Will Elimination of the Optional Medicaid Hospice Benefit Save the State of Florida Money?

A White Paper

Prepared for: Florida Hospices & Palliative Care

December 2008

THE MORAN COMPANY

Will Elimination of the Optional Medicaid Hospice Benefit Save the State of Florida Money?

A White Paper

Introduction

On December 16, the Florida Agency for Health Care Administration (AHCA) proposed to the Health Care Appropriations Committee in the Florida House that the Medicaid Optional Hospice Benefit be eliminated.[1] AHCA claims to save the State $343,343,046 in Medicaid hospice payments including $154,042,260 in general revenues.

Florida Hospices and Palliative Care, an association of Florida hospice providers, retained The Moran Company, a national research and consulting firm based in Arlington, Virginia, to examine the State's financial assumptions and develop an independent evaluation of the impact of eliminating the Medicaid hospice benefit. Other researchers have also produced a variety of estimates and critiques suggesting that ACHA's estimate of savings vastly overstates any real savings likely to be achieved by the proposed action.[2]

In this report, we explore the State's claim that elimination of the optional Medicaid hospice benefit will result in savings referring to two of AHCA's *Guiding Principles* for making reductions to the Medicaid budget:

1) To better manage utilization and find efficiencies; and
2) To attempt to minimize impacts on beneficiaries.

We also discuss the attempts of other states to eliminate the Medicaid hospice benefit or prevent its addition to optional services in a state Medicaid program. Finally, we describe characteristics of Florida's Medicaid hospice program in relation to similar programs in other states, and illustrate differences in the patient population served compared to the Medicare hospice population.

Key Findings

- Eliminating the optional Medicaid hospice benefit will not save the State money, and will likely result in increased spending for mandatory services.
- Such action will also likely increase the burden on Florida counties to provide indigent care through already financially stressed indigent care programs and participating hospitals, as hospices must stretch their limited uncompensated care resources to cover those losing the Medicaid benefit.

---

[1] Florida House of Representatives, Appropriations Committee on Healthcare, Meeting Packet, December 16, 2008. http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2452&Session=2009&DocumentType=Meeting%20Packets&FileName=HCAC_Mtg_12-16-08_online.pdf (accessed December 20, 2008).

[2] State Data Center on Aging, University of South Florida, Issue Brief, December 2008.

- The loss of the service coordination, care management, and supportive services offered by hospice will increase fragmentation of care for terminally ill patients, limit their access to palliative care, and burden families and caregivers, potentially limiting their employment and educational options.
- Other states that have considered elimination of the optional hospice benefit have rejected such action in the face of arguments and research showing that hospice would cost less than the alternative. Connecticut recently added the benefit, and now only two states do not offer the benefit.
- Florida's Medicaid hospice program is 24th in the nation (as of 2007) for the proportion of all hospice days used by Medicaid patients, including dual eligibles. While Florida has a fast growing hospice program (dominated by Medicare), its growth is consistent with Medicare hospice growth nationwide.
- The beneficiaries in Florida's Medicaid hospice program are different from the Medicare population that dominates hospice services. Florida Medicaid-only hospice patients are younger and more likely to be in the terminal stages of cancer or have HIV/AIDS related conditions than Medicare or dual Medicare/Medicaid patients. Their average length of stay in hospice is shorter, and their care is more likely to be complex and involve management of severe symptoms that, unmanaged, trigger emergency room visits and/or hospitalization.

Methods and Data

To evaluate the role of hospice care in the service delivery system for Medicaid patients, we examined the following data sources:

- Submitted a data request and received from AHCA data on hospice payments for state fiscal year 2007, and on Medicaid patients that died while receiving hospice services in that year.
- Examined Medicaid fee schedules and payment rates published on the AHCA web site for medications, physician services, and hospital services. These were all for state fiscal year 2008. We also examined Medicaid fee schedules and payment rates for other states.
- Conducted a survey of hospice providers requesting state fiscal year 2008 data by payer on admissions, days of service, revenues, expenses, and diagnoses for patients admitted to hospice during the period. Data were submitted by 32 of 42 hospice providers. Also collected data on Medicaid only nursing facility days as a proportion of all Medicaid nursing facility days from a geographically representative subset of hospices that tracked this data in State FY 2007.
- Analyzed Medicare cost reports for all hospices in the US for 2005 through 2007.
- Analyzed Medicare inpatient claims for costs of inpatient care for patients who died during 2007.
- Interviewed hospice clinicians and other Florida professionals working in the hospice field.

- Reviewed the available literature published and unpublished on the cost effectiveness of hospice compared to costs of care during end-of-life without hospice, and trends in growth in the hospice program including all Medicare Payment and Advisory Committee (MedPAC) reports.
- Reviewed literature describing the efforts to make changes to Medicaid hospice benefits in other states.

ACHA Guiding Principle for Reductions in Medicaid: To better manage utilization and find efficiencies

Our analysis shows that elimination of the Medicaid hospice benefit will neither improve utilization of mandatory services, nor improve efficiency in the delivery of health care services to Florida Medicaid beneficiaries. Quite to the contrary, elimination of hospice for Medicaid beneficiaries, particularly those not eligible for Medicare, will likely result in increased Medicaid expenditures for mandatory services, and will remove a care management function that currently creates efficiency in care delivery, minimizes unnecessary care and prevents the delivery of very expensive mandatory curative and institutional services that are not desired by the patient and his/her family.

