most readily identifiable and may be the way to approach resolving a good number of the issues we have identified as barriers to hospice utilization. Hospice is a unique and highly regulated area of healthcare service as it can be carried out in a variety of settings. It focuses on preventing, treating and eliminating discomfort and pain to include physical, spiritual and psychosocial distress. As such, it is unlike other forms of healthcare treatment, yet little consideration is given to the unique impact laws and regulations have on the hospice programs and patients. Time and again, hospice is overlooked and therefore not included in necessary and beneficial programs and regulations or excluded from burdensome regulations. Examples include Health Care Facility Transformation funding, Criminal History Record Check payment system, extension of the billing timeline for required physician signatures, to name a few. The new “lead” will identify and address issues under DOH programming and jurisdiction that impact Hospice programs and how to best address “best practices” or “carve-outs” for Hospice within regulations and assure applicability to hospice for future regulations. We have listed at the end of this document the issues HPCANYS has been working on with the Department of Health – sometimes for many years – which could be worked on by such a hospice expert.

2. Create a Universal Bed Designation for All Hospice Facility Beds

Rationale: New York Public Health Law, Article 40, declares hospice programs to be a socially and financially beneficial alternative to conventional curative care for those afflicted by terminal illness. It further finds that hospice is a unique, interdisciplinary program of palliative and supportive care to meet the stresses associated with illness, death and bereavement through the innovation and reorganization of home and traditional inpatient health services. The current designation imposed on hospice programs that separates residential beds from general inpatient beds violates these fundamental principles and goals of end-of-life care. This artificial separation hinders good patient care and prohibits the hospices from having the flexibility to meet the patients’ needs and operate in an efficient manner.

There are 3 types of these facilities. *Hospice Residence Bed Designation:* Hospice programs can be residential in care, character and physical structure and may include certified hospice in-patient beds for individuals who are terminally ill to receive end-of-life services and supports in a home-like setting. A place in which to live your final days when home is not an

option. These programs are paid for by private funds, charity care, and New York State Medicaid at 94% of the Long-Term Care/ Nursing Home rate. *General Inpatient Bed Designation:* Hospice programs can also be General Inpatient Facilities (GIP), which provides “hospital level” care paid by the patient’s insurance at a predetermined rate. These stays are generally of short duration and the patient returns home after their condition stabilizes. Even with a patient who could benefit from a longer stay in the GIP facility under residential care, due to family circumstances and the inability to provide care in the home, the hospice is not allowed under state law to use this bed for residential care. This necessitates a long term care bed placement in a nursing home, often paid for under Medicaid. *Combined Facility Designation:* When a facility has the ability to have both types of beds, hospice programs are currently limited in the percentage of beds that can be dually certified for either residential level of care or inpatient level of care to 50%. “Swing beds, as they are called, provide the opportunity to offer a higher level of care to patients and avoid hospitalization or a lower level of care avoiding nursing home placement. These beds must be built to construction standards for inpatient level of care and comply with Federal regulations ranging from staffing levels to pharmaceutical administration. Current law allows facilities to “swing” up to 50% of residential beds to GIP beds after submitting a CON request.

The current limit on the number and type of beds is disruptive to terminally ill patients served by the hospice facilities. If temporarily hospitalized, patients are forced to wait readmission to the hospice residential bed, often in a nursing home, if a residential bed is unavailable, even if there are several general inpatient beds available but unusable by state law for residential care. In the reverse, under Medicare, it would be fraudulent to have a Medicare patient in a GIP bed when they no longer medically qualify for that level of care yet this bed, by state regulation, cannot be used for a residential patient. Further, the current artificial designation is detrimental and disruptive to the patients and their families, which is entirely inconsistent with the purpose and intent of hospice care, and contrary to the legislative declaration of New York Public Health Law, Article 40.

The creation of a “universal bed” designation in a hospice facility will also allow terminally ill patients in hospitals, who still require in-patient care to be transferred to hospice facilities sooner. For hospice patients residing in the community who require advanced pain

control or symptom management and are struggling to be maintained comfortably at home, it would avoid unnecessary re-hospitalization and expedite safe, effective care.

The universal bed care designation is a holistic, humane, and fiscally responsible approach to patient care, not just focusing on clinical outcomes, but also addressing psychosocial and family needs to augment care to those who are terminally ill.

