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MassHealth Hospice Program: Overview & Analysis Final Report

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In cooperation with:

MassHealth Office of Long Term Services
and Supports

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Table of Contents

Acknowledgements.....	iii
Executive Summary	vii
1 Introduction	1
2 Background	1
2.1 Access/Election of Hospice.....	1
2.2 Hospice Utilization and Expenditures.....	2
2.3 Benefits of Palliative Care.....	2
2.4 Expert Panel on End-of-Life Care	3
3 Methods	3
4 Synopsis of Study Findings	5
4.1 Access, Eligibility and Election.....	6
4.2 Service and Payment Structure	6
4.3 Utilization and Expenditures	7
4.3.1 Utilization	7
4.3.2 Expenditures.....	8
4.4 Member and Family Satisfaction.....	9
4.5 Alternative Models for Hospice and End-of-Life Care in Other States	9
5 Study Limitations	10
6 Discussion.....	10
7 Recommendations.....	11
7.1 Examine MassHealth Hospice Reimbursement	11
7.2 Consider Opportunities for Further Study.....	12
8 Conclusion	12
9 References.....	14

List of Tables

Table 1. Summary of Methodologies Employed in the MassHealth (MH) Hospice Program: Overview and Analysis Study.....	4
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List of Figures

Figure 1. Hospice Length of Stay for MH-Only (MHO) and Dual Eligible (DE) Hospice Beneficiaries (FY 2006-2008 Average)	7
Figure 2. MassHealth (MH) Hospice Expenditures for MH-Only (MHO) and Dual Eligible (DE) Hospice Beneficiaries, FY 2006-2008	8

Executive Summary

Hospice has been shown to improve quality of life for terminally ill patients and their families by addressing pain and symptom management, and providing emotional and spiritual support (MA Expert Panel on End-of-Life Care, 2010). Hospice is administered as an optional benefit under a Medicaid state plan for beneficiaries who are certified by a physician to be terminally ill with a life expectancy of six months or less and who forego curative treatment. The benefit covers the palliation and management of terminal illness, inclusive of all related care, medication and supplies, counseling, and room and board in nursing facilities.¹

MassHealth, the Massachusetts (MA) Medicaid program, administers a hospice benefit for eligible Fee-for-Service (FFS) plan members. MassHealth began offering a FFS hospice benefit in 1988. During State Fiscal Years (FY) 2006-2008 (July 1, 2005-June 30, 2008), the MassHealth hospice program experienced increased utilization and expenditures. To better understand this growth and its effect on services and customer satisfaction, MassHealth requested that the Center for Health Policy & Research (CHPR), at the University of Massachusetts Medical School's (UMMS) Commonwealth Medicine Division, conduct a study pertaining solely to its FFS hospice benefit.

The MassHealth Hospice Program: Overview and Analysis study (the Hospice study) employed mixed methods to conduct a descriptive analysis of primary and secondary data, using document review, key informant interviews, and MassHealth claims and enrollment data. The study encompassed four phases, and each phase concluded with a detailed report. Phase 1 explained the structure and implementation of the MassHealth hospice benefit. Phase 2 examined the increase in MassHealth hospice benefit utilization and expenditures. Phase 3 assessed MassHealth member and family satisfaction with the benefit. Phase 4 described the end of life (EOL) services related to a terminal illness, including hospice, provided by Medicaid programs in five selected states. This final report synthesizes and summarizes the study's four phases.

Key Findings

- **Access, Eligibility, and Election:** The FFS hospice benefit is available to eligible MassHealth members, except those in the Basic, Essential and Limited coverage plans. Adults, age 21 and older, who elect the benefit, are required to forego curative treatment. Key informants report that members' delay in hospice election or their refusal of the benefit may impact their length of stay in hospice, their EOL care or both.

¹ Commonwealth of Massachusetts MassHealth Provider Manual Series, Hospice Manual, pp. 4-9 through 4-11, and 4-8 (130 CMR 437.423 and 130 CMR 437.421(D)(5))

