

Hospice Care and New Hampshire Medicaid Enrollees

EXECUTIVE SUMMARY

The Foundation for Healthy Communities created the NH Partnership for End-of-Life Care in 1999 to improve end-of life care and advance care planning in New Hampshire. Advance care planning is a process to anticipate, understand, discuss and make plans about how one wants to be treated should serious illness or injury leave them without the capacity to make decisions or communicate. Promoting access to hospice care for Medicaid enrollees is one of several policy objectives of the NH Partnership for End-of-Life Care. This objective is based on the goal of ensuring access to basic quality end-of-life care regardless of a person's income level. Hospice is a team approach to providing comprehensive medical, nursing, social services, spiritual care and bereavement services to support a patient and family, regardless of the patient's location. It is designed to ensure comfort and symptom relief at the end-of-life. Working closely with the New Hampshire Hospice Organization and the New Hampshire Department of Health and Human Services, the Foundation for Healthy Communities has collected and analyzed Medicaid data from January 1-June 31, 1999 related to end-of-life medical care. Key findings include:

- Approximately 700 individuals ended their participation in the Medicaid program due to death. The claims paid in the 4-month period prior to death accounted for about \$5.3 million in Medicaid expenditures.
- In the six-month study period, 52 people age 64 or younger and 321 people age 65 or older ended their Medicaid enrollment due to death.
- In the six-month study period, the Medicaid program expended \$461,000 for care received in the 120 days that preceded the death of decedents age 64 or younger. The care received by decedents age 65 or older cost the Medicaid program \$2,225,000 in the 120 days that preceded their death.
- Hospital claims accounted for 41% of all provider claims for Medicaid decedents age 64 or younger.

- Nursing home claims accounted for 79% of all provider claims for Medicaid decedents age 65 or older.
- Expenditures for the treatment of psychiatric disorders accounted for 24% of claims near end-of-life for decedents age 64 or younger, and diseases of the respiratory system accounted for 23% of the expenditures. Cancer represented 13% of the expenditures.
- Expenditures for the treatment of psychiatric disorders made up 25% of near end-of-life claims for decedents age 65 or older, and diseases of the circulatory system accounted for 21% of their expenditures. Cancer represented 5% of expenditures.

There are 21 licensed hospice programs in New Hampshire, and all were invited to participate in a statewide survey to assist in the understanding of the need for a Medicaid hospice benefit. This analysis is based on data from 17 hospice programs (81% response rate) using their 1999 service data. Key findings include:

- There were more than 1,800 persons who received hospice care from the responding programs in 1999 in New Hampshire. A significant majority (82%) of the hospice patients were age 65 or older and 61% of the hospice patients had a cancer diagnosis.
- Most hospices in New Hampshire are Medicare certified and accredited by the Joint Commission on the Accreditation of Health Care Organizations.
- More than 700 volunteers help deliver hospice care through the responding programs in New Hampshire.
- A majority (63%) of patients age 64 or younger who used hospice services were insured by private commercial insurance.
- Hospices provide “free care” to about one out of every 10 patients that they serve.
- About 2 out of 5 (41%) responding hospices have a written policy for providing access to hospice services for low income/uninsured persons.

These findings are being used to assist health professionals and policy makers in the assessment of need for an end-of-life care benefit for Medicaid enrollees. Creating a benefit will require four major issues to be addressed: licensure (what organizations can offer the services); identifying and defining the covered services; establishing a rate methodology and setting a payment rate.

Hospice Care and New Hampshire Medicaid Enrollees

Introduction

The NH Partnership for End-of-Life Care is a group of organizations that helps people to plan for their health care, talk about their choices and have them respected. It was formed in 1999 by the Foundation for Healthy Communities to improve end-of-life care by increasing professional and public knowledge and promoting policy changes that support the delivery of quality end-of-life care. Advance care planning or the process to anticipate, understand, discuss and make plans about how one wants to be treated should serious illness or injury leave them without the capacity to make decisions or communicate, is the major focus of the Partnership activities at this time. The Foundation for Healthy Communities is a non-profit corporation that forms partnerships with health providers and others to improve health and health care in New Hampshire.

The NH Partnership for End-of-Life Care has several policy objectives including study of the potential for establishing a hospice benefit for Medicaid enrollees. New Hampshire is one of only six states that does not offer such a benefit. Access to comprehensive, high-quality end-of-life care for all regardless of income level is a priority of the Foundation for Healthy Communities and therefore assessing the need for a Medicaid hospice benefit is a priority.