The hospice benefit replaces a number of mandatory benefit services, covering within all inclusive rates, all medical care related to the terminal condition, including: medications, home health, durable medical equipment, and inpatient care. Hospice also offers a wide range of supportive and care coordination services that include services to family members and caregivers. Hospice services are not duplicative, but supplementary to nursing home services, providing additional expertise in palliative care and symptom management not available within most nursing home settings, as well as medications and durable medical equipment (e.g., special mattresses for acute bed sore management).

When patients choose hospice, they forego intervention by the health care system to attempt to cure their terminal conditions or extend their lives. Absent hospice, terminally ill patients will continue to use health care services, but chances increase that health crises will emerge that cannot be handled by care givers, leading to emergency room visits and hospital admissions that confront patients with precisely the interventions they chose to avoid, under circumstances where they are unprepared to advocate for their own preferences.

Elimination of the Medicaid hospice benefit will increase costs to the State for mandatory benefits

Documents released by AHCA combine Medicaid payments for hospice services with payments to the hospices for nursing home room and board (paid at 95% of Medicaid room and board rates) claiming that the State would save the entire amount of Medicaid payments if the hospice benefit is eliminated. In fact, the Medicaid room and board payments cannot represent any savings to the State. Medicaid patients, including those with Medicare coverage who are

admitted to nursing homes, are eligible for room and board payments with or without hospice. If the hospice benefit were eliminated the State would pay 5 percent more for these services for Medicaid-only patients, as it would be obligated to pay 100 percent of the Medicaid room and board rates.

Exhibit 1 shows the state fiscal year 2007 hospice payments as reported by ACHA, and the increase in Medicaid payments just for nursing home room and board, if patients were not in hospice. Here, maximum potential savings are reduced from $65.1 million by slightly more than a half million dollars.

Exhibit 1

Medicaid Payments and Estimated Changes in Payment with Elimination of the Medicaid Hospice Benefit (inclusive of Federal and State shares)	
Total Medicaid hospice payments State Fiscal Year 2007	$ 254,268,359
Medicaid payments for nursing home room and board for hospice patients.	$ 189,217,016
Medicaid payments for hospice services only	$ 65,051,342
Eliminate the Medicaid Hospice Benefit	
Maximum Savings to the Medicaid Program (Federal and State share)	**$ 65,051,342**
Additional payments required for nursing home room and board for Medicaid only patients	$ (567,651)
Revised maximim net savings to the State if patients used no mandatory benefits	**$ 64,483,691**

If the patients that received hospice services during state fiscal year 2007 had not received hospice, it is possible to create estimates of the costs associated with Medicaid mandatory services they would have been likely to use, based on studies of end-of-life care.

Studies of costs associated with end-of-life care demonstrate that health care costs for patients not in hospice are significantly higher than hospice costs during the last month of life. Our 2008 provider survey of 32 Florida hospices shows that 75 percent of hospices report a shorter average length of stay for Medicaid patients compared to other hospice patients, and overall, a 12 percent shorter average length of stay (71 days). The end-of-life cost effectiveness studies demonstrate that hospice costs only exceed other health care costs for end-of-life care for patients who are in hospice for prolonged periods of time (e.g., 90-180 days). The Medicaid beneficiaries using the Florida hospice benefit, by and large, are in hospice for less than three months, and many for much shorter stays. Given the research, and data on Florida Medicaid hospice length of stay, we would expect the cost of end-of-life care for these beneficiaries without hospice to exceed the costs for their care in hospice. This is, in fact, what we find making the most conservative estimates of cost of care without hospice.

In estimating the costs the State would incur if the hospice benefit were eliminated, we will use the AHCA counts of Medicaid hospice deaths (11,159 deaths) in fiscal 2007, even though more than 16,000 Medicaid patients were enrolled in hospice during this time period. The estimates in Exhibit 2 are very conservative and suggest that State Medicaid expenditures (excluding the nursing home room and board payments) would have increased by at least $3.7 million in 2007, had the hospice benefit been eliminated in that year.

Exhibit 2

Maximum Savings to the Medicaid Program (State and Federal share) after accounting for nursing home room and board payments.	**$ 64,483,691**
Conservative Estimate of additional payments for hospitalizations avoided by hospice	$ (55,047,816)
Conservative Estimate of additional payments for new nursing home admissions room and board payments avoided by hospice	$ (9,958,790)
Conservative Estimate of additional payments for prescription medications previously paid as part of hospice	$ (2,204,000)
Conservative Estimate of additional payments for emergency room visits avoided by hospice	($976,413)
Estimated minimum net costs to the state for fiscal 2007 if hospice had been eliminated	**$ (3,703,328)**

The assumptions and methods used to make these estimates are shown in Appendix A to this report. The additional costs estimated are for 2007 only. State projections show significant increases in estimated hospice payments, assuming increases in Medicaid hospice utilization. The State would also assume some decreases in provider payments for mandatory benefits due to projected rate cuts. However, even with these assumptions, the cost of care for these patients projected to future years will likely be materially greater without hospice, than if hospice benefits are available.

Beyond the increased estimated payments discussed above, other costs are likely to be imposed upon the State Medicaid program with the elimination of the hospice benefit. Unmanaged symptoms and limited caregiver capacities may lead to increased visits to physicians, community health centers, and outpatient clinics. For many patients, health care providers are likely to order diagnostic tests that would be avoided with hospice services. Physicians may order home health services. Children are eligible for a broader array of services under Medicaid than adults. Services provided through a hospice are delivered under a plan of care. Absent hospices, patient care is likely to become fragmented across a number of providers. Because these patients are very ill and difficult to care for without help, many are likely to have increased contact with the

health care system. We have no basis in the end-of-life care literature for estimating costs for these types of care as shown in Exhibit 3. They are, however, likely to be non-trivial.