- Reimbursement:** For members with only Medicaid coverage (MH-only), MassHealth pays the hospice provider on a per diem basis according to the level of care provided, as well as for room and board (R&B) when the member resides in a skilled nursing facility (SNF). When members covered by both Medicare and Medicaid (dual eligible) elect hospice, MassHealth pays only for R&B in a SNF, while Medicare pays for all other hospice services regardless of where the member resides. Hospice providers are responsible for billing MassHealth and passing R&B payments to SNFs. This is known as the “pass-through” system. According to federal regulations, hospice R&B must be equal to at least 95% of what the state would pay a SNF for a non-hospice beneficiary. MassHealth reimburses 95% of the SNF R&B rate. In some cases, hospice providers contract with SNFs to pay the full R&B charge, absorbing the 5% rate difference.
- Utilization and Expenditures:** During the period FY 2006-2008, the number of MH-only hospice beneficiaries remained virtually constant, averaging 620 annually, and approximately three-fourths had a length of stay (LOS) of three weeks or less. Simultaneously, the number of dual eligible hospice beneficiaries rose 68%, from 3,849 in FY 2006 to 5,702 in FY2008. More than 60% of these dual eligibles had an average LOS of at least four weeks. The number of dual eligibles with a LOS of more than 6 months rose 81%, from 587 in FY 2006 to 1066 in FY 2008. MassHealth hospice expenditures rose 78%, from \$58.9 million in FY 2006 to \$105.0 million in FY 2008, with the largest expenditure category being R&B payments for dual eligibles, comprising 90% of all hospice expenditures in each study year.
- Beneficiary and Family Satisfaction:** Family members of hospice decedents who participated in the study described the MassHealth hospice benefit as ‘5’ (excellent) on a scale of 1 to 5. They stated that hospice “more than met” patients’ needs for pain and symptom management as well as for assistance with activities of daily living. They also reported that hospice met the emotional and spiritual needs of both patients and family members.
- Other States:** An examination of the Medicaid hospice benefit in five other states showed variation in the populations eligible for hospice, coverage models, and R&B reimbursement. Palliative care was provided on an ad-hoc basis for Medicaid beneficiaries who were either ineligible for, did not have access to, or did not elect hospice.

Conclusions

While hospice can improve quality of life for terminally ill patients with a prognosis of 6 months or less to live, the study found that patient and provider knowledge of EOL services, their preferences for EOL care, as well as federally-defined eligibility requirements, impact MassHealth members’ use of the hospice benefit. Those interviewed see these challenges to electing the benefit as missed opportunities for both MassHealth beneficiaries and their families.

Hospice providers report administrative and financial challenges when acting as the intermediary between MassHealth and SNFs for R&B reimbursement. Further, over 90% of the annual MassHealth hospice budget pays for the R&B expenses of hospice beneficiaries in SNFs who are dually eligible for Medicare. This fiscal reality overshadows the relatively small annual expenditures for patient care and family support the MassHealth hospice benefit provides.

MassHealth and the other state Medicaid programs studied currently do not offer a palliative care benefit for their members with a terminal illness who are not eligible for hospice. By covering a range of services that includes curative treatment and palliative care, as well as hospice, states can increase access to high quality EOL care for these members and their families.

Recommendations

The following recommendations from this study suggest opportunities for MassHealth to provide a continuum of care in a cost efficient manner, from the time of terminal diagnosis through the end of life and during bereavement, for all MassHealth members with serious chronic and terminal illness.

- Conduct further claims analyses to determine and compare utilization and expenditures for EOL services provided to MassHealth decedents without access to the hospice benefit, those who were eligible but had short hospice LOS, and those who did not elect the benefit. Results can advise the feasibility of extending the hospice benefit, for example, to terminally ill members in the Basic, Essential and Limited coverage plans, which do not include hospice.
- Examine the hospice R&B pass-through reimbursement system, the “95% rule” for reimbursing hospice R&B, and R&B expenditures isolated from payments for hospice care.
- Consider further analyses of quantitative and qualitative data to better understand utilization and cost of EOL care related to a terminal illness, including hospice, for MH-only and dually eligible beneficiaries.

1 Introduction

Hospice is an optional benefit under a Medicaid state plan for beneficiaries who are certified by a physician to be terminally ill with a life expectancy of six months or less and who forego curative treatment. The benefit covers palliation of the terminal illness, inclusive of all care, medication, supplies, counseling, and room and board in a nursing facility for the member, and support for the member's family.

MassHealth has administered a Fee-for-Service (FFS) hospice benefit under the Massachusetts (MA) Medicaid state plan since 1988. During State Fiscal Years 2006-2008 (July 1, 2005-June 30, 2008), the MassHealth hospice benefit experienced increased utilization and expenditures. To better understand this growth, the MassHealth Long Term Services and Support Unit requested the Center for Health Policy and Research (CHPR), in the University of Massachusetts Medical School's (UMMS) Commonwealth Medicine Division, to conduct a multi-phase study of its FFS hospice benefit. As a program evaluation project, the study was exempt from the UMMS Institutional Review Board process.

The MassHealth Hospice Program: Overview and Analysis study comprises four phases. Each phase produced a detailed report addressing the following aims:

- Phase 1: Described how the hospice benefit is currently structured and implemented (Lang, Posner, & Anderson, 2011)
- Phase 2: Examined utilization and expenditures of the hospice benefit during State Fiscal Years (FY) 2006, 2007, and 2008 (Bhang & Zhang, 2010)
- Phase 3 : Assessed beneficiary and family member satisfaction with the hospice benefit (Lang & Posner, 2011)
- Phase 4: Identified alternative models for hospice and other services for terminally ill Medicaid beneficiaries that exist in other states (Lang & Posner, 2012)

This Final Report provides a brief background section and then summarizes the methods and key findings from Phases 1 through 4, and offers recommendations for MassHealth's consideration.