This report was developed to assist health policy makers in understanding who might use hospice care or another end-of-life care benefit if Medicaid paid for it and how Medicaid enrollees are currently served. Section A is an analysis of Medicaid claims data obtained from the Department of Health and Human Services¹. Section B includes information from New Hampshire hospice providers which provides a better understanding of resources used in end-of-life-care for Medicaid and low-income consumers.

¹ No confidential information was released by the NH Department of Health & Human Services during this study. Claims data was provided only after identifying information was removed.

Section A. – 1999 Medicaid Claims Data

This section of the report uses a six-month sample (January 1-June 30, 1999) of Medicaid claims data to help understand who might utilize hospice care services if New Hampshire provided a Medicaid hospice benefit. Hospice is a team approach to providing comprehensive medical, nursing, social services, spiritual care and bereavement services to support a patient and family, regardless of the patient’s location. It is designed to ensure comfort and symptom relief at the end-of-life. The Foundation for Hospice and Homecare describes hospice care as, “comprehensive palliative medical care (treatment to provide for the reduction or abatement of pain and other troubling symptoms, rather than treatment aimed at a cure), and supportive social, emotional and spiritual services to the terminally ill and their families, primarily in the patient's home.” Hospice services are an essential option within the continuum of healthcare.

Background

Forty-four states, as displayed in Table 1, have adopted a Medicaid hospice benefit since 1987. New Hampshire is in the minority, however, and does not offer such a benefit to its Medicaid beneficiaries.

**Table 1
States Offering a Medicaid Hospice
Benefit and the Year of Effectiveness**

Year	Total Number	States Added	States Dropped
1987	6	FL, KY, MI, MN, ND, VT	
1988	15	DE, HI, IL, MA, NE, NY, NC, RI, TX, WI	MN
1989	24	AZ, CA, GA, ID, TN, UT, AI, AK, IA, MD	NB
1990	32	MN, NM, OH, VA	
1991	34	WA	TN
1992	35	CO, MS, TN	
1993	36	NJ	
1994	38	DC, WV	AZ
1995	40	OR, WY	
1996	41	AK, SC	
1997	42	AR	
1998	44	IN	
1998	44	AZ, NV	

Source: State hospice and home care organizations, and HCFA, Bureau of Data Management and Strategy

There are twenty-three state-licensed hospice organizations and two hospices operate hospice houses or residential facilities in New Hampshire (Concord's 10 beds opened in 1994, and Merrimack's 10 beds opened in 2000). All of the Medicare-certified hospices in NH are part of a home care/visiting nurse agency, with one exception.

Medicare Part A covers hospice care (see Appendix I.), and therefore the majority of the state's population age 65 and older are covered for hospice services. Most private insurance plans also include hospice care for their terminally ill members. Unlike the federal Medicare program, many private insurers and the majority of other states, New Hampshire's Medicaid program does not have a hospice benefit. While the New Hampshire Medicaid program covers some components of hospice care, (such as pharmaceuticals), other essential components, (such as social support, spiritual care and bereavement) are not covered. The lack of a Medicaid hospice benefit also inhibits the ability to offer the hospice approach to patients and their families in the Medicaid program. The lack of coverage for hospice care to Medicaid enrollees may lead to less comprehensive end-of-life care services for low-income people and may direct them to more costly and aggressive efforts in acute care settings. A New Hampshire Medicaid hospice benefit would allow terminally ill individuals with Medicaid eligibility and without Medicare eligibility to access a full-range of quality end-of-life-care services.

Medicaid Claims Data

This report uses recent Medicaid claims² as a primary data source to understand potential end-of-life care resources that might be used if a Medicaid hospice benefit were created. The initial data request identified the total number of deaths of Medicaid enrollees for a six-month period (January 1-June 31, 1999) and dichotomized the results into Medicaid decedents age 64 or younger and those age 65 and older. This was done because a significant number of people age 65 and older are covered by the federal Medicare hospice benefit. A follow-up query provided more detailed service utilization information for the Medicaid decedents. The objectives of the data requests were to:

- create a descriptive profile of Medicaid enrollees use of services during their final stages of life to assess potential demand for a Medicaid hospice benefit and

² No confidential information was released by the NH Department of Health & Human Services during this study. Claims data was provided only after identifying information was removed.

- increase awareness of the services related to end-of-life care and New Hampshire’s Medicaid consumers use.

The initial data query (see Table 2) identified 373 New Hampshire Medicaid enrollees who died between January 1-June 31, 1999. The majority (86%) of the Medicaid enrollees who died were age 65 or older with 14% age 64 or younger. There were 9,451 deaths in New Hampshire in 1997. According to the 1997 Institute of Medicine report *Approaching Death: Improving Care at the End of Life*, women may now expect to live nearly 79 years and men, almost 73 years. A June 1999 report by the Foundation for Healthy Communities, *DEATH in New Hampshire: A Review of Medical Charts*, identified the average age of nursing home decedents in the state as 84 years old.

