

# Medicaid and Hospice Care

National Hospice and Palliative Care Organization



## Issue Brief – October 2011

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### Introduction

In 2009, over 1.5 million people received services from a hospice provider. Of the approximately 2.5 million Americans who died in 2009, nearly 42% were under the care of hospice at the time of their deaths.<sup>1</sup> As the nation ages, and as more people experience the difference hospice care can make at the end of life, the numbers of hospice patients will continue to grow rapidly.

Hospice is a benefit offered by most insurance programs including Medicare and Medicaid. Many studies demonstrate the high value and quality of hospice care. Despite this evidence, some states have considered eliminating their Medicaid hospice benefit due to the severity of the current fiscal crisis.<sup>2</sup> The purpose of this paper is to examine the costs and benefits of offering hospice care in Medicaid programs.

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### Health Care Reform and Hospice

Hospice care is aligned with the goals of health care reform, which include:

- provides care management for patients across the care continuum;
  - increases overall patient and family satisfaction by offering individualized patient centered services through use of an interdisciplinary team;
  - manages all of the terminal care needs through a risk based per diem reimbursement;
  - decreases the costs of care at the end of life by minimizing use of the emergency room;
  - decreases the number of costly rehospitalizations common to this population; and
  - decreases the grief based health risks of survivor's following the death of a loved one.
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<sup>1</sup> National Hospice & Palliative Care Organization (NHPCO), *Facts & Figures: Hospice Care in America*, 2010 Edition

<sup>2</sup> Center on Budget and Policy Priorities: <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>

## Hospice Care Defined

Hospice is the recognized model for high quality and efficient care for people facing life-limiting illness. Hospice provides expert medical and nursing care as well as emotional and spiritual support tailored to each patient and family's unique needs. Hospice focuses on caring, not curing, and provides Americans with a choice of palliative care rather than continued burdensome and costly attempts at curative care for the treatment of their terminal illness.

The Medicare Hospice regulations define hospice care as:

**Hospice care** means a comprehensive set of services described in 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

[42 C.F.R. §418.3]

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## Hospice Care Delivery

Most hospice care is delivered in the patient's home, but care may be provided in any setting. Such other settings might include a hospice residence, hospital, or a nursing home. Hospice services are available to all patients with a diagnosis of a terminal illness and a life expectancy of 6 months or less. The hospice team, in collaboration with the patient and family, develops a care plan that meets each patient's individual needs. The hospice interdisciplinary team usually consists of the patient's personal physician, hospice physician, nurse, hospice aide, social worker, bereavement counselor, chaplain, volunteers, and other disciplines as defined in the patient/family care plan.

Members of the hospice interdisciplinary team make regular visits to assess patients and their families, communicate with the primary care physician and provide additional care or other services as needed. Hospice is on-call 24 hours a day, seven days a week to respond to the emerging and urgent issues of patients and their families.

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## Hospice Care Reimbursement

The Medicare Hospice Benefit was established by the Congress in 1982, after proving its value in a national demonstration project. In 1986, hospice was added as an optional benefit under Medicaid. In 2009, Medicare reimbursed 83.9 % of all hospice services. By contrast, Medicaid

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reimbursed about 4.9% of hospice care while private insurance covered about 8.6%<sup>2</sup> For individuals eligible for both Medicare and Medicaid (dual eligibles), Medicare pays for their hospice care while Medicaid pays for their room and board in a nursing facility if the individual otherwise qualifies for Medicaid-covered nursing home care.

Hospice care is reimbursed through an all-inclusive, per diem rate. The rate includes payment for the following items, when they are related to the terminal illness:

- Care by an interdisciplinary team composed of physicians, nurses, social workers, hospice aides, clergy, volunteers, and other therapists as needed
- Medications
- Supplies
- Durable Medical Equipment, such as oxygen, wheel chairs and beds
- Additional treatments that are required for comfort care

Electing the Medicaid Hospice Benefit does not eliminate Medicaid coverage for issues not related to the terminal illness.