2 Background

2.1 Access/Election of Hospice

Studies indicate that hospice provides high quality care at the end of life (EOL) and elicits excellent patient and family satisfaction ratings (Rickerson, Harrold, Kapo, Carroll, & Casarett, 2005). However, Medicaid patients historically either lack access to needed

EOL care, or may delay or refuse hospice care for several reasons: lack of direct knowledge of hospice, cultural beliefs around death and dying, or a reluctance to accept a terminal prognosis and stop curative treatments (Head et al., 2010).

2.2 Hospice Utilization and Expenditures

The literature suggests that terminally ill patients and their families benefit most from hospice care with a length of stay (LOS) of at least 60 days (MA Expert Panel on End-of-Life Care, 2010). Yet, nationally, the median hospice LOS remained steady at three weeks from 2006-2008 (The National Hospice and Palliative Care Organization, 2010). In 2008, over one-third of hospice patients either died, or elected curative or emergency treatment within seven days of enrollment in hospice and were thus discharged (NHPCO, 2010). With very short stays, there is inadequate time for providers to assess patient and family needs and implement effective hospice services. Thus, patients and their families may benefit from earlier enrollment in hospice leading to longer lengths of hospice stay (Casarett, 2011; Medpac, 2011; Rickerson et al., 2005).

Over the last decade, more terminally ill patients have elected hospice and stayed longer. The National Hospice and Palliative Care Organization (NHPCO) reports that from 2000-2009, the number of Medicare hospice beneficiaries in the U.S rose 19% to 1.1 million.² With greater hospice use, Medicare hospice expenditures more than tripled. In the same 10 year period, the average LOS at the 90th percentile rose from 141 to 237 days (very long stays). Increases in very long LOS for Medicare hospice beneficiaries account for the significant rise in hospice expenditures (Medpac, 2011).

NHPCO also reports that the majority of Medicaid hospice beneficiaries are dually eligible for Medicare. For dually eligible beneficiaries, Medicare pays for hospice care, and for those who reside in a skilled nursing facility (SNF), the state Medicaid program pays only for room and board (R&B). State hospice budgets can be misleading to policymakers because Medicaid hospice expenditures in large part cover SNF R&B “that the state otherwise would have been paying directly to the SNF...if hospice had not been involved”. Thus, it is important to consider the cost of Medicaid hospice care aside from the residential cost (NHPCO, 2011).

2.3 Benefits of Palliative Care

Palliative care focuses on “relieving suffering and achieving the best possible quality of life” for both patients with a life-threatening illness, and their family members (Head et al., 2010; Kelley & Meier, 2010). Palliative care can be provided along with curative treatment prior to election of hospice (Lang & Posner, 2012). Studies have shown that incorporating palliative care early in the progression of the disease provides better quality of care, and supports the transition to hospice when curative treatment is neither effective nor desired (Greer et al., 2011; Meier, Tuch, Campbell, Keyserling, & Morrison, 2009; Rickerson et al., 2005). The American Society of Clinical Oncology, in its February

² According to NHPCO, Medicare covered over 84% of hospice patients nationally in 2008.

2012 Provisional Clinical Opinion, states, "...combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden" (Smith et al., 2012).

While improving quality of life, hospice may also lower the cost of EOL care. Palliative care programs, including hospice, provide case management and care at costs lower than those associated with acute care services for patients at the end of life who do not access hospice (Head et al., 2010; NHPCO, 2010). As state Medicaid authorities implement initiatives to improve EOL care and reduce costs, they may consider payment models other than the FFS system (Meier et al., 2009).

2.4 Expert Panel on End-of-Life Care

The Massachusetts Expert Panel on End-of-Life Care (the Expert Panel) was established by the state legislature and convened in 2009 to study the Commonwealth's health care delivery for patients with serious chronic conditions, and to identify best practices and "any legislative, regulatory, or other policy changes necessary to implement its recommendations". The Expert Panel's October 2010 report (MA Expert Panel on End-of-Life Care, 2010) recommends that:

- all health care organizations should provide access to palliative care and hospice services for patients with serious advancing illness, as demonstrated by passage of the New York State Palliative Care Information Act (Ibid, pg. 20); and
- all health plans should provide hospice coverage, referring specifically to the three MassHealth plans that currently exclude it - MassHealth Basic, Limited, and Essential (Ibid, pg. 23)

3 Methods

CHPR collaborated with MassHealth in determining the methods used for each of the four study phases. As Table 1 summarizes, CHPR used primarily qualitative methods in Phases 1, 3, and 4, and quantitative methods in Phase 2.