Table 2:

January-June 1999 Medicaid Enrollee Deaths

Age	Jan '99	Feb '99	Mar '99	Apr '99	May '99	Jun '99	Jan '99-June '99
18 – 64	8	8	6	9	10	11	52
65+	52	56	61	64	45	43	321
Total	60	64	67	73	55	54	373

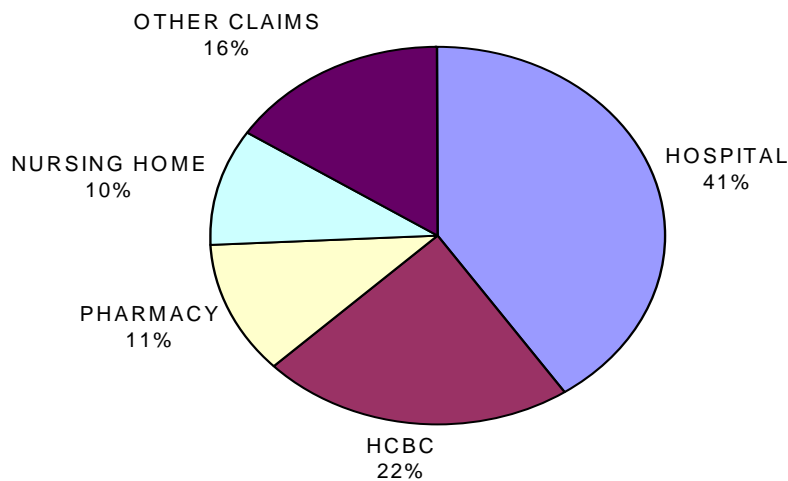
Medicaid Enrollee Deaths Age 64 or Younger:

The data identified 52 people ages 18-64 who died during the six-month study period. A follow-up data request retrospectively queried for any claims in the four-month period (120 days) preceding the date of death for these Medicaid enrollees. The data cleaning process in this follow-up query reduced the sample size by 7 decedents in the detailed analysis of Medicaid decedents age 64 or younger.

Medicaid claims for the 120 days preceding date of death for the 45 decedents totaled more than \$461,000. Of the 373 Medicaid decedents who died between January 1-June 31, 1999, these 45 people represent 17% of the claim expenditures. The mean expenditure for the 45 decedents age 64 or younger was \$10,249. The largest single claim was \$67,273, which was for a person with a primary diagnosis relating to respiratory illness. The lowest single claim, \$364, was for a patient with the primary diagnoses of cystic fibrosis. Medicaid decedents with a cancer

diagnosis, as determined by ICD-9 codes on claims, represent a significant proportion of the expenditures identified in this analysis. Ten of the 45 (22%) Medicaid decedents were identified

Figure 1
January -June, 1999 Claims for Decedents Age 64 or Younger by Type of Provider
(N= \$476,440)

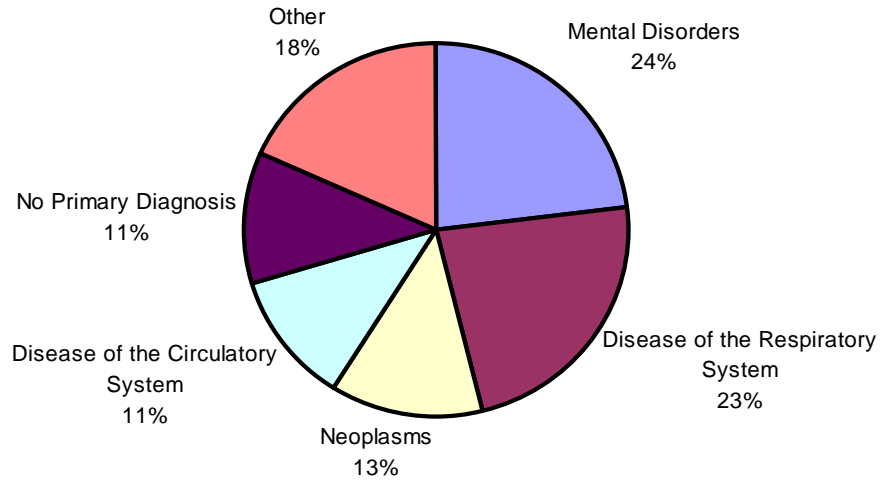


(See Table 3A in the Appendix for more detailed information)

with a primary diagnosis relating to cancer. Their total medical claims expenditures for the 120 days prior to the date of their death was \$123,167 with a mean expenditure of \$12,316. This mean expenditure for decedents with cancer exceeded the mean for all patients in the study group by more than \$2,000.