The guiding principle in structuring the reimbursement system for the Medicare Hospice Benefit was to have an all-inclusive rate that promoted high quality and cost effective health care. In this managed care model, Medicaid hospice services are reimbursed at essentially the same rate as Medicare hospice services. Reimbursement rates are determined prospectively and are independent of the actual cost of care for the individual patient. Hospice providers are responsible for providing all care necessary for the palliation of the terminal illness.

Under both Medicare and Medicaid, hospice services are reimbursed at the following four different levels or types of care, based on the needs of the patient and/or their family:

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

The vast majority of hospice care is delivered in the patient's place of residence at the lowest reimbursement rate, the routine home care level of care. There are times, however, when the burden on caregivers is so great that alternative short term living arrangements need to be made to care for the patient. Thus, the inpatient respite level of care was established to provide families a break from the on-going stress of caring for a terminally ill patient. Respite care diminishes caregiver burnout, making it more likely that patients will be able to remain in their own homes.

Likewise, Medicare and Medicaid recognize that at times, symptoms at the end of life become severe and can no longer be controlled in the home setting. The patient requires the intensive

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<sup>2</sup> NHPCO. *NHPCO FY2009 National Summary of Hospice Care*, October 2010.

services found only in an inpatient setting. The general inpatient level of care requires the hospice to contract with a hospital or skilled nursing facility with additional staffing requirements or to provide inpatient services in a hospice-specific inpatient unit or facility. Continuous care is available for those individuals who require at least 8 hours of care during a 24 hour period, with skilled nursing care as the majority of the care provided. Both inpatient care and continuous care are provided for a limited time to patients experiencing an acute symptom management crisis which cannot be managed with routine home care services.

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## Medicaid Hospice Benefit

States offer the hospice benefit as an optional benefit through their Medicaid programs. The structure of the hospice benefit offered by state Medicaid programs and the Medicaid hospice reimbursement rates are, by statute, modeled after the federal Medicare hospice benefit. Medicaid is often the second largest expense in most states' budgets (after education). In the current fiscal environment, states are under pressure to reduce spending levels further, and are scrutinizing the benefits available to Medicaid recipients. In recent years several states have proposed, or are currently considering, cuts in their optional Medicaid benefits, including hospice benefits.

Details regarding Medicaid hospice services in specific states can be found in the Appendix A.

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## State Medicaid Hospice Budgets are Deceiving

Because the vast majority of Medicaid hospice patients are elderly, and therefore are also Medicare eligible ("dual eligibles"), Medicaid budgets can be misleading regarding the cost of hospice care. Typically, when a dual eligible individual resides in a nursing home, the nursing home would bill the state Medicaid program for nursing home residential care. However, when such residents are admitted to a hospice program, federal law requires that the nursing home "room and board" payments instead be remitted by Medicaid directly to the hospice, which in turn pays the nursing home for providing room and board, as well as, in some circumstances, additional services, under an agreement. The Medicare program pays the hospice for hospice care to the patient.

Under federal law, these nursing home room and board payments to the hospice must be at least 95% of what the Medicaid program would have paid directly to the nursing facility if hospice had not been involved.<sup>3</sup> Therefore, the vast majority of Medicaid funds paid to

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<sup>3</sup> Centers for Medicare & Medicare Services. *State Operations Manual Section 4308.2*.

hospices are actually for the nursing home room and board care that the state otherwise would have been paying directly to the nursing home. Considering these Medicaid payment rates to hospices are only 95% of the usual nursing home rate, the state is actually saving 5% of the normal room and board costs for these hospice patients.

When states are assessing the cost for the Medicaid Hospice Benefit, they should be cautious to not include the room and board component as a cost of care that will be reduced with the elimination of the Hospice Benefit. The state Medicaid agency is still required to pay for Medicaid room and board for dually eligible nursing home residents, regardless of whether there is a hospice benefit under Medicaid in the state.

Furthermore, if the Medicaid Hospice Benefit were eliminated, the need for care would not be diminished. In fact, Medicaid families and caregivers have fewer resources with which to navigate the health care system and advocate for the terminally ill family member. Consequently, these Medicaid patients will revert to the classic and expensive practice of high emergency room utilization with frequent rehospitalizations.