Exhibit 3

Other Possible Medicaid Payments Incurred without the Hospice Benefit	
Additional payments for physician and outpatient hospital visits	unknown
Additional payments for laboratory and diagnostic tests	unknown
Additional payments for home health services	unknown
Additional payments for services to children	unknown

Elimination of the Medicaid hospice benefit will result in increased costs to Florida counties for health care and social services

In state fiscal year 2008, 32 of 42 hospices report providing $36,215,385 in uncompensated care[3] for 184,356 days of patient care representing 2.8 percent of hospice days. Florida hospice uncompensated care resources could absorb only part of the loss of Medicaid revenue if the hospice benefit is eliminated. Patients historically served using hospice uncompensated care resources would then become a burden on Florida counties, increasing utilization of emergency rooms, hospital outpatient clinics, and inpatient care covered under indigent care programs.

Hospices supplement their resources with the use of volunteers, thereby providing additional services that are not paid for by the State or the counties. Supportive and respite care services provided by hospices allow some family members to maintain employment and/or participation in education programs, limiting absenteeism. Removal of these services for Medicaid and uninsured families increases their risks for use of other social services, and for unemployment.

ACHA Guiding Principle for Reductions in Medicaid: To minimize impacts on beneficiaries

Elimination of the hospice benefit leaves Medicaid patients with terminal conditions without the choice of coordinated palliative care: a choice to control the circumstances surrounding their last weeks and months of life, and often the choice to die at home. Medicaid patients are more likely than insured/Medicare patients to have experienced fragmented care and to have their illness diagnosed later when symptoms are evident and treatment options are more limited. Medicaid

[3] The Moran Company, Survey of Florida Hospices, November 2008.

families and caregivers have fewer resources with which to navigate the health care system and advocate for the terminally ill family member. Generally, palliative care is not provided in emergency rooms, hospital outpatient clinics, or in nursing homes unless hospice professionals are present. Some palliative care may be provided in a limited number of hospitals. Palliative care provides management of the symptoms of terminal illness to keep the patient as comfortable as possible

Elimination of the Medicaid hospice benefit will almost certainly result in increased pain and suffering for terminally ill patients. Some patients will find themselves receiving intrusive care that is not desired. Some will die in hospitals and nursing homes rather than at home with their families as they had wished. Elimination of Medicaid hospice will also deny the families and caregivers of terminally ill patients the supports that may be keeping families together, supporting employment and education, and coping strategies that keep people productive and healthy.

Who are the patients that utilize the Medicaid hospice benefit?

State data for FY 2007 show that 22 percent of Medicaid deaths occurred in hospice. See Exhibit 4. Forty-four children under age 18 died in hospice during this period. Medicaid deaths for people between ages 19 and 64 made up 32 percent of hospice Medicaid deaths compared to 28 percent of non-hospice Medicaid deaths. Males made up 38 percent of the Medicaid deaths in hospice compared to 44 percent of Medicaid deaths outside of hospice. The mix of Medicaid hospice patient deaths by race/ethnicity is similar to non-hospice Medicaid patient deaths, though slightly fewer minority patients die in hospice than outside hospice. See Exhibit 5. Since most patients over age 65 are eligible for Medicare hospice benefits, the patients most directly affected by the elimination of the Medicaid hospice benefit are those under age 65, less than one third of Florida Medicaid patients receiving hospice.[4]

Based on our Florida hospice survey data for FY 2008, Medicaid hospice patients have a different diagnostic profile than Medicare/insured hospice patients. Exhibit 6 shows that Medicaid patients are much more likely to have cancer diagnoses and less likely to have the degenerative conditions that lead to the longer length of stay in hospice that is identified in research as a cause of increasing hospice costs.

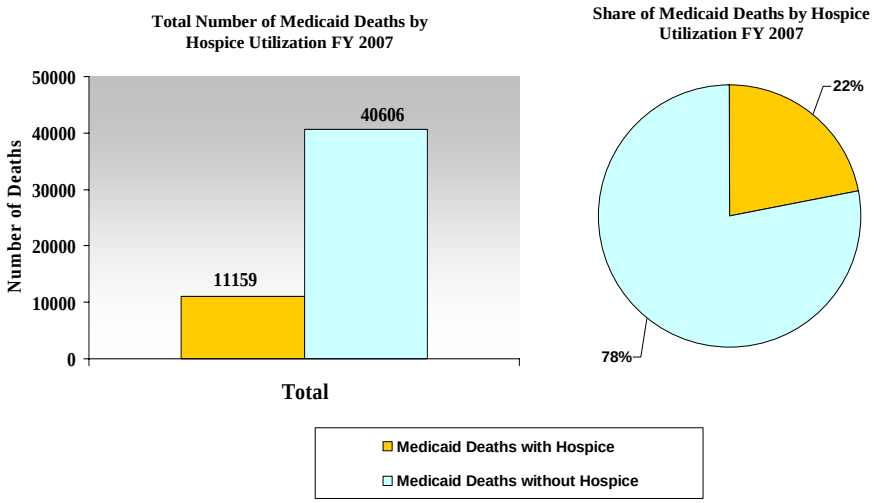
The survey data provides an overview of the size of the Medicaid program in 32 of 42 hospices in Exhibit 7 below. Medicaid is a small part of the Florida hospice program.