Phase 2, conducted first, used MassHealth enrollment (MA-21) and claims (MMIS³) data for the three year period FY 2006-2008. Data for this period were both complete and current in 2009. The study population was defined as all MassHealth members who had at least one paid FFS hospice claim, and was divided into three subgroups: MassHealth only (MH-only) members (those with no other health insurance); dual-eligibles (MassHealth members also enrolled in Medicare); and those with MassHealth and

³ MMIS = Medicaid Management Information System

Table 1. Summary of Methodologies Employed in the MassHealth (MH) Hospice Program: Overview and Analysis Study

	Phase 1	Phase 2	Phase 3	Phase 4
Approach	Qualitative	Quantitative	Qualitative	Qualitative
Data Sources	Federal and state legislative, regulatory, policy, and program documents Eleven (11) key informant face-to-face and phone interviews, conducted between March 12-June 16, 2010 Published reports	MH MMIS hospice claims and MA 21 member enrollment data, pulled February-November 2008	MH MMIS hospice claims and member enrollment data, pulled December 2010 Nine (9) key informant phone interviews, conducted between June 20-July 28, 2011	Nine (9) key informant phone interviews, conducted between January 18-April 27, 2011
Sample	Hospice providers Hospice/EOL care provider associations Federal and state government Subject matter experts	MH-only, dual eligible, and 3 rd party members with ≥1 paid hospice claims in FY2006-2008	Family members of MH hospice beneficiaries who died during CY2008-2009	Medicaid and the Hospice Association in five selected states: Arizona (AZ) Florida (FL) New Hampshire (NH) New York (NY) Oklahoma (OK)
Sample Size	13 informants	Total MH hospice users: 4,492 (FY2006) 5,847 (FY2007) 6,358 (FY2008)	9 informants	20 informants
Data Outputs	Document summaries Interview transcripts	MH hospice utilization and related expenditures Member demographics	Interview transcripts	Interview transcripts
Analysis	Transcript coding using Atlas.ti [®]	Descriptive statistics using SAS [®] v9.1	Transcript coding using Atlas.ti [®]	Transcript coding using Atlas.ti [®]

commercial insurance.⁴ CHPR accessed the MassHealth hospice claims and enrollment data from the Massachusetts Executive Office of Health and Human Services Data Warehouse, and linked the two datasets using the Recipient History Number (RHN) for

⁴ Another much smaller subgroup included MassHealth members with commercial insurance. Data from commercial insurers was not available for this study.

each hospice beneficiary. Frequency statistics with proportions were calculated using SAS 9.1.

Phases 1, 3 and 4 employed qualitative methods. In Phase 1, the study population consisted of MA hospice providers, hospice/EOL care provider associations, government administrators, and subject matter experts. With MassHealth assistance, CHPR generated an initial list of individuals, and then employed snowball sampling techniques to identify the final group of 13 key informants representing various hospice stakeholders. Semi-structured guides were used in 90-minute interviews conducted in person or by telephone. Interview transcripts were inductively coded. Content coding and analyses of the CMS Conditions of Participation (CoPs), the MassHealth Hospice Manual, and 13 other policy documents were also completed.

For Phase 3, the study population consisted of surviving family members of MassHealth hospice beneficiary decedents. A sample was developed using claims data to first identify MH-only hospice decedents from CY2008-2009. This time period was chosen to ensure that at least 18 months had lapsed prior to making contact with family members. Using the decedents' case number as a matching criteria, CHPR generated a study sample of 64 adult (age 21 years or older) family members of FFS hospice beneficiaries who were also enrolled in MassHealth. Following recruitment by mail, a semi-structured guide was used to interview subjects by telephone. Transcripts were deductively coded and the results analyzed to assess family member experience and satisfaction with the hospice benefit.

In Phase 4, study subjects consisted of key informants from five selected states whose Medicaid hospice policies or programs may differ from those in MA. MassHealth approved the five states, and CHPR then contacted the state Medicaid office and the state Hospice Association to identify participants. A semi-structured interview guide was administered via telephone with 20 key informants. Transcripts were coded, and the coded text was analyzed to identify differences from, and potential innovations to, the MassHealth hospice benefit.

For this Final Report, CHPR reviewed and analyzed the findings, as detailed in the four Hospice study reports, along with relevant literature. The subsequent analysis forms the basis for this summary report, including its recommendations regarding policy actions and areas for further study.

4 Synopsis of Study Findings

Findings from the four phases of the Hospice study are organized around the following five themes:

- 1) Access, eligibility and election
- 2) Service and payment structure

- 3) Utilization and expenditures
- 4) Member and family satisfaction
- 5) Alternative models for hospice and EOL care in other states

4.1 Access, Eligibility and Election

To access hospice services in MA, as well as the five states examined in Phase 4, eligible Medicaid members must have documentation of a terminal illness with a life expectancy of six months or less, as certified in writing by a physician. Members must waive their rights to curative treatment. Informants noted this policy as a barrier to hospice access for those patients not ready to “give up” treatment.