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## Value Based End-of-Life Services – How Medicaid Dollars Can Be Saved

Most of what we know is derived from studies of Medicare populations where about 30% of all spending is incurred in the last year of life.<sup>4</sup> In 2008, Medicare paid \$50 billion just for doctor and hospital bills during the last two months of patients' lives. As much as 20 to 30 percent of these medical expenditures may have no impact on improving the quality, or length of a patient's life.<sup>5</sup> It is likely that the costs incurred and negative outcomes experienced by the Medicaid decedent population are even higher. The relative lack of access to coordinated and subspecialty care, often experienced by Medicaid patients, has historically lead to higher rates of hospital and intensive care unit use at the end of life.

Elimination of the Medicaid hospice benefit would lead to greater use of acute care services (i.e. hospital admissions, emergency room visits, nursing home admissions, medications, etc.) at the end of life. Medicaid patients who once relied on hospice will seek care in an emergency department or hospital setting.

Many studies of hospice care have demonstrated substantial cost savings across multiple care settings. For example:

- A March 2011 study, published in Health Affairs, finds that using well-established palliative care teams to coordinate the care of seriously ill Medicaid patients can save money.

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<sup>5</sup> Ira Byock'. *The Cost of Dying*, 60 Minutes, Nov. 22, 2009.

Inpatient costs were reduced on average \$6,900 per patient admission. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals compared to patients without a palliative care team.<sup>6</sup>

- A 2009 study found that patients with cancer who disenrolled from hospice were 38% more likely to be hospitalized, 30% more likely to be admitted to the emergency department or intensive care unit, and 9.4% more likely to die in the hospital. Patients who disenrolled from hospice incurred higher, (\$124 per-day) Medicare expenditures than patients who remained with hospice until death. Hospice disenrollment is a marker for higher health care use and expenditures for care.<sup>7</sup>
- A 2009 Health Affairs article, “Opportunities to Improve the Quality of Care for Advanced Illness” details an Aetna pilot program offering concurrent hospice and curative treatments. The study demonstrated that the increase in hospice election was associated with a decrease in the use of acute care, intensive care, and emergency services. In Aetna’s commercially insured populations, hospice eligibility was increased to twelve months. The increase in hospice election and decrease in acute care services was estimated to represent a net medical cost decrease of 22 percent.<sup>8</sup>
- Researchers at Duke University in 2007 found that hospice reduced Medicare costs by an average of \$2,309 per hospice patient. Additionally, the study found that Medicare costs would be reduced for seven out of 10 hospice recipients if hospice was used for a longer period of time.<sup>9</sup>
- A study commissioned by the National Hospice and Palliative Care Organization (NHPCO) and conducted by Milliman USA Inc. demonstrated that hospice saved approximately \$7,000 per Medicaid beneficiary enrolled. Hospice realized Medicaid cost savings through three broad mechanisms:
  - Avoiding unnecessary and undesirable hospitalization.
  - Providing medications, durable medical equipment and home care visits as part of a per diem cost.
  - extending high quality end of life care to nursing home residents<sup>10</sup>

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<sup>6</sup> *Health Affairs, March 2011 vol. 30 no. 3 454-463*

<sup>7</sup> Melissa D.A. Carlson, Jeph Herrin, Qingling Du, Andrew J. Epstein, Colleen L. Barry, R. Sean Morrison, Anthony L. Back and Elizabeth H. Bradley, Impact of hospice disenrollment on health care use and Medicare expenditures for patients with cancer. *J Clin Oncol.* 2010 Oct 1 ;28(28):4371-5. Epub 2010 Aug 30

<sup>8</sup> Randall Krakauer, Claire M. Spettell, Lonny Reisman, and Marcia J. Wade. *Opportunities To Improve The Quality Of Care For Advanced Illness*. Perspective: Quality, Health Affairs, Vol. 28, Number 5, pages 1357 – 1359.

<sup>9</sup> Donald H. Taylor, Jr, Jan Ostermann, Courtney H. Van Houtven, James A. Tulsky, Karen Steinhauser. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine* 65 (2007) 1466-1478.

<sup>10</sup> Milliman USA, Inc., Value of Hospice Benefit to Medicaid Programs, May 2, 2003.