Examples of Medicaid hospice patient situations reported by hospice professionals interviewed for this project are shown in Exhibit 8.

[4] Hospice most often paid for by Medicare, and nursing home room and board paid by Medicaid.

Exhibit 4

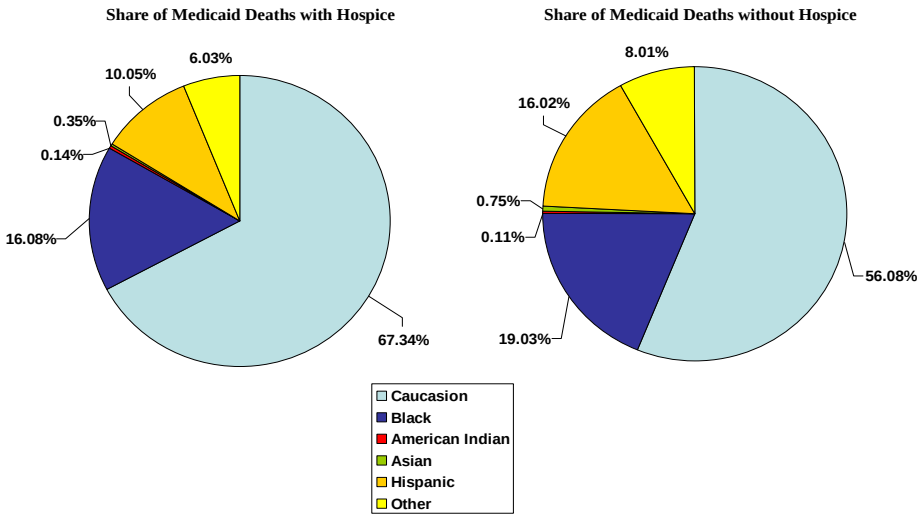
Medicaid Deaths by Hospice Utilization FY 2007



Source: Data provided by analysts at Florida's Agency for Health Care Administration in December of 2008 from a data request submitted by The Moran Company in October, 2008.

Exhibit 5

Share of Medicaid deaths by Hospice Utilizations by Race/Ethnicity FY 2007



Source: Data provided by analysts at Florida's Agency for Health Care Administration in December of 2008 from a data request submitted by The Moran Company in October, 2008.

Exhibit 6

By Diagnosis	Cancer	Alzheimers	Degenerative Neurological	Heart Failure	Chronic Kidney Dis	AIDS related	COPD	Other
Average Proportion of All Patient Days	26%	8%	9%	8%	1%	1%	8%	41%
Average Proportion of Medicaid Only Patient Days	48%	2%	2%	3%	1%	4%	7%	34%

Exhibit 7

32 of 42 Florida Hospices Reporting for State Fiscal Year 2008

	Admissions		Patient Days		Nursing Home Hospice Admissions		Nursing Home Hospice Days	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All Patients	82,118	100%	6,582,995	100%	11,573	14.1%	1,235,582	18.8%
Medicaid Only	4,113	5.0%	290,586	4.4%	228	5.5%	76,765	26.4%
Uncompensated Care	3,552	4.3%	184,356	2.8%				

Exhibit 8

Patient HJ, a 37 year old male, was hospitalized for intense leg pain and the diagnosis was made of AIDS. He had never been tested before, and was not aware of his HIV status prior to this hospitalization. His prognosis was very poor. He was weak and unable to walk. His cognitive status was declining rapidly. He was admitted to a nursing home as he could not be cared for at home. Hospice was called in to manage symptoms of discomfort and also to provide emotional support to his 27 year old wife and their 3 small children ages 4, 2 and 7 months. His wife needed a lot of support as she and her children were tested for HIV. She also needed support in adjusting to this life altering tragedy. The patient's mother, who had been estranged from this patient for many years, came to say goodbye to this young man. There was a lot of friction between the patient's wife and the rest of his family. Even before he died, they often argued over who would have custody of the patient's ashes. Multiple social workers and chaplains were used to provide support to this family. After the patient died, the children and family counselor met with the patient's wife and children to support them in their grief. Also, around Christmas time, a hospice team adopted the family and provided toys for the children and help with utility payments as they were suffering from great financial hardship. Patient HJ was in hospice for 17 days.

Patient QR was age 10 in a family with a mother and two other children ages 7 and 14. Mom worked outside of the home. The hospice nurse attended doctor visits with child and mother, reviewed orders and care plans with the mother to ensure compliance, and provided detailed information to the doctor about symptoms. Nurse visits to the home were once a week and more often as needed. Prescriptions were obtained through the hospice pharmacy. Prior to hospice, the family received a weekly home health nurse visit and was instructed to bring the child to the ER for any problems. Problems arose with timely delivery of medication and durable medical equipment. Hospice social workers provided counseling to the child and siblings, visited the school, coordinated with school counselors and teachers for all three children, and assisted with the probation officer for the child with juvenile legal problems. Prior to hospice, no counseling services were provided, mental health center waiting lists were 6 months long, and children faced school problems, failing grades and anger issues. Hospice provided Mom with additional assistance at home. Trained hospice volunteers provided respite care and Mom was able to continue working. Hospice counseling and support services continue after death of QR.

Other states that have looked at eliminating the optional Medicaid hospice benefit have decided to keep the benefit.