Consistent with results from the literature, this study finds that hospice coverage is not available to all Medicaid members. States, such as MA, AZ and OK, restrict eligibility to the hospice benefit based on age, disability status, and/or coverage type. MassHealth currently excludes members in its Basic, Limited, and Essential coverage plans from the FFS hospice benefit. MA hospice providers report they provide free care to Medicaid members lacking hospice coverage, based on their indigent status.

Adult members may postpone hospice election to continue treatment or because they are unfamiliar with the range of services the benefit provides. According to key informants in Phase 1, LOS in hospice is often too short to implement a comprehensive hospice plan of care for patients and families (Lang et al., 2011). While the average LOS for all MassHealth hospice beneficiaries increased during the Phase 2 study period (FY 2006-2008), MassHealth hospice users were more likely to have a LOS of one week or less.

4.2 Service and Payment Structure

The “all-inclusive” service structure of the Medicare hospice benefit is specified in the federal Hospice CoPs⁵, and replicated in the MA Medicaid state plan as well as in the five Phase 4 study states. Hospice services are paid on a per diem basis based on four levels of care: routine home care; continuous home care; inpatient respite care; and general inpatient care. For Medicaid-only hospice beneficiaries, states pay for all hospice care, as well as R&B when the member resides in a SNF. For dual eligibles, Medicare pays for hospice care while states reimburse only for R&B in SNFs.

The CoPs dictate that the hospice R&B reimbursement rate must be at least 95% of the rate the state would otherwise pay for SNF R&B. This is known as the “95% rule” (Lang et al., 2011). States have the authority to pay more than 95% of the SNF rate for hospice R&B. Among the states studied, MA, FL and NH reimburse at 95% of the SNF rate,

⁵ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 418 Medicare and Medicaid Programs: Hospice Conditions of Participation, Federal Register, Vol. 73, No. 109, June 5, 2008, pgs. 32088-32220

while NH and AZ reimburse at 100%. Phase 1 informants reported that in some cases, hospice providers in MA have agreements with SNFs to pay 100% of the R&B rate.

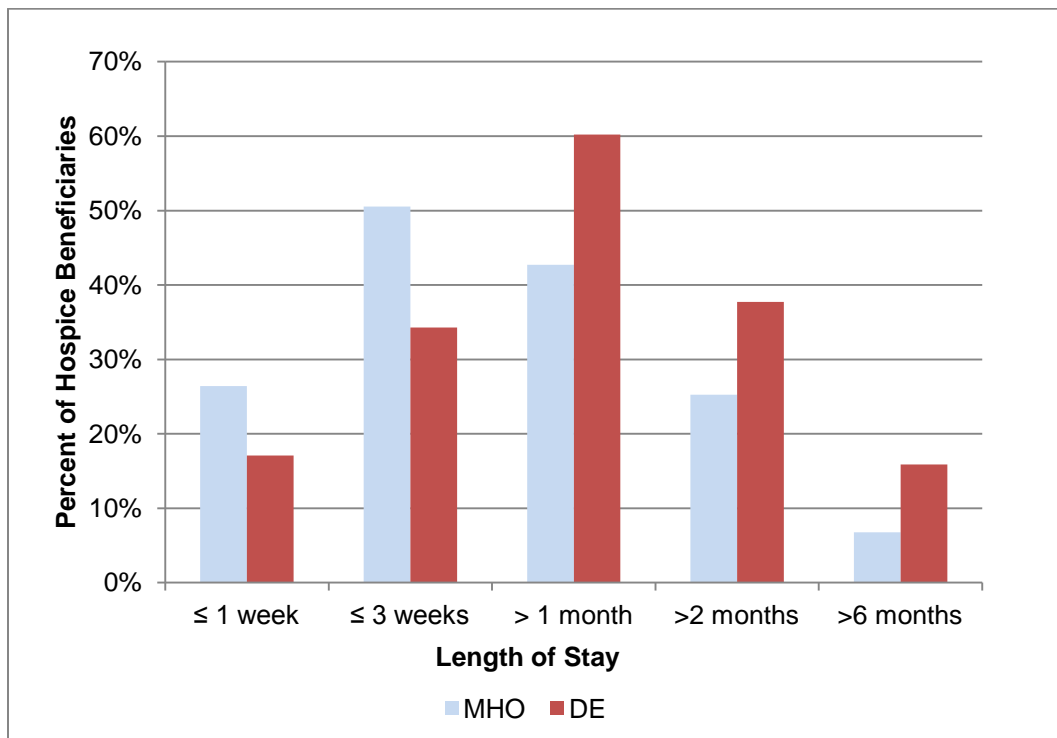
States also differ in regard to hospice R&B reimbursement policies and procedures. Generally, hospice providers bill Medicaid for R&B reimbursement which they pass to the SNF. MA, as well as FL and NY, use the R&B pass-through system. In MA, hospice providers are responsible for obtaining information from SNFs in order to accurately calculate the hospice R&B rate. The AZ and NH Medicaid program informants reported, however, that their state reimburses hospice R&B directly to SNFs.