## Impact on Patients if the Benefit is Eliminated

Hospice provides care to frail and vulnerable beneficiaries at the end of life, when care is very costly. However, the fiscal impact should not be the only indicator that is considered when a state considers eliminating a benefit for the poorest terminally ill citizens.

Medicaid patients are more likely than privately insured or Medicare patients to have experienced fragmented care and to have their illness diagnosed later when symptoms are evident and treatment options are more limited.<sup>11</sup> These families and caregivers have fewer resources with which to navigate the health care system and advocate for the terminally ill family member.

- Some patients may find themselves receiving aggressive care that is not desired.
- Some patients will die in hospitals and nursing homes rather than at home with their families as they wished.
- The removal of the Medicaid Hospice Benefit will remove the family's and caregiver's support that may be keeping families together, supporting employment, education, and coping strategies that keep people productive and healthy.
- The elimination of the Medicaid Hospice Benefit would result in increased pain and suffering for terminally ill patients and their families.

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## Fiscal Impact on the State if the Benefit is Eliminated

- There will always be patients with advanced illness in Medicaid. The question then becomes – where will these patients be care for – in a hospital emergency department or at home with hospice?
- The needs of terminally ill recipients would increase utilization of emergency rooms, hospital outpatient clinics, and inpatient care covered under indigent care programs, and would increase the costs of those services.
- The lack of a Medicaid hospice benefit would increase the risks for use of other social services paid for with state funds and for unemployment.

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<sup>11</sup> Kaiser Commission on Medicaid and the Uninsured, KCMU analysis of MEPS 3-year pooled data, 2004-2006

## Medicaid Managed Care

State Medicaid agencies have increasingly turned to Medicaid managed care programs to control costs and benefits for a wide array of Medicaid recipients. The Kaiser Family Foundation has produced a 50-state profile of Medicaid managed care programs – as of 2010. The full report, entitled ***A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*** can be found at:

<http://www.kff.org/medicaid/8220.cfm>

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## Conclusion

Hospice is the solution to providing high quality and efficient care to our most vulnerable citizens. The Medicaid hospice benefit supports comprehensive care for an impoverished and desperately ill population. Multiple studies suggest that elimination of the Medicaid benefit will also result in increased use of state resources, either in Medicaid or in other state programs. Elimination of the benefit will increase the suffering of dying Medicaid beneficiaries, their families and the communities that serve them.

Hospice care does not increase the cost of care. In the studies we have cited above, hospice has been shown to reduce expenses for care at the end of life and patients are able to age and die in place. With Hospice there are fewer ambulance, emergency room, intensive care and futile medical expenditures.

As one hospice leader stated: “They [the state policymakers] realized keeping [the Medicaid hospice benefit] was a way to prevent other services — emergency room, intensive care unit, long-term hospital stays — from going sky-high. There will always be patients in Medicaid who are very seriously ill that need hospice and end-of-life care. Just because we eliminate hospice doesn’t mean they are no longer Medicaid patients. They’re going to get their care some place or another.”

Hospice is not only an important part of the State’s budget solution, it is also the most effective and compassionate approach for our most disenfranchised population experiencing their last days of life.



# **APPENDICES**

## **State Specific Information**

## APPENDIX A: Data from States

### ARIZONA

In 2009, the state of Arizona eliminated their hospice benefit under a Medicaid managed care program. However, the Arizona Health Care Cost Containment System (AHCCCS) asked that nurses and actuaries model what the costs would be if the same end of life services were provided in other non-hospice settings, as the same services “bundled” in the hospice benefit. Their result was a 4.4% savings if the services were bundled under hospice. As a result of this analysis, Arizona allows hospices to provide care under the Medicaid managed care program on a case-by-case basis.

