



TESTIMONY BEFORE THE HUMAN SERVICES COMMITTEE
REGARDING S.B. 558
AN ACT CONCERNING THE AVAILABILITY OF HOSPICE SERVICES
UNDER THE MEDICAID PROGRAM

March 4, 2008

Senator Harris, Representative Villano, and members of the Human Services Committee, my name is Anne Rich, RN M.Ed. CHCE, and I am the Executive Director Visiting Nurse & Hospice Care of Southwestern CT. I am presenting testimony on behalf of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 80,000 elderly, disabled and terminally ill Connecticut citizens.

The Association **strongly supports** the SB 558, which would amend the Medicaid state plan to include hospice services as a benefit for Connecticut Medicaid patients. Addition of the hospice benefit to CT's Medicaid program, as 47 other states have done, will fill gaps in coverage¹ in our otherwise excellent, but underutilized, hospice delivery system.² The benefit will allow hospices to provide the full array of end of life services to Medicaid patients and their families.

It is important to note that, unlike other Medicaid optional benefits, states are required to follow most of the Medicare rules regarding structure of the benefit, including requirements for client eligibility, payment rates, levels of care and service package. A physician must certify that the patient has a prognosis of six months or less if the illness runs its normal course. Election of the hospice benefit by patients is voluntary. Services include: medical director, nursing, social worker, bereavement counselors, chaplain, volunteers, therapists, home health aide, dietician and pharmacist as needed, medical equipment, supplies and medications related to the patient's terminal illness.

¹ For example, the Medicaid hospice benefit provides payments to cover social work, up to one year of bereavement for families (mandated for all patients by the public health code, but not paid for by Medicaid), as well as coverage for terminally ill residents of nursing homes who are under age 65 and on Medicaid.

² Only 28% of CT *Medicare* decedents utilize hospice (national 40%), and use it for a shorter period of time.

Aligning the rules for the Medicaid hospice benefit with Medicare also helps to streamline the administration (for both the Department of Social Services and providers) and will help to ensure that the Medicaid rules will be in sync with the Public Health Code.

We recognize that the components of a hospice benefit are very complex and would take much more time than we have today to fully explain the details. Therefore, we are offering to interested legislative members and staff the opportunity for a briefing. We have also attached, for your information, a report by the Office of Legislative Research, which provides an excellent overview for CT.

CAHCH has included the Medicaid Hospice Benefit as part of our legislative agenda for the past few years, and we are pleased to know that this proposal enjoys broad support within the General Assembly. We look forward to working with all stakeholders to develop a comprehensive benefit that meets our citizen's needs for appropriate hospice services to be provided in all settings.

Thank you for hearing our testimony. I would be pleased to answer any questions you may have.

Topic:

HOSPICES; MEDICAID; MEDICARE;

Location:

MEDICAL CARE; WELFARE - MEDICAL ASSISTANCE (MEDICAID);



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MEDICAID COVERAGE OF HOSPICE

By: Robin K. Cohen, Principal Analyst

You asked (1) if Connecticut's Medicaid program covers hospice services and if not, why and (2) how many other states cover these services.

SUMMARY

States that run Medicaid programs have the option of offering hospice services to program enrollees. According to David Parrella of the Department of Social Services (DSS), the state's Medicaid program provides some coverage for hospice services, but in a way that is more limited than the coverage most other states offer ("bundled services"). According to a 2006 Kaiser Family Foundation report, Connecticut, New Hampshire, and Oklahoma were the only states not offering the more extensive coverage.

Medicaid state plan coverage for hospice is based on the Medicare benefit, which is available to people who are enrolled in Medicare Part A (hospital benefits). The eligibility criteria are essentially the same, as is the reimbursement. But because the state has not elected the option, its services and reimbursement are not linked to Medicare. According to Brian Ellsworth, president and chief executive officer of the Connecticut Association of Home Care (CAHC), the main differences between what the state actually offers and the bundled benefit that most other states do is that Connecticut does not pay for (1) terminally ill residents of nursing homes who are under age 65 (hence probably not eligible for Medicare, which pays for these services) and (2) for social workers (i. e. , counseling). Attorney Terry Berthelot of the Connecticut-based Center for

Medicare Advocacy asserts that there is a considerable gulf between what the state's home health care agencies can provide under Medicaid and what the bundled benefit offers.