Making Progress Happen: Reforming Medicaid

The FY 2021 Budget reconstitutes the MRT, bringing stakeholders who bring experience as health care providers, back to the table to find solutions that will once again contain spending growth so that this critical program that provides health care to more than 6 million New Yorkers remains financially sustainable for the future. MRTII process must consider the role of hospice and palliative care in Medicaid reform and redesign. Hospice can contribute to Medicaid Reform in the following ways:

1. Create a Palliative Care Benefit Under Medicaid

Rationale: Creating a palliative care payment source in the Medicaid program that compensates not just for physician reimbursement, but the care coordination and team approach that is required for good palliative care. New York State has received a “B” grade by the Center for the Advancement of Palliative Care for the availability of hospital based palliative care programs. However, there are only 34 post-acute care palliative care programs for the entire state. Palliative care is patient centered, affordable care that has a proven track record in reducing rehospitalizations. Not only is this care helpful to the patient, but it could also save Medicaid dollars in copayments and deductibles for the dually eligible patients The California MediCal Palliative Care program is a model to review.

2. Allow Emergency Medicaid Payments for Hospice

Rationale: New York State's Medicaid for the Treatment of an Emergency Medical Condition helps eligible, undocumented and temporary immigrant New Yorkers pay for medical costs when an individual needs immediate medical attention for a serious health issue. As hospice is not a covered service, the only option available for an individual eligible for Emergency Medicaid who is terminally ill would be in a hospital setting, rather than at home or in a hospice residence. Hospice care would both improve the quality of the remaining days and provide a more appropriate environment for the patient while also saving Medicaid dollars by avoiding

readmission costs. Our proposal in 2019 showed a conservative estimate of \$1.5 to \$2 million savings based on admission and readmission avoidance of the Medicaid only population.

3. Provide Priority to Hospices for Health Care Facility Transformation Money

Rationale: Hospice was not included in Facility Transformation funding in Phase 1 and 2. When funding for Phase 3 projects was reallocated from Phase 3 to fund Phase 2 projects, the potential for hospices to receive money in phase 3 decreased. This would significantly help those hospices with negative operating margins having facility needs, and those with hospice owned patient care beds.

4. Include End of Life Care in the Delivery System Reform Incentive Payment (DSRIP) Program

Rationale: Hospice meets the primary goal of DSRIP to reduce rehospitalizations by 25%. Hospice and palliative care services have a proven track record for decreasing rehospitalization, particularly among the nursing home population. **Despite the fact that all hospice patients are seriously ill, hospice has a 2% rehospitalization rate.** Therefore, it was surprising that so few DSRIP plans chose end of life care programs or palliative care projects. Therefore, end-of-life-care should be a required component of the new DSRIP process.

5. Abolish the Skilled Nursing Facility Pass-Through

Rationale: The current payment system does not create an incentive for nursing homes to contract with hospice programs. Medicare regulations, unless you apply for a waiver, requires the nursing home to bill the hospice. The hospice is then required to bill the state for room and board for hospice patients residing in a SNF. This pass-through requirement decreases access to hospice because the delay in reimbursement causes cash flow issues to either the hospice or the SNF. Also, OIG has noted that this pass-through process can lead to double billing. Therefore, HPCANYS recommends the state work to obtain a waiver from CMS to pay the SNF directly when Hospice is involved. Several states have obtained such a waiver.

Making Progress Happen: Strengthening Public Health and Aging Programs

What happens at end of life has been called a public health crisis in the US. The crisis can be described as languishing in pain, in hospitals and other care facilities, receiving unnecessary, painful, and ineffective treatments and medical interventions without adequate understanding of our personal goals and needs. Solutions to this alternative are the availability of quality hospice

care and the personal knowledge and engagement in advance care planning so that our wishes are known and honored.

1. Advanced Care Planning

Rationale: Despite the benefits offered by hospice, there is still a significant gap in awareness and understanding about this benefit including who is eligible and when it would be appropriate to make a referral. This gap exists not only with the public, but also with the greater healthcare community. There is a critical need to increase this awareness in both the public as well as in the healthcare system providers so that more individuals have the option to access this end of life care.

Currently, hospice programs provide outreach efforts to their communities to varying degrees. Hospices undertake outreach activities within their local communities, to offer educational programming at senior centers and community events and allow use of gardens and meeting spaces by the wider community. Many participate in education of health care providers as well. Such activities help to raise much needed awareness of services among the public and health professionals, as well as break down barriers and negative perceptions.