In the Arizona Acute Care Actuarial Memorandum for CY2011, signed by the actuarial staff of the AHCCCS on September 15, 2010, they stated:

#### **Hospice and In-Lieu of Services**

Hospice coverage for members aged 21 and older was eliminated. However, almost all of the services previously provided as part of the hospice benefit individually remain covered services. Many of these services previously delivered in both inpatient hospice and home settings at the hospice per diem rates will now be delivered in more expensive inpatient settings including acute care hospitals and nursing facilities, as well as in-home settings on a fee basis for each service provided. Using AHCCCS' fee-for-service rates for these settings/services results in an estimated increase in costs of approximately 4.4% to provide the same services. Federal law permits AHCCCS' Contractors to provide services in alternative settings in-lieu of services in more costly inpatient acute care hospitals and nursing facilities, and paying a bundled per diem rate in-lieu of individual fee-for-service rates for in-home care. Allowing use of alternative settings in this instance will result in total cost savings of approximately \$160,000.<sup>12</sup>

The document is retrievable at:

[http://www.azahcccs.gov/commercial/Downloads/CapitationRates/AcuteCare/AcuteCYE11ActuarialCertification09\\_15\\_10TMACHange.pdf](http://www.azahcccs.gov/commercial/Downloads/CapitationRates/AcuteCare/AcuteCYE11ActuarialCertification09_15_10TMACHange.pdf)

### FLORIDA

A study done in Florida by The Moran Company concluded that the highest percentage of Medicaid hospice payments represented payments for nursing home room and board for hospice residents. The chart below illustrates that 74.4% of the Medicaid payments were for dual eligible nursing home residents, where the Medicare Hospice Benefit paid for hospice care

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[http://www.azahcccs.gov/commercial/Downloads/CapitationRates/AcuteCare/AcuteCYE11ActuarialCertification09\\_15\\_10TMACHange.pdf](http://www.azahcccs.gov/commercial/Downloads/CapitationRates/AcuteCare/AcuteCYE11ActuarialCertification09_15_10TMACHange.pdf)

and Medicaid paid for the nursing room and board. Only 25.6% of the Medicaid hospice payments were for Medicaid hospice services only.

Medicaid Payments for Hospice FY2007 Florida	Amount	Percentage <sup>13</sup>
<b>Total Medicaid hospice payments State Fiscal Year 2007</b>	\$ 254,268,359	100.0%
<b>Medicaid payments for nursing home room and board for hospice patients.</b>	\$ 189,217,016	74.4%
<b>Medicaid payments for hospice services Only</b>	\$ 65,051,342	25.6%

The document is retrievable in the Regulatory and Compliance Center at [www.nhpco.org/regulatory](http://www.nhpco.org/regulatory)

## OHIO

In 2009, the Moran Company conducted a study of the potential consequences of eliminating the Medicaid hospice benefit in Ohio. The study determined that 90% of the state Medicaid budget for “hospice” services actually reimburses nursing home room and board costs for dual eligible Medicare hospice residents. Again, the state would incur these costs with or without a Medicaid hospice benefit. The report states:

*“Many states have implemented Medicaid Managed Care programs, where hospice is included in the benefits package, because it makes the resource use by terminally ill Medicaid patients more manageable, and without hospice coverage would suggest a net increase in costs of care due to increases in hospitalization, ER use, nursing home use, physician, DME and home health costs) in the absence of hospice.”<sup>14</sup>*

<sup>13</sup> The Moran Company, Survey of Florida Hospices, November 2008.

<sup>14</sup> The Moran Company, *Will Elimination of the Optional Medicaid Hospice Benefit Save the State of Ohio Money?* June 2010.

The Ohio Department of Job and Family Services (ODJFS) provided the number of Medicaid hospice fee-for-service patients in Ohio for FY2008, broken down below:

Type of Beneficiary Ohio	Number of beneficiaries receiving hospice services in SFY 2008	Percentage <sup>15</sup>
Dual eligible (Medicare & Medicaid) beneficiaries	10,751	79.4%
Medicaid only beneficiaries	2,777	20.6%

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<sup>15</sup> The Moran Company, Will Elimination of the Optional Medicaid Hospice Benefit Save the State of Ohio Money?, June 2010

**APPENDIX B**

**TALKING POINTS FOR STATE POLICYMAKERS**

## **The Medicaid Hospice Benefit: Compassionate and Efficient Care to Meet the Needs of Terminally Ill Medicaid Patients**

