



## Hospice & Palliative Care Association of NYS

2 Computer Drive W., Suite 105

Albany, NY 12205

Ph: 518-446-1483 ■ Fax: 518-446-1484

[www.hpcanys.org](http://www.hpcanys.org)

[www.facebook.com/HPCANYS](https://www.facebook.com/HPCANYS)

<https://twitter.com/HPCANYS>

January 26, 2016

Timothy Nichols, President/CEO  
Hospice & Palliative Care Association of NYS  
[tnichols@hpcanys.org](mailto:tnichols@hpcanys.org) | (518) 446-1483

### **Re: HPCANYS Comments on the United States Senate Committee on Finance Bipartisan Chronic Care Working Group Policy Options**

The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the opportunity to provide comments on this Policy Options Document. Both Hospice and Palliative Care organizations regularly provide and coordinate care for chronically ill patients and struggle within the structure of the existing Medicare and Medicaid benefits which incentivize treatment over coordination. We applaud the Committee and Working Group for their efforts to improve care for the chronically ill with a strong focus on the need for coordination of care.

#### **Receiving High Quality Care in the Home**

- **Expanding the Independence at Home (IAH) Model of Care**

HPCANYS has a concern that with the IAH model, practices will be dis-incentivized from referring patients to hospice care when the patient has a life expectancy of six months or less. Hospice provides interdisciplinary care with a physician or nurse practitioner, nurse, social worker, spiritual counselor and grief services. All members of the interdisciplinary team are specialists in end-of-life care, familiar with the best treatments to achieve symptom control, and support family care and communication. This concern could potentially be addressed in the design of the expansion, but it will be critical to do so to foster quality end-of-life care and patient choice.

#### **Advancing Team-Based Care**

- **Providing Medicare Advantage Enrollees with Hospice Benefits**

Medicare Advantage Carve-in of the Hospice Benefit raises many critical concerns and HPCANYS is opposed to this recommendation.

As Medicaid Managed Care has expanded in New York State, hospice providers have faced significant challenges in providing the hospice benefit under managed care. As hospice cares for patients with a six month or less prognosis if the disease runs its normal course, 80-90% of our

patients have Medicare coverage either because of age (over 65) or disability. While many New York hospice patients are, or may be, Medicaid eligible, Medicare is their coverage for hospice. Medicaid is generally only 3-15% of hospice revenue but the challenges in ensuring hospice care have caused New York State Department of Health staff and other State officials to regularly intervene between hospice providers and Medicaid Managed Care programs in an effort to address persistent problems related to the expansion of Medicaid Managed Care.

- Only in-network hospice would be covered under Medicare Advantage (as is the case of Medicaid Managed Care). In New York State, Medicaid Managed Care patients from other areas often come to live with family and friends in geographic areas outside their plan's network creating issues with hospice coverage. As a result, many hospices care for these patients when they have no ability to pay, even according to the hospice's sliding fee scale. This is a burden that impacts patient care finances. Hospices could not afford to provide such free care for the much larger Medicare Advantage population. In the case of Medicare patients, many would have some ability to pay and would be charged out-of-pocket. Remember, this would be charging them for hospice care currently covered under Medicare fee-for-service, but now denied to them because they moved out-of-network to live with family or friends who could care for them as they were dying. Under the proposed Medicare Advantage carve-in program, Medicare would not pay for care for these patients.
- Medicare Advantage programs could also charge higher co-pays and deductibles. This would again increase the costs to patients as well as increase the costs for our member hospices, given that they provide care regardless of ability to pay. This would create another barrier to hospice care. Some patients would not have the ability to make the co-payments and cover the deductibles. Hospice providers report that high deductible plans, though a small percentage of their patients, are still a drain on resources. Therefore, Medicare Advantage patients will actually pay more because the enhanced "in-plan" benefits do not factor into account the costs associated with needing to move out-of-network when plan members become terminally ill and need to live with family and friends out of the area.
- Medicare Advantage often requires pre-approvals for care, and our experience with Medicaid Managed Care indicates that this will most likely occur for hospice. Though pre-approval for a 90 day benefit would be a slight burden, most Medicare Advantage plans will not understand hospice, as it is a different model of care than any they have been used to overseeing. Our experience with Medicaid Managed Care in New York State is that plans would approve a day of care, and then want a care plan for review to determine medical necessity. The next approval might take a week or longer, approving just one day of care for the 35% of patients that die within seven days of admission. It typically takes numerous telephone calls and meetings for hospice providers to be able to change the approval to cover 30 days.
- Medical necessity is an additional concern to HPCANYS. The criterion for hospice is not medical necessity; it is simply a prognosis of six months or less if the disease runs its normal course. That is incomprehensible to most reviewers who are focused on medical