Claims were analyzed by provider type and are displayed in Figure 1. Hospital claims, at \$189,332, accounted for about 41% of all provider reimbursements for this age group. More than half (56%) of the decedents age 64 and younger received hospital services. The mean hospital claim amount was \$7,573, and the largest claim was \$55,703.

Figure 2
 45 Medicaid Decedents, Age 64 and Younger,
 Claims by ICD-9 Code
 (n=\$461,108)



See Table 3A in the Appendix for more detailed information

Most of New Hampshire’s hospice providers also offer home health care. These agencies may offer some components of hospice (e.g. nursing care in the home) and receive some Medicaid reimbursement because home health care is a covered Medicaid service. Home and Community Based Care (HCBC), with claims expenditures exceeding \$103,695, represents the second largest portion of Medicaid payments for patients in the last four months prior to death. Home health agency reimbursement, which is included in the ‘Other’ portion of the chart, totaled \$14,298.

The data were desegregated by primary diagnosis. Figure 2 illustrates what health conditions the decedents were treated for in the four months before death. Financial need thresholds are not the only requirements for Medicaid. Individuals must be both financially and categorically eligible to receive Medicaid benefits. Some of the categorical eligibility requirements include permanently and totally disabled, or blindness. Expenditures pertaining to psychiatric diagnosis make up 24% (\$106,091) of Medicaid claims near end-of-life. Thirteen decedents (29%) had a primary diagnosis relating to psychiatric disorders.

Expenditures for diseases of the respiratory system account for 23% (\$106,070) of end-of-life claims for the 45 people in the study sample. Sixteen decedents (36%) had diagnoses pertaining to respiratory illness. The mean end-of-life cost per Medicaid enrollee with this diagnosis was \$6,629. This amount is similar to the mean end-of-life cost for decedents with a primary diagnosis of cancer.

Total expenditures for a Medicaid eligible individual with a primary diagnosis of neoplasm (cancer) was \$59,020, which accounted for 13% of the total claims for the 45 people in the sample. About 20% of the decedents (10 people) had primary diagnoses relating to neoplasm.

Disease of the circulatory system accounted for about 11% of the total claim expenditures. Fourteen consumers had primary diagnoses relating to this disease category. Pharmacy claims (Medicaid Provider Code #070) accounted for 81% of the total claims with no primary diagnosis. Table 3A, in the Appendix II, further desegregates ICD-9 codes contained within the 'Other' category of Figure 2. In sum, Medicaid paid about half a million dollars for 4 months of care to 45 patients who died during the 6-month study period.

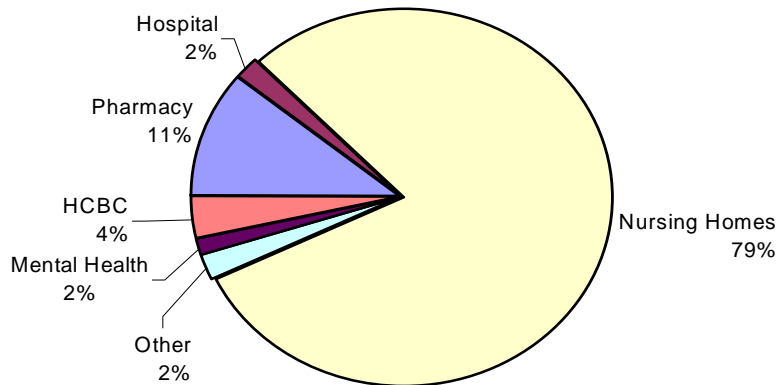
Medicaid Deaths Age 65 and Older:

Claim records from 321 Medicaid decedents age 65 and older who died between January 1-June 31, 1999 were extracted and analyzed. The data cleaning process on the initial query for this age group eliminated 65 decedents resulting in 256 for this analysis.

The 256 decedents, age 65 or older, had \$2,225,800 in Medicaid claims paid within the 120 days that preceded their date of death. A pharmacy claim of \$0.14 was the lowest single claim and four hospital claims of \$8,278 each were the largest claims. The mean expenditure for Medicaid decedents age 65 or older for 120 days preceding death was \$8,400.

