New York State Department of Health’s
Demonstration to Integrate Care
for Dual Eligible Individuals

Comments from
Hospice and Palliative Care Association of New York State

April 17, 2012

Introduction

Hospice and Palliative Care Association of New York State (HPCANYS) is pleased to offer comments on the New York State Department of Health’s Draft Proposal to Integrate Care for Dual Eligible Individuals.

The proposed Fully-Integrated Duals Advantage program (FIDA) is designed to be person-centered and meet the complex needs of dual eligible individuals. The Hospice and palliative care models are based on case management patient-centered care.

Medicaid Redesign

New York’s Medicaid Redesign Team (MRT) proposed, and the Legislature and Governor accepted, two proposals specific to palliative care and hospice:

- MRT 109, to facilitate access to palliative care, which was implemented by the Palliative Care Access Act, included in the 2011 NYS Budget bill; and
- MRT 209, to expand hospice including: 1) changing the definition of terminal prognosis from 6 months to 12 months (included in the Hospice Modernization Act, passed and signed into law in 2011; and a Medicaid State Plan Amendment to extend the 12 month definition to Medicaid has been submitted to CMS); 2) including hospice in Accountable
Care Organizations and Medical Health Homes; and 3) concurrent care for adults (which we believe would also require a state plan amendment).

We urge the New York State Department of Health to assure that MRT's intent to facilitate access to palliative care and expand hospice are incorporated into the Plan to Integrate Care for Dual Eligible Individuals.

**Hospice and Palliative Care**

The proposed plan states, “It is imperative that Participants have timely access to all necessary providers.” Palliative care is not mentioned in the draft proposal; hospice is included as a “carve-out.” The draft plan notes the low rate of hospice utilization in New York (page 21). It is crucial that FIDA does not create further barriers for New Yorkers having access to quality hospice and palliative care. We are deeply concerned that unintended consequences may result in:

1) Palliative care not being recognized as an appropriate referral and the intent of MRT #109 and the Palliative Care Access Act being impeded.

2) Hospice being marginalized and dual eligible individuals not having timely and appropriate access to their hospice benefit. Our cause for concern is based on experience. Currently, individuals enrolled in the PACE program and LTHHC program are seldom referred to hospice. Individuals enrolled in MLTC must disenroll prior to electing hospice, a process which can take from 15 to 45 days. With hospice median length-of-stay at approximately 18 days, it is very likely that patients will die before the MLTC disenrollment/hospice election process can be completed.

3) Nursing home residents being disenfranchised. Nursing home residents are a particular group whose access to hospice care may be compromised by the plan. Currently, nursing facility residents who are using Medicaid to pay their skilled nursing costs are able to use their Medicare benefit to pay for hospice services. When the nursing facility resident elects hospice, Medicaid stops paying the facility directly, and instead pays the hospice 90% of the nursing home rate for room and board. With hospice excluded as a service we are concerned that nursing facilities might perceive that this arrangement is prohibited under FIDA.
Through FIDA we have an opportunity to address current and potential barriers to hospice and palliative care. HPCANYS stands ready to work with you to ensure that patients in need of these services can access them in a timely and efficient manner.

How Hospice and Palliative Care Support the Goal of the Demonstration

Hospice and palliative care are perfectly aligned to support the goals of the demonstration to provide quality, cost effective, patient-centered care to dual eligible individuals. Proposed improvement targets include: 1) potentially avoidable hospitalization, 2) 30-day readmission rates, 3) quality of life, and 4) use of advance directives. Hospice and palliative care can help achieve all of these targets. A study conducted by Brown University, supported the role of hospice in nursing homes, concluding that hospice patients:

- Are less likely to be hospitalized in the last 30 days of life; and
- Received superior pain assessments.

Hospice and palliative care provide the quality, compassionate care that patients want and need, while being cost effective. 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.
- A recently published 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.” (A Comprehensive Case Management Program to Improve Palliative Care, C.M. Spettell, PhD et al, Journal of Palliative Medicine, Vol. 12, Number 9, 2009)
- Data from the Dartmouth-Atlas of Health Care 2008, “Tracking the Care of Patients with Severe Chronic Illness” demonstrates “…more resources and more care (and more spending) are not necessarily better.”
- A 2008 study by Dr. Sean Morrison validates costs savings associated with hospital-based palliative care consultation programs (Morrison, R.S., et al, 2008; Cost Savings Associated with US Hospital Palliative Care Consultation Programs. Archives of Internal Medicine, 163(16), 1783-1790)
• Palliative care alongside usual care has maintained or improved the quality of care while generating substantial cost savings. (Smith, T., Cassel, J.B.; 2009. Cost and Non-Clinical Outcomes of Palliative Care; Journal of Pain and Symptom Management, 38(1), 32-34)

• According to the National Hospice and Palliative Care Association’s 2010 Family Evaluation of Hospice Care Survey, 94.4% of families reported that hospice care provided was consistent with the patient’s end of life care wishes; and 98.3% would recommend hospice to others.

Conclusion

On behalf of the patients and families served by hospice and palliative care, we urge the Department of Health to: 1) assure that dual eligible individuals will have easy, transparent, timely access to quality hospice and palliative care services while still being able to receive other services, and 2) incentivize plans to appropriately refer patients to palliative care and hospice in a timely manner.

We stand ready to assist in any way possible to help the Department assure that FIDA does not create unintended barriers to quality hospice and palliative care.

HPCANYS represents the state’s certified hospice providers and palliative care providers, as well as individuals and organizations concerned with care for patients and their families 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, and hospice residences. Hospice uses a unique interdisciplinary team approach.

Palliative Care, as defined by the World Health Organization, 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. 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. 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.

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