Medicaid costs and expenditures have grown rapidly placing major budget constraints on most states. As a result, states have proposed policies aimed at reducing Medicaid costs and expenditures, including eliminating or opting not to implement the Medicaid hospice benefit. Such efforts have been undertaken in North Dakota, Nebraska, Alabama, Ohio, Indiana, Illinois and Kentucky.

In each case, the conclusion reached was to keep the optional Medicaid hospice benefit for reasons that reiterate the findings in this report. In several instances, state agencies conflated the Medicaid nursing home payments with hospice payments, treating the nursing home payments as savings. In each case, this presentation was refuted. In addition, advocates made the case that the Medicaid hospice benefit saves the state costs in mandatory Medicaid services that would be used in lieu of hospice. Shared findings across states include:

- Hospice saves state Medicaid dollars in overall spending for the terminally ill by including medications, durable medical equipment, and diverse health care services in the hospice benefit per diem rate.
- Hospice saves state Medicaid dollars by providing a 5% cost savings for Medicaid nursing home room and board expenses.
- Hospice saves state Medicaid dollars by reducing costly hospitalizations.

These assertions are based on studies widely cited by advocates arguing for the Medicaid Hospice benefit. The most frequently sited studies are summarized below.

A Milliman study[5] published in 2003 found that:

- The number of terminally ill Medicaid beneficiaries dying in hospitals would increase by 40% if the Medicaid hospice benefit was eliminated;
- Medicaid Agencies can predict a cost savings of $7,000 per beneficiary that enrolls in hospice due to decreased hospitalization, reductions in pharmaceutical costs, and savings from room and board payments to nursing homes; and
- An estimated 64,000 Medicaid beneficiaries die in hospitals every year and almost 70% (45,000) of these beneficiaries have a typical hospice diagnosis.

A 2000 "ASPE" study by the US Department of Health and Human Services (DHHS)[6], later validated by a Brown university study[7] demonstrated that:

[5] Fitch, K. and Pyenson, B. "Value of Hospice Benefit to Medicaid Programs," Milliman USA, Inc., May 2, 2003.
[6] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, Synthesis and Analysis of Medicare's Hospice Benefit, March 2000.
[7] Miller, S. and Shield, R., "Palliative Care/Hospice for Persons with Terminal and/or Chronic Progressive Illness: The Role of State and Federal Policies in Shaping Access and Quality for Persons Receiving Long-Term Care," Center for Gerontology and Health Care Research, Department of Community Health the Warren Albert Medical School of Brown University, July 2008.

- Nursing home residents enrolled in hospice are clinically similar to non-hospice dying nursing home residents;
- Hospice residents are less likely to be hospitalized in the last 30 days of life (12.5% vs. 41.3%) and in the last 90 days (24.5% vs. 53%);
- Hospice patients receive superior pain assessments compared to those who did not receive hospice;
- Hospice patients have lower percentages for use of physical restraints, parenteral/intravenous feedings, or feeding tubes in place; and
- When hospice is in a nursing facility, there is a beneficial "spillover" effect to non-hospice residents. Facility staff changed their behavior by modeling it off of hospice staff.

A 1995 study by Illinois' Medicaid agency[8] found that:

- The costs per beneficiary with no hospice services were $18,680 compared to costs per beneficiary with hospice which was $7,877.
- This translated into cost savings of $10,803 per hospice beneficiary.

A 1994 report on hospice care by Lewin-VHI, Inc., commissioned by the National Hospice Organization[9] concluded that:

- Nationally, for every dollar Medicare spent on hospice, $1.52 in Medicare Part A and Part B expenditures were saved;
- "The best available research provides strong evidence that hospice is a less costly approach to care of the terminally ill;" and
- The two principal reasons for these cost savings are that hospice substitutes for inpatient services and that it reduces the intensity of services required.

A report sponsored by the State of Florida found that in 2002 "[T]he overall cost of caring for the hospice patients was 29.9% lower than non-hospice Medicaid patients with terminal conditions;"[10]

[8] As of December 2008, this study is not publically available. This study was done by the Illinois state agency for public assistance programs. Since the time this study was conducted, this agency has changed names and is now called the Illinois Department of Healthcare and Family Services.

[9] Manyard**,** B. and Perrone, C., "Hospice Care: An Introduction and Review of the Evidence," (Prepared for the National Hospice and Palliative Organization), Lewin-VHI, Inc. 1994.

[10] Health Council of South Florida, Inc., "The Hospice Medicaid Education Project," (Sponsored by the State of Florida, Department of Health, the Hospice Foundation of America, Inc. and the Health Council of South Florida Inc.), January 17, 2002.

A report by researchers from the Oregon Health Sciences University Center for Ethics in Health Care stated that Oregon, the state with the nation's lowest in-hospital death rate (31% in 1996)[11] also had one of the nation's highest hospice utilization rates[12] (31.5% in 1997).[13]

An unpublished 1995 IDPA study found that in the last 72 days of life, spending on hospice patients was $10,803 less on average than spending for non-hospice patients. According to the Nebraska Hospice Association, if the results were similar in Nebraska, implementing a Medicaid hospice benefit would save Nebraska over $1.5 million per year for the 150 affected Nebraskans.[14]

An unpublished 1993 study by the Texas Department of Human Services found that, in the last 12 months of life, hospice Medicaid recipients cost $2,761 less than those not using hospice services per patient, and in the last month of life they cost $5,882 less. The study found that, "Overall, the use of hospice appears to lower total Medicaid expenditures for terminally ill clients."