Claims were analyzed by provider type and are displayed in Figure 3. Unlike the age 64 and younger Medicaid population, Medicaid decedents age 65 and older utilized a substantially larger portion of nursing home care. More than 79% or \$1,781,000 of their expenditures went toward nursing home care. Medicaid decedents, age 65 and older, expended \$41,131 for hospital care, which is 2% of the expenditures. About 4% of Medicaid's expenditures, for the age 65 and older decedents, were for home and community based care (HCBC). These amounts

Figure 3
 256 Medicaid Decedents Ages 65 or Older,
 Claims by Type of Provider (January 1 to June 31, 1999)
 (n=\$2,225,869)



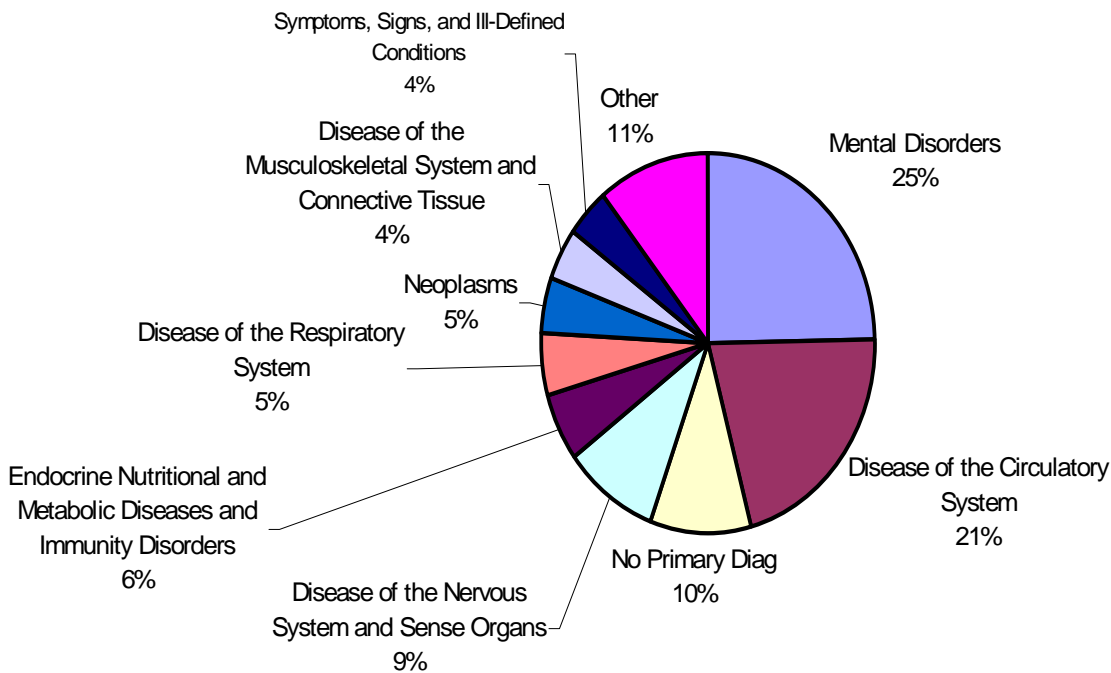
(See table 3C in the Appendix for more detailed information)

are substantially less than the hospital and HCBC expenditures for Medicaid decedents age 64 or younger.

Pharmacy claims, totaling \$243,218, made up the second largest category of expenditure. The 'Other' portion of Figure 3 consists of \$46,073 in expenditures, which is distributed among 10 different types of providers (e.g., physical therapist, speech therapist, etc.)

Expenditures for Medicaid decedents age 65 and older were analyzed according to diagnosis. Figure 4 displays the health conditions, according to ICD-9 Codes, for which the decedents were treated during the 120 days before death. Diagnoses of mental disorders accounted for \$538,185 of the expenditures (25%). This portion is similar to that of the age 64 and younger Medicaid decedents. Primary diagnoses relating to the circulatory system constituted 21% of the expenditures or \$465,067. Circulatory and psychological diagnoses utilized more than \$1 million dollars in this study's six-month timeframe.

Figure 4
 256 Medicaid Decedents Ages 65 or Older,
 Claims by ICD-9 (January 1 to June 30, 1999)
 (n=\$2,182.386)



(See Table 3D in the Appendix for more detailed information)

Figure 4 displays how the remaining expenditures are distributed among several other ICD-9 categories.

Discussion:

The Medicaid claims data provide a snapshot of how Medicaid currently uses its resources in the last 120 days before a Medicaid enrollee dies. A Medicaid hospice benefit would create a new category of expenditures for the Medicaid program in New Hampshire, but this new expenditure could result in reduced Medicaid costs in other categories such as acute care and pharmaceutical costs. Research at the national level on the Medicare hospice benefit provides the best evidence for savings and the re-allocation of resources to better meet end-of-

life care needs. According to *An Analysis of the Cost Savings of the Medicare Hospice Benefit* by Lewin-VHI,

“there have been three federally-sponsored studies of the relative costs of hospice and conventional care, and many more studies sponsored by health plans and other groups in the private sector (Abou-Sayf, 1991; Amado, 1979; Amado and Narkiewicz, 1986; Oji-McNair, 1984). Together, these studies provide strong evidence that hospice is a less costly approach to care for the terminally ill than the traditional approach.” The Health Care Financing Administration (HCFA) sponsored a study in 1988 by Abt Associates that concluded “for the first three years of the hospice benefit, Medicare saved \$1.26 for every \$1.00 spent on hospice care.” The substitution of home care days for inpatient days was found to be one of the largest contributors to these savings.

