

**Human Services Committee
Public Hearing
March 8, 2007**

1360

**Testimony of Deirdre Lawe, RN
Executive Vice President of Strategic Development and Public Affairs
VITAS Innovative Hospice Care**

My name is Deirdre Lawe, Executive Vice President of Strategic Development and Public Affairs for VITAS Innovative Hospice Care, the nation's largest provider of hospice services. I am here this morning to testify in support of the addition of hospice services as an optional service covered under the Connecticut Medicaid program.

I am appearing before you today in my capacity as a registered nurse who has worked in hospice for over 20 years and as a representative of VITAS which operates two Medicare Certified hospice programs in the State of Connecticut.

VITAS has been providing hospice services in Connecticut since 2004. In the few years in which we have been serving patients here in Connecticut, we have provided care to over 1,100 patients and families. For the record, I am submitting as an exhibit to my testimony a map that shows where Connecticut residents have received our services. In addition, I am providing the committee with copies of a few of the many letters we have received from patient families who have experienced our care. VITAS has created nearly 150 healthcare jobs for Connecticut workers.

I would like briefly to describe VITAS Innovative Hospice Care ("VITAS"). VITAS has been a pioneer and leader in the hospice movement since 1978. VITAS (pronounced VEE-tahs) operates 41 hospice programs in 16 states (California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Kansas, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, Texas, Virginia and Wisconsin). VITAS employs 9,059 professionals who care for terminally ill patients daily, primarily in the patients' homes, but also in the company's 25 inpatient hospice units as well as in hospitals, nursing homes and assisted living communities/residential care facilities for the elderly. At the conclusion of the third quarter of 2006, VITAS reported an average daily census of 11,213.

VITAS is committed to expanding access for traditionally underserved populations, particularly communities of color, the economically disadvantaged and those with non-cancer diagnoses including AIDS. Non-white populations are traditionally underserved for hospice.¹ VITAS has been successful in using specific strategies for serving inner city communities of color, notably in Chicago where it operates a program in collaboration with Rainbow/PUSH Coalition's *One Thousand Churches Connected*. This unique partnership fosters initiatives that promote hospice particularly in underserved areas. In addition, all VITAS caregivers are trained on how to care for persons of varying cultures

¹ O'Mara, AM and Arenella, C (2001) *J. Pain and Symptom Manage.* 21(4):290-7.; Greiner, KA, Perera, S and Ahluwalia, JS (2003) *J Am Geriatric Soc* 51(7):970-8.

and religions through the “Things Hospice Innovators Need to Know” (THINK) program developed to train VITAS employees and volunteers on diversity issues and how to approach individuals of various cultures and faiths such as African Americans, Euro-Americans, Hispanic/Latino Americans, Jewish Americans and Muslim Americans. VITAS was recently presented with an award by the Initiative to Improve Palliative Care for African Americans for demonstrated commitment to providing and improving quality end-of-life services for African American communities. In addition, VITAS has demonstrated a strong commitment to providing charity care from its beginning days when all patients were cared for solely depending on donations and volunteers. Year after year, VITAS provides in excess of one percent of revenues in charity care. For fiscal year 2005, this amount exceeded \$9.0 million.

I commend you for considering the addition of the hospice benefit to the services provided under Connecticut’s Medicaid program. Connecticut and Oklahoma are the only two states in the country that do not offer this vital benefit.

Dying can be very expensive. A study released by the Medicare Payment Advisory Commission (“MedPAC”) reports that between 1994 and 1998, end-of-life care accounted for approximately 25 percent of Medicare spending². Nearly 50% of those costs occur in the last two months of a person’s life. According to the Centers for Medicare and Medicaid Services (“CMS”), “Spending on behalf of beneficiaries in their last year of life is almost five times as much as for those who are not in their last year of life.”³ CMS further reports that, between 1992 and 1999, the average annual health expenditures for patients in their last year of life averaged \$35,516. CMS observes, “The dramatic increase in Medicare spending in the last few months of life results from the rapid acceleration of inpatient hospital spending.” Although more money is spent during the dying process, is it money well spent? Research has indicated that when given a choice, individuals want to die in their homes, surrounded by their loved ones rather than in inpatient hospital settings. Hospice supports this goal - and often does so in a cost effective manner - with more than 90% of hospice patients dying in a “home” setting (i.e., nursing facility, residential care, or traditional home).