A 1992 "Medicare Hospice Benefit Program Evaluation" prepared by Abt. Associates, Inc. found that for the first three years of the Medicare hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care.[15]

A 2003 report by the Alabama Medicaid Agency for FY 2002 found that hospice expenditures for Medicaid only accounted for .21% of all Medicaid expenditures and concluded that: "Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and supportive services for terminally ill individuals… This service is not only compassionate, but cost effective… The expense [of hospice care] was offset by a reduction in hospital costs to Medicaid."[16]

Florida's Medicaid hospice program is not out of proportion in size or growth to similar programs in other states.

While Florida's hospice program has the largest volume of care in the US, its Medicaid program has accounted for a declining proportion of all patient days between 2005 and 2007. See

[11] Center for Health Statistics. Mortality and Vital Statistics, 1996, Portland, OR: Oregon Health Division; 1997.
[12] Cushman, J., "Hospice Penetration: The Use of Public Data to Measure Hospice Performance," (Symposium conducted at the National Hospice Organization Senior Management and Leadership Conference in St. Louis), June 1998.
[13] Oregon Health Sciences University, Center for Ethics in Health Care, "The Oregon Report Card: Improving Care of the Dying," http://www.ohsu.edu/ethics/docs/barriers2.pdf (accessed December 22, 2008).
[14] Krutz, J., Nebraska Hospice Association, (Letter sent to Governor Mike Johanns and other executive lawmakers), July 12, 2002.
[15] Kidder, D., "The Effects of Hospice Coverage on Medicare Expenditures" *Health Services Research*, vol. 117, 1992, pp. 599-606.
[16] Alabama Medicaid Agency for FY 2002, 2003. http://www.medicaid.alabama.gov/documents/Resources/4J-4_Annual%20Reports/4J-4h_ANREPOR96.pdf (accessed December 23, 2008).

Appendix B. In 2007, Florida ranked 24th among states for the percentage of hospice days used by Medicaid patients.

Hospice utilization is growing nation wide. Research studies show that hospice penetration is higher among managed care populations. Given the proportion of patients in Florida managed care programs, and the size of the elderly population in Florida, demand for hospice will likely continue to grow among the Medicare population. It is entirely unclear whether and to what extent Medicaid utilization will grow. In areas of the State with mandatory Medicaid managed care, it would be reasonable to expect growth in referral to hospice care. Hospice is carved out of Medicaid managed care plans and would represent an economically rational choice for the plans, shifting cost from the plan to the State.

Hospices function as community based organizations that network with community health centers, hospitals, faith based programs, social service and aging programs and other points of contact through which citizens seek advice, information, and referrals for services. Demand for hospice has increased nationwide as more people have contact with its services, and come to understand its philosophy and the alternative choices it offers terminally ill individuals and their families. Demand for hospice services among Medicaid beneficiaries will likely increase in the same manner.

Conclusions

We can find no support for the State's claim that elimination of the optional Medicaid hospice benefit will save state general revenues. State payments for nursing home room and board services represent an obligation with or without Medicaid hospice. The remaining Medicaid payments for hospice services would only represent savings if the patients likely to use hospice could go without use of other health care services covered as mandatory benefits. Few would try to argue that terminally ill patients will not use costly health care services.

Florida hospices appear to be saving the State money by serving Medicaid beneficiaries, and providing a wide range of benefits to Medicaid and uninsured families. Based upon our review of national experience, the research and literature, and our own models of possible substitutes for hospice care, eliminating the optional Medicaid hospice benefit appears to be against the interests of the State, Florida counties, Medicaid beneficiaries with terminal illnesses, and their families.

Appendix A

Medicaid Payments and Estimated Changes in Payment with Elimination of the Medicaid Hospice Benefit (inclusive of Federal and State shares)		**Explanation**	**Data Source**
Total Medicaid hospice payments State Fiscal Year 2007	$ 254,268,359		Data provided by analysts at Florida's Agency for Health Care Administration in December of 2008 from a data request submitted by The Moran Company in October, 2008.
Medicaid payments for nursing home room and board for hospice patients.	$ 189,217,016		Florida's AHCA data request referenced above.
Medicaid payments for hospice services only	$ 65,051,342		Florida's AHCA data request referenced above.
Eliminate the Medicaid Hospice Benefit			
Maximum Savings to the Medicaid Program (State and Federal share)	**$ 65,051,342**		
Additional payments required for nursing home room and board for Medicaid only patients	$ (567,651)	FL Medicaid now pays 95% of room and board rates to the hospice which pays 100% to the facilities. Absent hospice, Medicaid would pay 100% of these rates for Medicaid-only patients.	Based on a geographically representative sample of FL hospices reporting Medicaid only nursing facility days for SFY 2007, 6% of Medicaid NF days are for Medicaid only patients.
Additional payments for hospitalizations related to terminal condition that would have been prevented by hospice services. Conservative Estimate	$ (55,047,816)	**Estimate:** Average Medicare payment per Florida hospitalization ending in death in 2007 = $16,442. There were 11,159 deaths of Medicaid hospice patients in this year. If Florida Medicaid pays hospitals at 75% of what Medicare pays, and 40% of Medicaid deaths for patients who would otherwise be in hospice occur in the hospital, the state would incur $55 million in additional costs	Medicare payments derived from 2007 final MedPAR file provided by CMS for all inpatient hospitalizations based on DRG payments. Medicaid deaths from Florida's AHCA data request referenced above. Studies that show hospitalization frequencies during the last months of life. Since FL Medicaid pays per diem rates for inpatient care that vary widely, it is difficult to identify an average cost/case.
Additional payments for nursing home room and board due to patient admissions to nursing homes that would have been prevented by hospice services. Conservative Estimate	$ (9,958,790)	**Estimate:** Assume a 5% increase in nursing home days	References above
Additional payments for emergency room visits that would have been prevented by hospice services. Conservative estimate	$ (976,413)	**Estimate:** Assume that 50% of the 11,159 Medicaid patients who died while in hospice experienced an ER visit that would have been prevented by hospice services. Emergency visit rates are not publicly available so we use an estimate of $175 per visit based on level II visit rates in some other states.	Medicaid hospice deaths from FL AHCA data referenced above. Average hospital outpatient Medicaid per diem from AHCA web site. These rates vary considerably and tend to be higher in the urban areas where Medicaid eligibles are more likely to access these services.
Additional payments for drugs that would have been covered within the hospice per diem rates.	$ (2,204,000)	**Estimate:** Based on medication scenarios provided by hospice clinicians of actual drug regimens for sample patients, medications were priced at 2008 Medicaid rates for a 30 day month. The cost per patient ranged between $50 and $700 per month. Assume a $250 cost per month as average and multiply by the 8816 Medicaid patient deaths (79%) reported for 2007 estimated as not in nursing homes based on provider survey information for the last month of life.	Prescription medications and dosage for selected patients provided by a Florida Hospice priced using AHCA published 2008 rates for each drug from AHCA website. Number of hospice deaths from FL AHCA data referenced above. The Moran Company surveyed FL hospice providers for State Fiscal Year 2008 and found that 21% of admissions for 32 reporting hospices were to nursing homes.