Realizing that many forces have changed in the health care environment, Lewin-VHI conducted a follow-up study in 1995 to determine if HCFA’s findings, regarding the savings associated with hospice, are still true today. The study concluded that Medicare consumers with a cancer diagnosis who enrolled in hospice cost Medicare \$2,737 less, on average, than non-users of hospice. Like many previous studies, Lewin-VHI found that the majority of savings occurred in the last month of life because of the substitution of hospice care at home for inpatient hospital care. This study also found that Medicare beneficiaries with cancer, who died in the last six months of 1992, saved Medicare \$1.52 for every dollar spent on hospice. The Lewin-VHI study demonstrated, like HCFA’s previous study, that hospice costs less than traditional forms of medical care. More important than cost savings, however, is the notion that a hospice benefit provides a choice for quality end-of-life care for Medicaid enrollees.

A more recent national study released this year by the US Department of Health & Human Services, Assistant Secretary for Planning & Evaluation (ASPE) found that in 1996 the average payment for a Medicare enrollee in hospice was \$6,433, however, half the enrollees averaged payments of \$2,809 per user. The 350,000 people who enrolled as Medicare hospice users in 1996 tended to be older than other Medicare beneficiaries, were more likely to be male and were more likely to have a cancer diagnosis (63%). The study also focused on the ‘value added’ of hospice care for nursing facility residents. It found that hospice care may increase their quality of life, especially for longer stay patients in nursing facilities. The study found nursing residents who used the hospice benefit had better pain management, were significantly less likely to be hospitalized and had fewer invasive procedures (e.g., feeding tubes, IV feeding).

There was a ‘spill over’ effect with pain management and there were fewer hospitalizations of patients in nursing facilities that had high concentrations of hospice care.

On an annual basis New Hampshire has almost 750 Medicaid enrollees who die, and the Medicaid claims paid in the last 120 days before death for these decedents is approximately \$5.3 million. It is important to be sure that these resources are providing Medicaid enrollees with access to comprehensive, quality end-of-life care.

Section B. – Survey of Hospice Organizations

All 21 licensed hospice providers in New Hampshire were invited to participate in two data collection efforts to help assess the need for a Medicaid hospice benefit. These surveys were constructed to complement the Medicaid claims obtained from the NH Department of Health and Human Services.

Data Collection Methods:

The survey was a result of collaboration between the Foundation for Healthy Communities and The New Hampshire Hospice Organization (NHHO). The survey was reviewed and piloted by three NHHO members before distribution to the 23 hospices in New Hampshire. The initial surveys were mailed in July with a supplemental survey sent in September. A follow-up call was made to each hospice to encourage its participation. Seventeen hospices responded to the initial survey in July 2000 (81% response rate), and 16 hospices responded to the supplemental survey in September 2000 (76% response rate). Hospices that responded to these data inquiries represent all regions of the state. Appendix III contains the survey instruments.

Hospice Patients:

The September survey identified 1,822 patients served in FY 1999 by 16 hospices in New Hampshire. This reporting sample includes all the larger hospices in the state. There were 1,498 patients age 65 years or older (82%) with 324 patients age 64 years or younger (18%). Among the younger patients, 12 patients were age 18 years or younger. There were 1,120 patients (61%) who received hospice care and had a cancer diagnosis.

Figure 5
Hospice Patients by Age:
(n=1822)