4.3 Utilization and Expenditures

4.3.1 Utilization

Both hospice utilization and expenditures grew in MA over the three-year study period, driven by change in the number of beneficiaries dually eligible for Medicaid and Medicare. The number of dual eligible hospice users grew from 4,117 to 6,051, and their average LOS increased from 79 days to 91 days. Further, the proportion of dual eligibles within the longest LOS category (more than 6 months) also increased, from 14.3% to 17.1%. As displayed in Figure 1, for LOS categories longer than one month, the proportion of dual eligibles was higher than the proportion of MH-only hospice users.

Figure 1. Hospice Length of Stay for MH-Only (MHO) and Dual Eligible (DE) Hospice Beneficiaries (FY 2006-2008 Average)



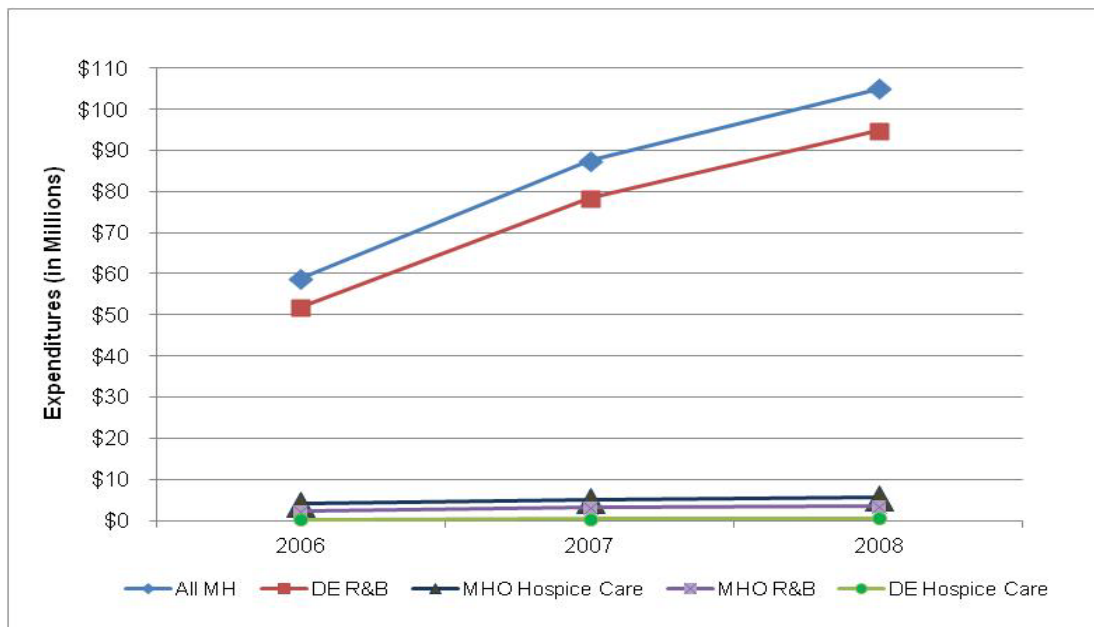
Source: (Bhang & Zhang, 2010)

MH-only hospice utilization remained steady during FY2006-FY2008, with the number virtually constant (619, 621, 622). In each of the three years, the median length of stay was 30 days or less (median range, 19 to 30). Less than 10% of all MH-only hospice beneficiaries in each year had a LOS longer than 6 months and most (over 50%) were served in the community.⁶ Across the study period, the number and proportion of MH-only members receiving SNF R&B increased from 224 (36.0%) in FY2006 to 256 (41.4%) in FY2008.

4.3.2 Expenditures

MassHealth hospice expenditures totaled \$58.9 million in FY2006, rose to \$87.4 million in FY2007, and reached \$105.0 million in FY2008, an increase of 78.3% over the three years. Expenditures for MH-only hospice users during this period rose from \$6.3 million to \$9.1 million, a 69.2% increase. On average, nearly two-thirds of these expenditures covered routine care (53.3%) and general inpatient care (9.2%), and just over one-third paid for R&B. Hospice expenditures for dual eligible members increased 82.5% in the same period. R&B for dual eligibles residing in SNFs had a great impact on MassHealth hospice expenditures, comprising approximately 90% of all MassHealth hospice expenditures in each study year (Bhang & Zhang, 2010). Figure 2 below compares total hospice expenditures, as well as R&B and hospice care, for MH-only (MHO) and dual eligibles (DE) members over the study period.