treatment and care that is curative. However, these patients are dying, and although a small number actually do initially improve while on hospice, the norm is that the patient will decline in health until death. As hospice care is focused on the needs of the patient and family beyond those that are purely clinical, this can result in a plan of care that may be utterly foreign to a managed care plan reviewer, who is accustomed to determining “medical necessity.” For example, for a patient who has expressed a regret that he has never taken his wife on a Hawaiian vacation, the care plan may be for the Case Manager, LPN, Social Worker and Spiritual Counselor to dress up in grass skirts and Hawaiian attire and bring luau food to the patient’s home so the patient and spouse can have the Hawaiian experience that is his dying wish. That cannot equate to medical necessity – but it is definitely hospice, and the type of care we provide regularly. This type of care may not neatly correlate to managed care algorithms, but our 40 years of experience has shown that this type of patient-centered care is key to relieving anxiety and spiritual pain, and improving quality of life for the dying.

- HPCANYS is concerned that the multitude of competing Medicare Advantage Plans in each county of New York State will be disruptive and highly burdensome to small, community-based providers, like hospices. The administrative costs and time required negotiating contracts with so many plans would be highly burdensome. In addition, it has been our experience that managed care companies sometimes have different staff working on different plans. Thus, even within one company a member hospice might be forced to find its way through different systems. Based on our Medicaid Managed Care experience, it is likely that when the hospice contacts the plan, the plan often will have no idea what hospice is or who in their company or plan would handle hospice. The hospice staff is consumed by the managed care plan’s bureaucracy, switched from phone number to voice mail then after several calls on to another number. Finally, hospice staff will need to educate the plan representative on what hospices does and how to work with a hospice. And because of the size and complex bureaucracy of the managed care plans, even after that plan representative has a good grasp of hospice provision, hospice staff will most likely be connected with a different plan representative the next time, and be obligated to repeat the phone tree/education process. Juggling multiple plans and multiple contacts within each plan would be exponentially burdensome.
- Medicare Advantage and all managed care plans desire to contract with as few entities as possible. Based on our experience with Medicaid Managed Care, the negotiations for a contract will be hampered from the start because the plan will want to contract with one hospice and close negotiations with the other hospices in the area, once they have secured their mandatory “hospice contract.” Our experience has shown that plans will be dubious of the claim that the plan really needs to contract with a hospice in each part of their plan service area or all hospices within the plan service area. This condition impedes patient choice.
- The Hospice Benefit is based on an interdisciplinary team composed of a physician, nurse, social worker, spiritual counselor, bereavement counselor and aides/therapists/nutritionist. There is grave concern that spiritual counseling will not be viewed as necessary or reimbursable by Medicare Advantage plans. As noted above

under the pre-approval discussion, Medicare Advantage plans will at best have difficulty with and at worst exclude as unnecessary, much of the care that hospice provides.

- HPCANY is concerned that Medicare Advantage Plans will be able to negotiate rates and, again, experience indicates that the plans will attempt to negotiate discounts that will impair the quality and efficacy of the hospice benefit.
- A further concern is that the plan will not understand end-of-life care and attempt to force unnecessary care on hospice patients because it would be common or accepted practice for patients who are not dying.
- There is also great concern that a carve-in will create payment problems. Our Medicaid Managed Care experience indicates that payment software systems will have difficulty with the hospice payment-by-day concept. For example, it is not uncommon for a hospice to bill for 31 days and be paid for one day, as many systems equate 30 days to one month. A payment-by-day system, however, recognizes that some months have 31 days. Reconciling a situation like this often requires numerous phone calls, rebilling (and the re-billing rejected as a duplicate billing) and more phone calls, resulting in months of delay, cash flow issues and diversion of staff time. The work to correct the error is an additional expense which impacts dollars available for patient care.

It is encouraging that the Committee is seeking measures to ensure appropriate care and safeguards to assure access. Unfortunately, it is difficult to picture what those might be when the culture of Medicare Advantage plans is so alien and unrelated to the hospice benefit. Even with measures and safeguards in place, who will enforce them? How will Medicare Advantage staff be trained to comply with them? If there is any thought to pursuing a hospice benefit carve-in, a work group of hospice professionals familiar with actual operations and Medicare Advantage professionals would need to be pulled together to investigate how to address all of the issues noted above.