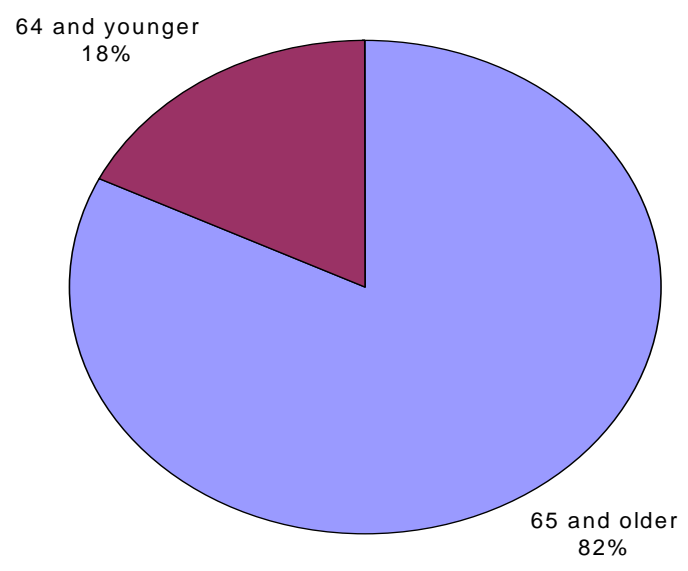
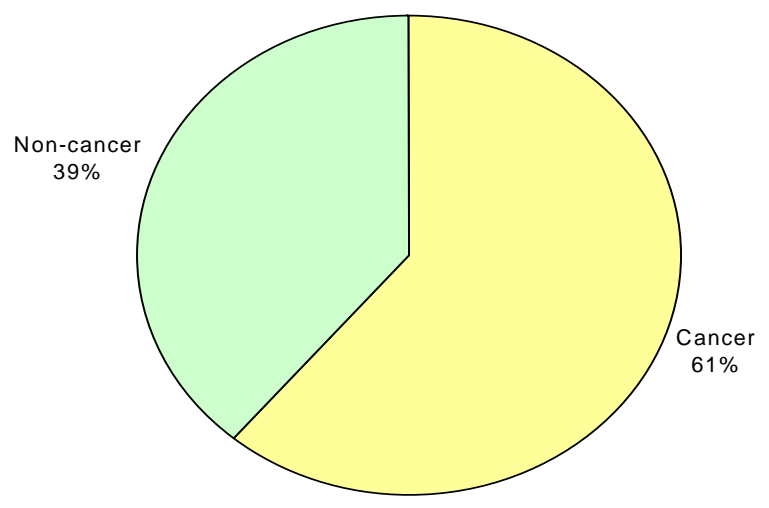


Figure 6
Hospice Patients by Diagnosis
(n= 1120)



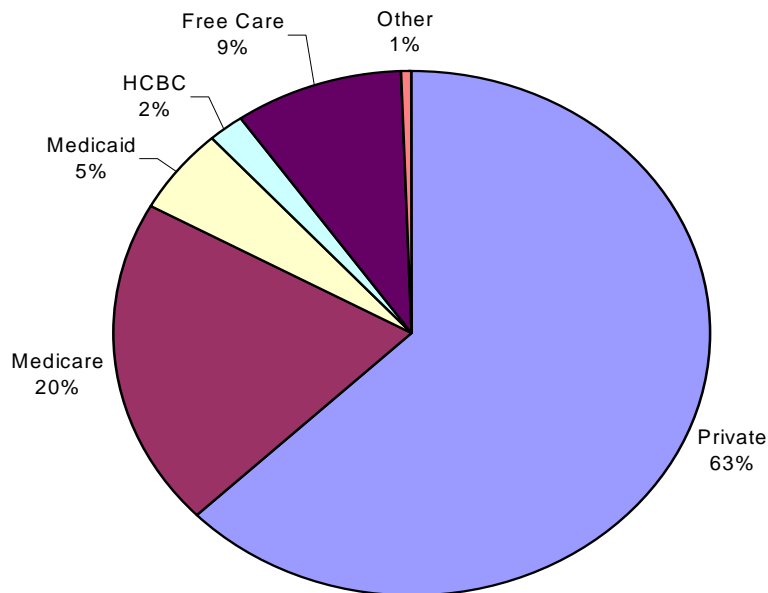
The range for the average length of stay was 15-59 days among the 13 hospices responding to this question. The average daily census ranged from two-37 patients among the 14 hospices responding to this question.

Hospice Provider Data:

Fourteen reporting hospices were Medicare certified, and two hospices did not have Medicare certification. Thirteen hospices reported being accredited by the Joint Commission on the Accreditation of Health Organizations. All but one of the 16 hospices in the sample reported using volunteers, with a total of 701 volunteers among 15 hospices. Bereavement programs are offered by 15 of the 16 hospices in the sample.

The July survey examined issues related to providing hospice care to uninsured and low income persons. The survey identified 196 patients age 64 or younger who received hospice care and whose source of reimbursement could be identified for the period between January 1-December 31, 1999.

Figure 7
Hospice Survey
1999 Hospice Patients, Ages 64 or Younger, Source of Reimbursement
(n=196 patients)



Many hospices did not have the database capabilities to separate their patients by age and reimbursement source. The survey identified 63% of the age 64 or younger hospice patients who were covered by private insurance. This is not unexpected because most people in this age category are not eligible for Medicare, and Medicaid does not offer such a benefit. Although a Medicaid hospice benefit would not have covered all of the 'free-care' patients, it may decrease the number who fall in this category of uncompensated care.