Figure 2. MassHealth (MH) Hospice Expenditures for MH-Only (MHO) and Dual Eligible (DE) Hospice Beneficiaries, FY 2006-2008



Source: (Bhang & Zhang, 2010)

⁶ MassHealth members who receive hospice services in the community paid for by Medicare or commercial insurance are not represented in the Hospice study as data for this population was not available.

4.4 Member and Family Satisfaction

All family members interviewed in Phase 3 of the study rated the MassHealth hospice benefit as “excellent”. They reported that hospice “more than met” the patients’ needs for palliative care and assistance with activities of daily living. Further, hospice supported the family members as caregivers. Informants also spoke of the spiritual and emotional support which hospice staff provided. This often included helping the families accept and prepare for their loved one’s death. One respondent noted the importance of having hospice staff available who could speak to family members in their primary language.

4.5 Alternative Models for Hospice and End-of-Life Care in Other States

The five states in Phase 4 of the Hospice study have implemented care models and policies to improve both the efficiency and breadth of EOL care. While none currently offer an EOL care benefit for adult Medicaid members other than hospice, they will authorize FFS payment for services, in addition to treatment, that are related to a member’s terminal illness, regardless of hospice eligibility. Such services include home health, personal care attendants (PCAs), private duty nursing, durable medical equipment, and medication.

States have the flexibility to develop Home and Community-Based Services (HCBS) waivers for Medicaid members who are elderly or disabled and who would otherwise be institutionalized. AZ and OK include FFS hospice in their HCBS waiver programs for adult members needing long term care. FL and NY each use waivers to provide palliative care services to Medicaid children with chronic or life-limiting conditions.⁷

MA and all the study states, except FL, have implemented Section 2302 of the federal Affordable Care Act, Concurrent Care for Children, which allows coverage of curative treatment for Medicaid members younger than 21 years of age who elect the hospice benefit.⁸ NY enacted laws⁹ aimed at improving all patients’ knowledge of and access to palliative care, and is currently considering Medicaid redesign to both implement the law’s provisions through its Medicaid program and to expand hospice eligibility (Lang & Posner, 2012).

Unlike MA, AZ does not use the pass-through payment system for SNF reimbursement. Rather, it directly pays SNFs 100% of their R&B rate for FFS hospice beneficiaries. NH also reimburses at 100%, a policy implemented to promote positive relationships

⁷ The Massachusetts Pediatric Palliative Care Program provides similar services; however, it is funded as a state Department of Public Health program, separate from MassHealth.

⁸ PL 111-148 Patient Protection and Affordable Care Act, Title II, Sub. D, §2302, “Concurrent Care for Children” (124 STAT. 293) 3/23/10.

⁹ The Palliative Care Information Act (PCIA), eff. 2/1/2011, and The Palliative Care Access Act, eff. 9/27/2011 (PCAA).

between hospice providers and SNFs and avoid the tensions MA providers reported in Phase 1.

5 Study Limitations

Data access and sampling issues limit the study's results and generalizability. For Phase 2, only MassHealth claims data were available. The availability of claims data for the four levels of hospice care was thus limited to the MH-only population. Without Medicare claims data, CHPR was not able to fully examine hospice care expenditures for dual eligibles. In addition, the available data was not sufficient to construct a valid comparison group of terminally ill MassHealth beneficiaries who did not elect the hospice benefit or were not eligible.

In Phase 3, MassHealth preferred not to rely on family member satisfaction surveys routinely used by hospice providers, nor to request family member contact information from providers as a means of identifying study participants. While this sample selection approach avoided potential bias associated with providers supplying data or selecting respondents, it limited the sample size. Thus, the results are not generalizable to the population of MassHealth hospice beneficiaries and their families. Although interviewing family members of hospice decedents who died 20-35 months prior to data collection was done purposefully to respect their bereavement, it may have introduced recall bias. Finally, the experiences and opinions of family members who volunteered to participate in interviews may have differed from those who did not.

6 Discussion

Many studies have found that hospice provides high quality care that is well received by chronically or terminally ill patients and their families. This finding was corroborated by the family members of hospice decedents who participated in Phase 3 of the Hospice study. Thus, delays in patients' hospice election and restrictions on eligibility for the benefit can limit its positive impact for terminally ill MassHealth members.

The R&B pass-through reimbursement system, where hospice providers serve as billing intermediaries between MassHealth and SNFs, presents a number of challenges. Payments are delayed when hospices must obtain data from SNFs to accurately calculate the hospice R&B rate, submit claims to MassHealth, and pass the R&B reimbursement to SNFs. As reported by Phase 1 informants, SNFs have been known to charge hospice providers 100% of the R&B rate, since MassHealth only pays 95%. These scenarios can create tension between SNFs and providers which may jeopardize: 1) access to hospice for MassHealth members residing in SNFs that are not inclined to accept the 95% hospice R&B rate; and 2) the financial viability of hospice providers when they are expected to subsidize R&B for MassHealth hospice beneficiaries in SNFs.