### **Improving Care Management Services for Individuals with Multiple Chronic Conditions**

As the Committee may be aware, approximately 15% of hospice patients are discharged live from hospice. Most often this is because the patient has improved or stabilized and no longer has a prognosis of six months or less if the disease runs its normal course. In our experience with hospice programs throughout New York State from New York City to Buffalo and from Painted Post to Canton, this generally comes from improved coordination of care and preparation of patients and caregivers to deal with anticipated exacerbations of chronic illness in their own home. Far too often hospices find that when medications are fully reconciled and patients understand what each medication does and how it can be used most effectively, the patient is greatly improved. There are too many stories of imminently dying patients with Congestive Heart Failure and COPD who come on hospice, only to be discharged in a few months and live comfortably for years.

Many New York State hospice programs have established community-based palliative care programs in an effort to provide the needed coordination of care earlier in the chronic disease

process. However, these programs are often not reimbursed or only reimbursed for physician and nurse practitioner consultation, which excludes the nurse, social worker and spiritual care professionals that are so crucial to full coordination of care for these patients. We would strongly encourage the Working Group to consider community-based palliative care programs as providers under this proposal. CareFirst in New York State, for example, has offered community-based palliative care since 2003. While there have been numerous constructions of the program, there has been little to no reimbursement. Despite this, CareFirst has cared for a number of patients with multiple chronic conditions for three years and longer. This care is not resource intensive yet has achieved excellent outcomes in keeping patients out of the emergency room and hospital.

We are witnessing Primary Care Medical Homes hiring nurses from hospitals as case managers. These nurses, in their new role as case managers, must unlearn the institutional model of care provision which values promoting services over outcome, and following pathways without critical thinking. Historically, hospice and palliative care programs have been pursuing an outcome-based, person-centered model of care. We have decades of experience in case management for the terminally ill, who are often afflicted with multiple chronic conditions, yet our with a hospitalization rate and emergency room rate stands at 1% and our readmission rate is zero. **We urge the Working Group to look at existing community-based palliative care programs as a resource with a proven track record.**

## **Expanding Innovation and Technology**

### **Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees**

- Again, we urge that community-based palliative care be recommended as a resource for Medicare Advantage Enrollees.
- We would encourage the Working Group to consider resource utilization rather than health status as a desired outcome, particularly for advanced chronic illness. Given that these are Medicare patients, it is likely the chronic illness is advanced, and that the illness will progress. What is desired is an empowered patient who has the tools to deal with exacerbations of chronic illness and is comfortable using those tools, keeping the patient out of the emergency room and acute care hospital. Certainly, the patient should be educated to avoid exacerbations or at least crisis through telehealth monitoring, or other technologies. However, chronic illness inevitably progresses, particularly in the elderly. It is important that the metric and incentives be geared to realistic goals, patient satisfaction and cost efficiency. The health care system suffers from far too much focus on cure or remission, and far too little focus on comfort, education, support and empowerment. It is important not to drive practitioners to the newest and most costly treatment that has only a small success rate.
- There are excellent studies defining the most costly patients by disease, combination of diseases and stage of disease. These tools should be further tested, refined and utilized to focus effort on the patients that will have the greatest opportunity for improvement, not necessarily in overall health status, but in minimal resource use.

## **Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees.**

- The example list of supplemental benefits appears appropriate other than the benefit *additional inpatient days*. **Hospice and community-based palliative care have consistently proven that inpatient days should be infrequent and only used when the care cannot feasibly be provided in the home.**
- This is another area where community-based palliative care could be added as a benefit assuring quality care that is patient/family driven, goal oriented and cost efficient.
- Again, the measures should be based on the comfort of the patient, the use of resources and patient satisfaction.

## **Increasing Convenience for Medicare Advantage Enrollees through Telehealth**

- We agree that telehealth should be promoted, both in Medicare Advantage plans and Fee for Service Medicare.
- We appeal to the Working Group to propose that hospices be eligible for funding for both Telehealth and EMR grants.
- We support the proposals to promote use of Telehealth in ACOs, to provide ACO flexibility to provide supplemental services and to expand the use of Telehealth for Individuals with Stroke. As noted above, we believe that telehealth should be supported for all payers including Medicare Fee for Service although the use should be to provide increased access for the patient rather than to support the provider.

We support all the remaining proposals with the understanding that both hospice and community-based palliative care should be supported and promoted.

Once again, we appreciate this opportunity to comment on the Working Group's Policy Options Document. If you have any questions, please feel free to contact me at 518-446-1483 or [tnichols@hpcanys.org](mailto:tnichols@hpcanys.org).

Sincerely,



Timothy Nichols  
President/CEO