### **Bullets for State Adaptation**

- When faced with a terminal illness, most Americans want to remain in their homes with family whenever possible, receiving excellent symptom management and support.
- The Medicaid Hospice Benefit is a proven system of care that families rank nationally at a 90.2% level of satisfaction.
- Hospice provides excellent pain and symptom management, individualized care planning, personal care, respite care, advance care planning, grief management, spiritual and bereavement support, in the home, hospital, nursing home or other inpatient setting.
- The hospice benefit is a comprehensive benefit covering **all** costs related to the patient's terminal illness. All home visits by the interdisciplinary team, medications, supplies, durable medical equipment, transportation and inpatient care are provided to meet the terminal needs of the patient.
- Eliminating the Medicaid hospice benefit will not save the State money, and will result in increased spending for mandatory services. Numerous studies have documented the cost savings of hospice benefit. Aetna has demonstrated a 22% cost savings for their commercial plans when hospice is offered as a covered service.
- Without hospice, the need for care for the dying will not decline. Medicaid patients will access the emergency department and hospital setting for their care, at increased cost to the state. Studies of the Medicaid hospice benefit in Florida and Ohio have demonstrated substantial cost savings to the Medicaid program when hospice is involved. An actuarial study completed by the Arizona Health Care Cost Containment System in September, 2010 showed that there would be an increased cost of 4.4% in Medicaid expenditures when hospice is not involved. In addition, the loss of the coordination, care management, and supportive services offered by hospice would increase fragmentation of care for a most vulnerable population.

- The Medicaid Hospice Benefit supports families and caregivers and enables them to cope with the stresses of caring for a terminally ill patient more effectively.
- *Direct* benefits of hospice:
  - Reduces the need for hospitalization at the end of life
  - Reduces the need for nursing home admissions
  - Reduces the complications of grief normally experienced by the patient’s family and caregivers
  - Reduces nursing home room and board costs for the state
- Hospice provides the kind of expert, compassionate and cost effective medical care that most Americans desire at the end of life.

## **APPENDIX C**

# **SAMPLE ONE-PAGER TALKING POINTS FROM SEVERAL STATES**



# HOSPICE Saves Ohio Money

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**Hospice in the budget.** In these challenging financial times, state leadership is forced into the position of making critical decisions which involve the elimination of Medicaid services. The Medicaid Hospice Benefit is an optional service for states. If a state elects to offer the benefit, rates are federally mandated. The choice involves either providing or eliminating the benefit.

**Medicaid recipients in nursing homes.** The majority of residents in nursing homes are “dually eligible”. Hospice services are billed to Medicare and the nursing home care is billed to Medicaid. There is a federal mandate that for the dually eligible resident, the nursing home payment must be paid to the hospice at 95% of the routine rate. Hospice in turn, pays the nursing home. This represents a savings to Medicaid of 5% for each day the resident is receiving hospice care. The savings to the State increases as more residents of nursing homes elect hospice. In examining the budget line item for hospice, it includes payment for hospice services and “room & board”. This number may mislead legislators in thinking that the entire amount will be saved if hospice is eliminated. In actuality, the payment for “room & board” will remain.

**Medicaid recipients in the community.** Terminal illness has no respect for age and affects all ages, even the very young. Hospice brings together the needed care for pain relief, management of symptoms, and comfort. The provision of these services by the interdisciplinary team in the home reduces costly intensive care at the end of life. These individuals are in the health care system and will access the Medicaid system at all levels including the emergency room, hospital, and intensive care units resulting in higher costs than hospice.

**Hospice saves money.** A research study, published in the Journal of Clinical Oncology, examined the impact of disenrolling hospice patients. Researchers at the Mount Sinai School of Medicine found that:

- 34% of patients who disenrolled were admitted to an ER in comparison with only 3% of hospice patients.
- 40% of disenrolled patients were admitted to the hospital in contrast to 1.6% of hospice patients.
- 10% of disenrolled patients died in the hospital compared to 0.2% of hospice patients.
- Cost of care for patients with cancer who disenrolled was nearly five times higher than for patients who remained in hospice.