Some states do not rely on the pass-through system, nor do they follow the 95% rule. For example, AZ and NH reimburse SNFs directly for 100% of the R&B cost for Medicaid residents who elect hospice. Informants from NH stated that the state's policy to pay the full SNF R&B rate was established purposefully to foster positive relationships between SNFs and hospice providers.

MassHealth, along with other Medicaid programs, has experienced significant growth in hospice R&B expenditures for dual eligibles, which accounted for 90% of its annual FFS hospice budget in FY 2006-2008. However, MassHealth pays R&B for its beneficiaries who reside in SNFs regardless of their hospice use. Pass-through merely shifts the attribution of R&B costs from SNFs to hospice, which may lead to misperceptions about the cost of Medicaid hospice care.

Despite federal and state legislative action, and innovative care models and payment policies for terminally ill Medicaid members, the states in the Hospice study do not offer a Medicaid state plan benefit providing palliative and hospice care, along with curative treatment, for all beneficiaries with chronic/terminal illness, regardless of their age or life expectancy. Further examination of MassHealth expenditures, e.g. curative treatment or acute care episodes, for terminally ill MH-only members who lack access to or forego the hospice benefit as compared to claims for MH-only hospice users, could inform the feasibility of expansion of the hospice benefit.¹⁰

7 Recommendations

Based on the Hospice study, the following recommendations suggest opportunities for MassHealth to improve EOL care in a cost efficient manner for all members with a terminal illness.

7.1 Examine MassHealth Hospice Reimbursement

- If deemed legal under federal regulations, consider eliminating the pass-through system by reimbursing R&B for MassHealth hospice beneficiaries directly to SNFs. Elimination of the R&B payment pass-through system, as exemplified in AZ and NH, and advocated by hospice providers in MA, could streamline hospice billing procedures and speed up the reimbursement process. It could also promote more positive relationships between hospices and SNFs. In turn, this policy change could foster access to hospice by MassHealth-only members already residing in SNFs.
- Consider reimbursing hospice R&B at 100% of the SNF rate. Once a MassHealth SNF resident elects hospice, MassHealth pays 95% of what it had

¹⁰ When Florida considered eliminating its Medicaid hospice benefit in 2008, an independent evaluation conducted by the Moran Company showed such action would "likely result in increased spending for mandatory services".

paid prior to hospice election. However, in cases where SNFs expect R&B reimbursement to continue at 100%, hospice providers either make up the 5% difference or decline to provide hospice services. Access to hospice care may thus be limited for MassHealth members in these SNFs.

7.2 Consider Opportunities for Further Study

- Given preliminary results showing differences in LOS and cost between MH-only and dually eligible hospice beneficiaries, further analyses of their characteristics (e.g., patient diagnoses, patient demographics); hospice eligibility, referral and election; care settings; and costs related to the terminal illness are warranted.
- Conduct a case-control study of FFS claims and caregiver experience for MassHealth members in Limited, Basic and Essential plans and MH-only hospice beneficiaries who died in the past three years to compare expenditures and care quality for these populations during the last six months of life. Results could determine potential savings for MassHealth and opportunities to improve EOL care, and thus advise the feasibility of expanding access to the hospice benefit.
- Analyze FFS claims related to treatment and palliative care services (e.g., medications, home health, PCA, medical equipment, physician services, consultations), as well as hospitalizations and/or emergency room visits, to determine utilization and expenditures for these services by terminally ill MH-only beneficiaries not enrolled in hospice.
- Examine palliative care and hospice offered through the MassHealth managed care plans. Analyses can examine the current utilization of hospice by MassHealth managed care plan members, including service delivery and payment structure.
- Conducted simultaneously with the analyses of claims data, the results from additional qualitative studies could advise how health care providers and skilled nursing facility officials, as well as hospice providers, view EOL care options for MassHealth hospice beneficiaries, including those enrolled in managed care plans.

8 Conclusion

Studies, including the MassHealth Hospice Program: Overview and Analysis, suggest that hospice can improve quality of life and meet the needs of terminally ill patients and their families. Family members of MassHealth hospice beneficiaries were very satisfied with the benefit. However, not all MassHealth coverage plans include hospice. Lack of

access to the hospice benefit, or delay in referral and election of hospice, may impact MassHealth members' end-of-life care. This may be countered by offering a benefit with a range of services, designed to meet the needs of terminally ill members and their families, as they transition from diagnosis through the end of life.

Room and board charges for dual eligibles in skilled nursing facilities comprised 90% of MassHealth hospice expenditures in SFY2008. The remaining 10% covered the array of hospice care services. By acknowledging this budgetary imbalance, and considering other state and national models, MassHealth can promote quality and cost-effective care options for all its members throughout the progression of a serious chronic and terminal illness.

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