Appendix B

APPENDIX B: National Profile of Hospice Utilization for Medicaid Only and Medicaid/Medicare Dual Eligibles 2005-2007

	2005 Medicare Cost Reports					2006 Medicare Cost Reports					2007 Medicare Cost Reports*				
State	# of Hospices	# of Hospices with at least 1 total medicaid day	Total Days	Percent Medicaid Only Days of Total Hospice Days	Percent Medicaid Paid NF Days Dual MM Patients	# of Hospices	# of Hospices with at least 1 total medicaid day	Total Days	Percent Medicaid Only Days of Total Hospice Days	Percent Medicaid Paid NF Days Dual MM Patients	# of Hospices	# of Hospices with at least 1 total medicaid day	Total Days	Percent Medicaid Only Days of Total Hospice Days	Percent Medicaid Paid NF Days Dual MM Patients
AL	88	74	2,634,195	3.5%	2.1%	98	81	2,868,014	2.6%	2.1%	52	44	1,357,715	5.3%	3.4%
AR	30	27	567,543	4.1%	0.8%	31	29	563,195	4.0%	1.1%	21	18	371,181	4.5%	0.9%
AZ	37	17	1,763,943	0.7%	0.2%	43	12	2,027,910	0.4%	0.1%	23	6	1,212,420	0.2%	0.0%
CA	118	107	3,084,690	8.3%	7.1%	125	106	4,076,772	8.2%	3.4%	78	67	1,889,212	6.8%	1.9%
CO	26	23	622,622	4.5%	2.6%	29	24	690,707	4.4%	1.2%	26	22	630,441	4.2%	1.9%
CT	3		17,546	0.0%	0.0%	4		52,250	0.0%	0.0%	3		20,456	0.0%	0.0%
DC	1	1	19,186	8.7%	3.0%	2	1	21,300	7.1%	1.8%	1	1	25,249	11.6%	1.7%
DE	7	7	201,078	3.5%	1.6%	7	7	258,171	5.3%	2.7%	5	5	259,104	2.7%	0.8%
FL	34	32	4,853,599	5.6%	3.1%	37	37	6,912,250	5.6%	2.2%	25	25	4,197,129	4.6%	1.4%
GA	70	65	1,564,997	7.2%	3.2%	84	75	1,792,790	7.1%	4.1%	64	57	1,463,492	9.4%	4.9%
HI	7	6	105,113	3.4%	1.6%	7	7	112,943	4.4%	0.2%	7	7	131,164	3.6%	0.8%
IA	23	19	427,311	2.6%	6.5%	23	20	540,030	4.3%	8.6%	26	22	616,113	3.1%	2.2%
ID	13	10	177,249	1.2%	0.2%	18	13	240,314	2.0%	0.5%	11	7	162,305	3.1%	9.1%
IL	46	40	1,071,569	5.9%	3.1%	48	43	1,505,305	5.8%	1.8%	31	30	777,891	4.5%	2.2%
IN	35	30	903,762	3.9%	4.0%	36	33	888,394	3.2%	5.0%	20	19	504,201	10.5%	9.9%
KS	20	17	518,559	3.6%	0.9%	26	19	646,224	4.8%	1.8%	18	14	316,462	3.5%	0.8%
KY	17	17	701,855	8.1%	1.4%	17	17	740,833	7.8%	1.2%	13	13	669,233	8.0%	1.0%
LA	73	58	934,773	6.3%	2.6%	85	70	1,042,786	6.0%	2.8%	54	46	643,848	5.0%	2.7%
MA	24	17	641,145	4.5%	4.6%	28	18	910,894	2.3%	9.5%	30	24	1,027,064	6.7%	5.7%
MD	16	15	443,534	2.2%	0.7%	16	14	526,246	2.5%	1.0%	16	16	550,350	2.6%	1.0%
ME	4	4	57,969	4.2%	1.3%	4	3	78,867	3.9%	2.7%	5	3	78,271	3.0%	1.5%
MI	54	51	1,531,413	6.1%	1.3%	57	57	1,620,338	2.9%	1.3%	24	22	673,163	3.1%	0.9%
MN	13	11	240,846	3.4%	1.6%	13	10	190,313	3.5%	3.1%	8	6	141,179	8.6%	6.6%
MO	46	41	1,024,524	3.7%	3.6%	54	49	1,248,838	5.7%	4.5%	45	37	1,048,725	4.1%	2.3%
MS	70	56	1,548,246	4.5%	2.7%	86	70	1,666,937	5.3%	3.4%	45	37	669,525	8.3%	4.1%
MT	4	4	36,892	4.0%	0.1%	4	3	60,582	3.3%	1.5%	2	2	63,408	3.3%	1.1%