More support and training would enable healthcare professionals to identify the needs and options available to people diagnosed with terminal illness and would result in improved communication and public understanding of the range of support available. **The length of stay in hospice in New York is significantly below the national average**

In his 2018 State of the State message, Governor Cuomo pledged to initiate a statewide Advance Care Planning campaign to include public outreach and education, engagement and encouragement of New Yorkers of all ages to complete Advance Care Planning documents. We support empowering the public with the knowledge, so that they can choose what is right for them. **Therefore, New York State should allocate funds, within its current public education budget, for an Advance Care Planning campaign.**

Governor Murphy of New Jersey recently signed A312 into law that advanced hospice and palliative care access by expanding public and clinician awareness of hospice and palliative care and created a Palliative Care and Hospice Care Consumer and Professional Information and Education Program within their Department of Health.

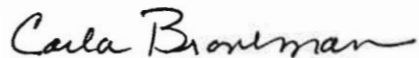
2. Creation of a Universal Worker Designation to Replace the Certified Nurse Aide and Home Care Aide/Hospice Aide

Rationale: As our population ages, we see an increasing need for personal care workers. Yet there are barriers within the educational requirements for each of these 3 similar categories. A CNA cannot pick up extra hours as an HHA or HA without taking the additional coursework. And such coursework is not available across the state. One way to address this need going forward is to consolidate the education requirements to include both levels to become an AIDE. This would both increase the supply of aides at home, as well as provide more opportunity of work for the aides themselves.

Conclusion

Today we ask you to invest both in the hospice and palliative care programs, and to advance end of life care for all citizens facing death in New York State because every New Yorker needs to be assured that they will receive compassionate, supportive and comfort care at the end of life.

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Examples Of Issues At New York State Department Of Health That Could Be Addressed By A Hospice Expert At The Department

1. Clarification of Managed Long-Term Care Plans and Hospice Involvement

Rationale: There remains confusion between hospices and MLTCPs related to responsibility for payment for aide level services. The billing guidance provided contradictory information and has not provided clarity. Further, the need for the patient to disenroll from hospice to join an MLTCP for needed custodial care subjects these patients to up to 6 weeks without hospice services. They can re-enroll in hospice after admission to MLTCP. However, until this re-enrollment occurs it is highly likely that this break in hospice care has increased hospitalizations, of which Medicaid is paying for. Medicaid must update billing guidance to clarify who pays for care and what is the criteria between MLTC and Hospice as it now in the DAL. Medicaid must also create a state plan amendment to allow for patients who are on hospice to apply for MLTCP without needing to disenroll and forgo comfort care in the process

2. Correct a Flaw in the System to Pay Hospice Physicians for Medically Necessary Visits as Required by Regulation

Rationale: Medicaid regulations acknowledge that medical care provided by a hospice physician to a hospice patient is a billable service outside of the hospice Medicaid payment. Yet DOH has not been able to create a payment code in its computer system to facilitate this payment. As a result, the hospice is unable to bill for the billable physician service. As more hospices have full time medical directors without private practices, this inability to receive reimbursement is forcing patients to find other doctors and get to their offices for care. This often forces the patient to seek another physicians care, and additional costs for transporting this very sick individual to the physician's office under Medicaid versus having the hospice physician visit in the home.

3. Extend Timely Filing for the Certificate of Terminal Illness (CTI)

Rationale: A CTI, which is signed by the referring or primary physician, is required for billing Medicaid. For Medicare, the time in which to bill an occurrence of hospice care is 1.25 years. Under Medicaid, the time to bill is 90 days. The CTI is dependent upon physician availability to complete. The CHHA billing requirement (physician orders signed) was extended from 90 days to 1 year to meet the timely filing requirements. This is an instance in which a Hospice Liaison

at DOH would have reviewed this CHHA regulation and recognized that it would also be applicable to hospice and perhaps would have added hospice into this extension.

4. Embed Quality Reporting in Health Care to Quantify the End of Life Care Education and Options

Rationale: Healthcare providers, whether hospice, hospital, nursing home, or physicians, respond to what is measured. Yet DOH does not measure or track patients who die without a hospice or palliative care referral. If we want to educate providers on the importance of hospice, we should also measure the results. The Department of Health should require and analyze quality data from various health care facilities on Hospice referral and utilization for the following: Hospital mortality discharge 30 days (% with and % without Hospice referral), CHHA – deaths while on service with CHHA, SNF’s with hospice contracts. SNF patient deaths on hospice and not on hospice excluding the Medicare SNF payment patients