**The elimination of the Medicaid Hospice Benefit would not save Ohio money because Medicaid individuals would seek higher cost services.**

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## **TennCare Bureau's Proposal to Eliminate the Hospice Benefit from the TennCare Program DRAFT**

### **Background**

The TennCare Bureau has proposed eliminating the hospice benefit for FY 2010-2011. According to the Bureau, the total amount spent on hospice care in Tennessee (in the most recent FY? 12 months?) was nearly \$70M<sup>16</sup>. The Bureau discounted the potential savings from this amount by 25% to allow for costs that would be incurred in other areas (hospital, EMS, etc) if the hospice benefit was removed. This puts the Bureau's estimated savings at \$52.4M (**\$18M state only**).

Under federal law, for hospice patients residing in nursing homes, hospice agencies are paid by the state for the nursing home room and board costs. The hospice then passes this payment directly to the nursing home ("pass through").

### **Why the state will NOT save money by eliminating the hospice benefit:**

- A preliminary estimate by the Tennessee Hospice Organization (THO) shows that the nursing home pass-through represents 78%<sup>17</sup> of total TennCare payments to hospice providers.
- If the TennCare hospice benefit is eliminated, the state will continue to incur these nursing home costs. Therefore, the cost savings projected by the elimination of the hospice benefit is grossly overestimated because of the nursing home payments associated with the majority of TennCare hospice patients.
- The Bureau's thinking is correct in one aspect: eliminating the benefit will dramatically increase costs in other settings<sup>18</sup>. Instead of being managed at home by a professional end-of-life care team, these distressed patients will be forced to other settings, including hospital ERs where they will receive aggressive, expensive, and often futile treatments.
- Hospice saves state Medicaid dollars in caring for the terminally-ill by including medications, durable medical equipment, and diverse health care costs in the hospice per diem rate.

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<sup>16</sup> According to the most recent Hospice Joint Annual Report (2007-2008), total hospice expenditures totaled \$50M.

<sup>17</sup> A recent Moran Company study estimated this number to be 75% in Florida

<sup>18</sup> A 2003 Milliman study found that Medicaid Agencies can predict a cost savings of \$7,000 per beneficiary that enrolls in hospice due to decreased hospitalization, reductions in pharmacy costs, and savings from room and board costs to nursing homes

## Hospice is Part of the State Budget Deficit Solution

State and Federal budget deficits are at an all time high. Everyone is struggling to identify cuts in order to balance the budgets. Healthcare spending continues to escalate and will continue to do so as the baby boomer generation begins to enter their elder years. Providing healthcare in the most cost effective manner is essential now more than ever.

Hospice plays an important part in managing the high costs of care at the end-of-life. Traditionally, the last 12 months of a person's life are the most costly. The Medicare Hospice Benefit was developed as a team-based, case managed approach to care at the end of life. Hospices are paid a per diem rate and focus on developing an individualized care plan that keeps the majority of care at home, where patients prefer to receive care. States can add hospice as an optional benefit in the services available in the state under Medicaid. Payment rates, services and the scope of care are set by the Federal government. States cannot change the scope of care or payment for hospice from the Federal scope and rates when hospice is offered as an optional benefit.

Many studies demonstrate the high value and quality of hospice care. Despite this evidence, some states have considered eliminating their Medicaid hospice benefit due to the severity of the current fiscal crisis. Research on the Hospice Benefit has demonstrated that it saves substantially over traditional care at the end of life. Savings range from \$2300 - \$10, 800 per beneficiary. Aetna insurance company has expanded hospice coverage under their private insurance coverage to those still seeking curative care and have found it to provide a savings of 22 percent over traditional end of life care.

As States struggle to balance their budgets, they need to understand how the cost of care for the terminally ill will increase if they remove their Medicaid Hospice Benefit. Those states that have seriously looked at this option have reversed their decision when they were able to identify how their expenditures would increase with the removal of the Medicaid Hospice Benefit. Dying is not a preventable outcome. If hospice is not available, more costly emergency room visits and multiple hospitalizations will be the only option.

Maintaining hospice as an optional Medicaid benefit makes fiscal sense for any State. The hospice industry is currently working with CMS, MedPAC and other researchers to identify payment reform options that will provide for further cost savings with hospice care. This is coupled with aggressive work on identifying quality indicators for the assurance of excellent end of life care. These new payment methodologies will be set for both the Medicare and Medicaid Hospice Benefit programs. States should maintain the current Medicaid Hospice Benefit as the best option for end of life care.