We assume that cost has been a factor in the state's decision not to cover the bundled benefit, but DSS' Parrella asserts that it has been more of a "systems" issue. He adds that his agency will likely analyze the effect of adding the benefit in the next several months. This analysis will have to include the effect this would have on people dually eligible for Medicaid and Medicare (most older hospice patients are).

COVERAGE FOR HOSPICE CARE

Medicare

Eligibility. Since 1982, Medicare has covered hospice care for terminally ill individuals eligible for Medicare Part A (hospital coverage). Hospice uses an interdisciplinary team approach to providing services that involves numerous caregivers (e. g. , nurses, social workers, dieticians). Together with the patient and his or her family, this team develops a care plan. To qualify for the benefit:

1. a physician must certify that the beneficiary is terminally ill (the patient has six or fewer months to live if the illness takes its normal course);
2. the beneficiary or his representative must elect the hospice benefit; and
3. the attending physician and the hospice physician must jointly certify the initial 90-day service period (beneficiaries are eligible for two 90-day coverage periods, with subsequent unlimited 60-day periods).

Covered Services. When a Medicare beneficiary elects the hospice benefit, he or she waives his or her right to regular Medicare benefits for services related to the terminal illness during the hospice election period (with the exception of physician services). The beneficiary may revoke the hospice benefit and resume regular Medicare coverage and may subsequently re-elect the hospice benefit.

The covered services, which the interdisciplinary team reviews on a regular basis, include:

1. physicians;
2. nursing care;

3. physical and occupational therapy and speech-language pathology;
4. medical social services;
5. home health aides;
6. homemakers;
7. medical supplies, including drugs and biologicals and medical appliances;
8. counseling, including dietary and bereavement; and
9. short-term inpatient care for respite care, pain control, and symptom management.

Reimbursement. When Congress passed the Medicare hospice benefit, one guiding principle for the reimbursement structure was that an all-inclusive rate (“bundling”) should be used that engaged the entity providing the hospice care (the provider) in the professional management and sharing of financial responsibility for care provided.

The payment system is independent of actual costs and is based on a daily rate for each day a program beneficiary is enrolled in the hospice benefit. The payment is made regardless of the amount of services provided, even for days for which no services are provided. The payment is intended to cover costs hospices incur in furnishing services identified in the care plans. (The original rate structure took into account the patient mix and various acuity levels and lengths of stay, but experts say that current rates are less reflective of these differences.) Rates are adjusted for regional wage differences.

Actual payments are made according to a fee schedule for each of four care level categories: routine home care, continuous home care, general inpatient care, and inpatient respite care. Two caps apply to hospice benefits: the number of inpatient care days a hospice can furnish cannot exceed 20% of total patient care days and an aggregate payment amount that is based on the number of Medicare patients electing the benefit within the cap period.

Routine home care (93% of hospice care is provided at this level according to the Center for Medicare Advocacy (CMA)) is the level of care provided to a patient who is not in crisis. It includes scheduled visits by nurses, aides, and social workers, as well as payment for palliative medications related to the terminal illness. It also includes coverage of durable medical equipment such as hospital beds and wheelchairs.

Beneficiaries can be charged a 5% coinsurance for the drugs, with a \$ 5 cap per prescription.

Continuous home care is available in the event of a medical crisis. The hospice team can provide up to around-the-clock care. During these periods, the hospice provider bills Medicare per hour instead of the daily rate.

When a patient requires short-term inpatient services (nursing home or hospital care when his condition cannot be handled at home), Medicare pays for this care.

Finally, Medicare will pay for inpatient respite care. It essentially gives the caregiver a rest and is available for up to five consecutive days. Hospices can charge beneficiaries 5% of the respite per diem payment.