Hospices are meeting the needs of terminally ill patients as demonstrated by a fourfold increase of the number who accessed the Medicare Hospice Benefit between 1992 and 2002, to approximately 640,000.⁴ In 2004, 1,060,000 patients sought hospice care, an increase of 110,000 patients in just one year’s time.

The Medicare Hospice Benefit proved to be so advantageous from both a quality and cost perspective that, in 1985, states were given the option to provide the Medicaid Hospice Benefit. Fortunately, the number of people accessing the Medicaid Hospice

² Medicare Payment Advisory Commission (MedPAC). Improving care at the end of life. Report to Congress: selected Medicare issues. 1999, 7: 119-132.

³ MCBS Profiles. Office of Research, Development, and Information. Last Year of Life Expenditures. May 2003, Issue No. 10.

⁴ US Government Accountability Office (GAO). Medicare Payment for Hospice Care. October 15, 2004, GAO-05-42.

Benefit is a great deal smaller. In order to qualify, an individual would need to be under the age of 65, impoverished, and be diagnosed with a terminal condition where death is anticipated within six months or less.

Medicaid budgets are being cut throughout the country at unprecedented levels. So some may ask, why is Connecticut considering adding an optional program to Medicaid?

The Illinois Medicaid Department asked a similar question in 1995. At that time, the Medicaid Hospice Benefit was being offered in their state and they were debating whether the benefit should be continued. After analyzing the costs for Medicaid recipients with and without hospice care, they found that, during the last 72 days of life, the cost savings to the State were \$10,803 for each recipient. These savings were realized because Medicaid beneficiaries without hospice were accessing the acute care system. Assuming a death rate of .81% of all Medicaid beneficiaries⁵ (or an estimated 2,750 persons receiving Medicaid who die annually in Connecticut) and a 50% hospice penetration rate among that decedent population, Connecticut savings could exceed \$15.8 million, or over 5% of the annual Connecticut Medicaid budget.

When a State makes the decision to incorporate hospice care into the State Medicaid Plan, the federal government determines the rate to be paid. The per diem rate includes payment for the following services (which mirror the Medicare provisions):

- Care by an interdisciplinary team composed of physicians, nurses, home health aides, social workers, clergy, volunteers, and therapists
- Medications related to the terminal illness
- Supplies related to the terminal illness
- Durable Medical Equipment, such as oxygen and beds
- Additional treatments that are required for comfort care
- Bereavement care to family and loved ones following the death of the patient

In the passage of the Medicare Hospice Benefit, the guiding principle in structuring the reimbursement system was to have an all-inclusive rate that engaged the provider in the professional management and sharing of financial responsibility for the care provided. Services are provided at four different levels of care, which are as follows:

- Routine Home Care
- Respite
- General Inpatient Care
- Continuous Care

Although the goal of the hospice program is to maintain individuals in their own home, or the place they call home, it was known that there are circumstances that would make it difficult for a caregiver to accomplish this goal. Thus, the respite rate was created to

⁵ U.S. Census data.

provide families a break from the on-going stress of caring for a terminally ill loved one. Likewise, there will be times when symptoms cannot be controlled at home and the patient will require more intensive services such as those found in a hospital. The general inpatient level of care creates a mechanism for this treatment to be received while holding the hospice responsible for the case management. In this way, patients do not get drawn into receiving curative care when this is no longer appropriate. Continuous care is similar to a private duty nurse benefit. This care is provided in the home for those individuals who require more skilled care than a caregiver can provide, however they do not want to return to the hospital.

In conclusion, hospice provides the quality care patients and families deserve, in the location they desire at a cost savings to the state.

Thank you for this opportunity to appear before you today. I would be pleased to respond to your questions.

Exhibit 1

Hospice Patients Served by VITAS Innovative Hospice Care