NC	41	39	1,359,241	4.6%	2.0%	41	40	1,662,631	4.7%	1.9%	37	36	1,391,813	4.1%	1.3%
ND	1	1	75,446	3.7%	1.5%	1	1	90,202	2.4%	0.7%	1	1	109,429	1.7%	0.7%
NE	7	5	89,183	4.6%	25.7%	6	5	113,261	4.2%	27.6%	5	4	145,080	30.9%	28.7%
NH	2		39,097	0.0%	0.0%	1		14,524	0.0%	0.0%	2		74,780	0.0%	0.0%
NJ	24	23	804,531	3.7%	1.8%	26	25	1,035,231	8.2%	5.2%	8	7	308,534	4.4%	2.7%
NM	18	13	456,372	5.4%	1.5%	17	15	614,322	7.5%	2.4%	10	7	424,042	4.6%	1.0%
NV	10	10	372,664	2.6%	1.1%	11	8	388,381	1.9%	1.0%	6	5	163,325	0.7%	0.4%
NY	33	33	1,295,946	4.6%	1.1%	33	33	1,429,217	6.0%	2.5%	6	6	385,802	7.8%	5.2%
OH	54	52	1,874,853	4.1%	2.3%	60	57	2,415,507	4.2%	2.5%	37	33	1,337,704	4.5%	2.6%
OK	113	18	1,950,770	0.7%	0.4%	112	16	2,034,648	0.7%	0.3%	70	15	1,240,501	0.6%	0.0%
OR	17	15	353,577	3.7%	0.7%	19	15	489,026	2.5%	0.4%	14	11	408,431	2.1%	0.5%
PA	62	46	1,529,739	1.9%	0.5%	66	52	1,960,090	3.1%	0.7%	59	46	1,771,596	1.9%	0.7%
PR	28		540,314	0.0%	0.0%	31	1	697,512	1.2%	0.0%	14		248,914	0.0%	0.0%
RI	3	3	79,750	3.1%	2.5%	3	3	107,692	3.2%	2.6%	3	3	140,747	2.2%	1.4%
SC	35	30	712,698	4.3%	0.9%	45	37	1,020,862	4.6%	0.8%	31	25	950,696	4.6%	0.9%
SD	1	1	5,862	1.5%	1.5%	1	1	17,772	28.8%	27.9%	2	2	20,353	10.7%	10.3%
TN	34	30	923,346	7.2%	3.0%	39	34	1,053,265	8.1%	5.1%	20	20	686,185	11.1%	4.8%
TX	168	127	3,782,542	4.4%	2.7%	199	151	4,944,079	6.4%	4.9%	114	86	2,585,825	5.9%	3.6%
UT	33	22	603,639	2.9%	1.7%	35	28	654,996	3.6%	1.7%	28	23	530,531	3.5%	1.4%
VA	24	20	461,624	3.9%	2.3%	30	27	589,999	3.7%	4.1%	20	19	406,629	6.0%	3.7%
VI	2		8,908	0.0%	0.0%	2		10,934	0.0%	0.0%					
WA	9	9	339,025	5.3%	0.4%	10	10	399,992	4.5%	0.7%	3	3	110,790	1.2%	0.1%
WI	17	16	489,524	2.2%	6.5%	19	18	573,851	1.5%	5.4%	9	9	254,754	13.7%	14.9%
WV	11	11	332,520	3.9%	0.0%	10	10	415,680	4.3%	0.0%	9	9	308,095	5.7%	0.0%
WY	5	3	23,437	3.0%	0.3%	5	3	19,164	1.9%	0.0%	3	3	11,935	4.6%	1.1%
Total Al	**1,631**	**1,276**	**44,198,767**	**4.5%**	**2.5%**	**1,804**	**1,408**	**54,036,041**	**4.8%**	**2.7%**	**1,164**	**923**	**33,515,792**	**5.0%**	**2.5%**

*File appears to be incomplete (missing some 2007 cost reports)

Florida has the most hospice days of any state 2005-2007
Florida has the 8th highest proportion of hospice days for Medicaid only patients in 2005
Florida has the 12th highest proportion of hospice days for Medicaid only patients in 2006
Florida has the 19th highest proportion of hospice days for Medicaid only patients in 2007
Florida has the 9th highest proportion of hospice NF days paid by Medicaid in 2005
Florida has the 23rd highest proportion of hospice NF days paid by Medicaid in 2006
Florida has the 24th highest proportion of hospice NF days paid by Medicaid in 2007
From 2005 to 2007, Florida's Proportion of Hospice Use by Medicaid Patients Decreases to Below National Averages