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Human Services Committee Public Hearing
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Testimony of Pat Tadel, RN, MSN, CHPN
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Good morning Senator Harris, Representative Villano and members of the Human Services Committee, my name is Pat Tadel. I serve as Patient Care Administrator for VITAS Innovative Hospice Care ("VITAS"), which operates two Medicare certified hospice programs in the Greater Waterbury, Hartford and Bridgeport areas of Connecticut. I am an advanced practice registered nurse, certified in hospice and palliative care, and I have been working in hospice and palliative care for over 16 years. I am a thanatologist and hold a post-doctoral certificate in clinical ethics. I am here this morning to testify in support of S.B. 558 An Act Concerning The Availability Of Hospice Services Under The Medicaid Program.

I would like to thank the chairs and members of this committee for their leadership and commitment to providing this benefit for Medicaid patients and their families in Connecticut for the past several years.

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 more than 2,140 patients and families with our 215 healthcare employees in Connecticut.

VITAS, a pioneer and leader in the hospice movement since 1978, is the nation's largest provider of end-of-life care. VITAS (pronounced VEE-tahs) operates 42 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 8,640 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 fourth quarter of 2007, VITAS reported an average daily census of 11,456.

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 by hospice.[1] VITAS has been successful in using specific strategies for serving inner city communities of color.

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[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.

For example, VITAS operates an outreach 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 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 proposing the addition of the hospice benefit to the services provided under Connecticut's Medicaid program. Connecticut, New Hampshire and Oklahoma are the only three 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 spending[2]. 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.

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[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.

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 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.

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 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 quality care that patients and families deserve and it does so in the location that most beneficiaries desire. Additionally, a Medicaid hospice benefit will provide this compassionate care 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.