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NEW YORK STATE MEDICAID REDESIGN TESTIMONY – FEBRUARY 4, 2011

I am Claire Haaga Altman, the Executive Vice President and Chief Operating Officer of the HealthCare Chaplaincy. We are a 50-year-old nonprofit that educates and places board certified chaplains in health care settings and conducts research on the relationship between health and spirituality. Much of our work is focused on palliative care and end of life care. We are concerned with the limited number and cost of home- and community-based long-term care options available to New Yorkers and believe there are more cost-efficient and higher quality models that could meet many of the needs of people with serious progressive illness.

Long-term care and other care services for the elderly are major contributors to New York State’s soaring healthcare costs. The current Medicaid funding system for long-term care in New York State emphasizes skilled nursing and intensive home care. In both modalities, consumers are likely to be frequently rehospitalized in the end of life because the attendant regulations incentivize heavy use of hospital services. NYS’s Enhanced Assisted Living licensure, on the other hand, allows those with chronic, progressive illnesses to enter assisted living needing only minimal assistance with activities of daily living and progress through the end of life with hospice and skilled nursing care provided in-house only as needed. With greater implementation, this model gives patients an intermediate form of care that keeps them out of expensive and unnecessary hospital, 24-hour home care, and skilled nursing settings.

We believe this model will help control the rapidly rising costs of end-of-life and long-term care. EALR costs approximately half of what skilled nursing and 24-hour home care cost. In-house calculations have shown the use of the new EALR model can save upwards of \$200,000 per patient in the last year of life alone. Much of the savings arise from better end-of-life planning and the fact that those persons who elect not to utilize extraordinary medical treatments can avoid expensive and unnecessary hospital stays when using enhanced assisted living. Money is also saved by having residents in a single location where all care can be provided, including on-site primary care. The table below shows that if even 10% of those in SNF and 24-hour care facilities in the last year of life shifted to EALR, the savings would be in the hundreds of millions of dollars. Additionally, EALR programs are scalable, making them more cost-effective and attractive for health care providers than residential hospice (limited to 8 beds per facility in NYS), skilled nursing, or extensive home care. We have prepared a chart showing sample care pathways for persons in the last year of life for the Redesign Team (see attached).

POTENTIAL SAVINGS: MOVING TO THE ENHANCED ASSISTED LIVING RESIDENCE MODEL

<i>Type of Care</i>	<i>Medicaid Patients in Last Year of Life*</i>	<i>Gross Cost</i>	<i>10% Shift to EALR</i>	<i>New Gross Cost</i>	<i>Savings</i>
Skilled Nursing Care	6,419	\$2,861,980,594	642	\$2,656,915,200	\$205,065,394
CC Retirement Comm.	Number not available	N/A	N/A	N/A	N/A
Home Care/CHHA	4,332	\$1,281,850,283	433	\$1,208,421,288	\$73,428,995
Assisted Living Program	236	\$58,441,475	24	\$55,580,309	\$2,861,166
Total:	10,987	\$4,202,272,352	1,099	\$3,920,916,796	\$281,355,556
Average Savings per Patient:					\$256,083

* Based on the assumption that 5% of patients in each category will be in the last year of life.

Not only does Enhanced Assisted Living offer a cost effective approach, but we believe it also provides the highest quality of life for residents. EALR provides more opportunities for residents to explore their relationships, beliefs and values during a time when spirituality and religious beliefs are extremely important to patients. Both studies and the personal experience of our chaplains indicate that consideration of all of these factors and spirituality in particular reduces the confusion and distress that many patients and their loved ones experience during serious illness and end of life.

Despite the apparent benefits of this model, there are currently no Enhanced Assisted Living providers in New York City and only two currently operational in New York State. HealthCare Chaplaincy hopes to begin to fill this gap by developing a model Enhanced Assisted Living Residence for 120 persons in Lower Manhattan to demonstrate the model's benefits. Yet as we have moved through the planning stages, we have found significant obstacles to developing residences of this type to a scalable level. We have recommendations regarding each of these "barriers" and hope that the Task Force will take a serious look at promoting EALR as a high-quality, cost-efficient option for end of life care.

- **Problem: Lack of public information and understanding of palliative care**, how it can meet patient and family needs, and how it can provide more choices at the end of life.
 - ✓ **Recommendation:** Create a public awareness campaign for consumers around the importance and value of palliative care, end-of-life choices, and advanced directives; work with senior centers and community clergy to "get the message out"; involve AARP.
- **Problem: Three separate licenses are required for EALR certification** and processing time is from 1-5 years. Medicaid support for enhanced assisted living in New York is also non-existent. New York's "Assisted Living Program" provides Medicaid support, but it is limited and bureaucratic.
 - ✓ **Recommendation:** Coordinate ALP and EALR licensing and funding to speed certification and avoid redundancy. We recommend developing demonstration projects to show feasibility, cost-savings and quality of life improvements as a result of EALR/ALP models.
- **Problem: There are no viable cost-sharing options for "middle class" individuals.** Many transfer assets to family members to become 100% dependent on Medicaid.
 - ✓ **Recommendation:** Some states offer middle class families a shared responsibility for elder care. NYS might emulate aspects of these state models. We also recommend increasing geriatric/palliative care outpatient services to help those with serious progressive illness understand their options when obtaining treatment.

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