Table 1 shows the daily Medicare hospice rates for FFY 08.

Table 1: Medicare Payments for Hospice Care, FFY 08

Care Levels	Daily Rate
Routine home care	\$ 135. 11
Continuous Care (24 hours/day)	788. 55/ \$ 32. 86 per hour
Inpatient Respite	139. 76
General Inpatient	601. 02

Source: U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2007)

Medicaid

In 1985, Medicaid coverage for hospice care became an optional benefit. (Medicaid mandates coverage for certain services, for example, inpatient hospitalization, but gives states the option to cover others). To qualify for the benefit, a Medicaid beneficiary must be (1) under age 65, (2) impoverished, and (3) diagnosed with a terminal condition from which death is expected in six months or less.

If a state elects to offer Medicaid coverage as a bundled, state plan benefit, it must follow many of the Medicare requirements. At a minimum, the state must offer at least 210 days of coverage. As with Medicare, the person electing Medicaid state plan hospice care must waive his or her right to regular Medicaid coverage for services related to the terminal illness. The services are essentially the same as those

provided by Medicare, including care by an interdisciplinary team composed of physicians, nurses, home health aides, social workers, clergy, volunteers, and therapists and medications and supplies related to the terminal illness.

States must use the same reimbursement methodology that Medicare uses for the four levels of hospice care. As with Medicare, these rates are adjusted to reflect geographical differences in wages. The reimbursement cannot be lower than Medicare and is adjusted to recognize Medicare coinsurance amounts. (For FFY 08, the rates are virtually identical.) Likewise, Medicare's caps on payments apply to Medicaid payments.

If a Medicaid hospice beneficiary resides in a nursing home, states pay the hospice provider an additional reimbursement to cover room and board. The hospice provider is expected to use this to reimburse the nursing home.

(U. S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *State Medicaid Manual, Section 4305*)

Connecticut Hospice Coverage

According to CAHC's Ellsworth, Connecticut's Medicaid coverage of hospice services is available in large part because of the way hospice agencies are licensed. State law requires hospice agencies to be licensed as home health care agencies. These agencies are eligible for Medicaid reimbursement for home health services they provide, including skilled nursing and home health aide visits. These services are subject to prior authorization requirements (e. g., more than two skilled nursing visits per week). But Medicaid will not pay for social workers, despite the fact that the home health care agencies may employ them. So, for example, the bereavement counseling that many believe is a critical component of hospice care is not covered.

But none of these services are available to someone under age 65 residing in a nursing home. Federal law generally prohibits the provision of home health care services anywhere except the Medicaid recipient's home. The regulations explicitly prohibit these services from being provided in a hospital or nursing home (42 CFR § 440. 70(a)).

Discussion

CAHC's Ellsworth suggests that the way the state currently provides hospice services has both strengths and weaknesses. A strength is that it allows some flexibility and does not require that a full panoply of benefits be provided when they might not be necessary. Moreover, it allows

Medicaid beneficiaries who may not be ready to elect the hospice to still receive medically necessary home health care benefits (which include most of the bundled services listed above).

But a more limited benefit has its drawbacks. In addition to the uncovered services described above (i. e., counseling, nursing home care for individuals under age 65, and respite), the lack of a bundled benefit denies the patient a holistic approach to managing his or her end-of-life care needs. (We do not know to what extent a terminally ill Medicaid recipient's care is managed under the present system.)

The CMA's Terry Berthelot asserts that the Medicaid home health care benefit is inadequate for many terminally ill Medicaid patients and their families. She believes that the hospice philosophy (holistic approach to caring for the dying) differs from that of home health care agencies, and points to the critical importance of respite and social workers.

We should note that Medicare is available to someone with a severe physical disability who is under age 65, but only once the person has been receiving Social Security disability benefits for at least two years. This waiting period can make it difficult, if not impossible, for someone whose disability is caused by the terminal illness to qualify for Medicare (and hence that program's hospice benefit).

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