Hospice is a vital component within the healthcare continuum of care, and therefore it is important to understand the barriers to care for those with low incomes and no insurance. Hospices were asked to estimate how many patients served might have been eligible for Medicaid but not enrolled and respondents indicated that about 45% of their 'free care' patients fit this category. The 17 hospices reporting; identified caring for 120 Medicaid enrollees who were in nursing homes between January 1- December 31, 1999.

The survey queried how hospices pay for hospice care operating expenses incurred in providing services to 'free care' or low income patients. According to the survey, 82% of hospices pay for operating expenses incurred in providing 'free care' through memorial donations. About 53% of the respondents rely on annual campaigns and other activities to pay for patients that are unable to pay for the care that they received. United Way, with a response rate of 47%, is also responsible for ensuring reimbursement to providers for the provision of hospice services. Although these sources of compensation exist for the provision of hospice to some 'free care' patients, the survey revealed that only 41% of the hospices actually have a written policy for providing access to hospice services for low income/uninsured persons.

Discussion:

This data collection effort was a challenge for several reasons: New Hampshire hospices vary greatly in their size and staff; hospices are often smaller programs within a larger health care organization, competition among hospices is prevalent throughout many areas of the state, and many organizations were involved in a major transition of their data and fiscal reporting systems in 2000 when data collection efforts for this project were underway. This data does indicate that many people select hospice services as part of their end-of-life care, and it plays a significant role in the delivery of comprehensive end-of-life care services. Advance care

planning is a process to anticipate, understand, discuss and make plans about how one wants to be treated should serious illness or injury leave them without the capacity to make decisions or communicate. Hospices can play a vital role in advance care planning and providing hospice care services for those who desire hospice care. There may be gaps in access to hospice care when people lack health insurance and must rely on the donation of services by the hospice.

APPENDIX

Appendix I. – Medicare Hospice Benefit Summary

Appendix II. – Medicaid Claims & Provider Types Information

Expenditures by Provider Type, Age 64 and Younger (Table 3-A)

Expenditures by ICD-9 Code, Age 64 and Younger (Table 3-B)

Expenditures by Provider Type, Ages 65 and Older (Table 3-C)

Expenditures by ICD-9, Ages 65 and Older (Table 3-D)

Appendix III. – Hospice Survey Instruments

MEDICARE HOSPICE BENEFIT

In 1982, Congress made a hospice benefit available to Medicare recipients. Hospice providers, including public agencies and private companies, approved by Medicare are reimbursed for their services. Depending upon the condition, Medicare consumers receive care in a hospice facility, hospital, or nursing home. If possible, however, care is provided within the home.

Hospice care is a benefit that is available under Medicare Part A (Hospital Insurance) and its eligibility requirements include:

- The recipient's doctor and hospice medical director certify a terminal illness with a prognosis of six months or less to live; and
- A statement is signed electing hospice care instead of routine Medicare covered benefits for the terminal illness; and
- Care is provided at a Medicare-approved hospice program.

The recipient's doctor will work with the hospice and the patient's family to develop a plan of care. Medicare covers the following services:

doctor services, nursing care, medical equipment, medical supplies, drugs for symptom control and pain relief, short-term care in the hospital, home health aide and homemaker services, physical and occupational therapy, speech therapy, social worker services, dietary counseling, and counseling to help the patient and their family with grief and loss.

These services are used to provide care, and help the recipient make the most of their remaining life rather than focus upon curative measures. A team that includes family, a doctor, a nurse, clergy or other counselors, a social worker, and trained volunteers cares for Medicare hospice patients. Medicare consumers can choose to use their regular doctor, who is not part of the hospice team, to get care.

Medicare recipients that elect hospice forfeit treatment aimed at curing their terminal illness, care from another hospice that was not set up by the hospice, and care from another provider that is the same care that must be given by the hospice. Recipients can receive hospice care as long as their doctor certifies that they are terminally ill. Hospice care is given to Medicare recipients in periods that include two 90-day periods followed by an unlimited number of 60-day periods. The recipient's doctor must certify the terminal illness at the start of each period of care. Medicare recipients are entitled to terminate hospice care or change their designated hospice.

Medicare payment for covered hospice care is made in accordance with the methods established by HCFA. HCFA establishes payment amounts for specific categories of covered hospice care. The categories include routine home care day, continuous home care day, inpatient respite care day, and general inpatient care day. HCFA established payment rates for each of the above mentioned categories and pays hospices a daily per-diem rate. This rate covers all professional services, ancillary supplies, and equipment defined under the Medicare Hospice Benefit that relates to the patient's terminal illness and that are documented in the plan of care. The per-diem rate varies by level of care and by the location where the service is delivered. The per-diem rate includes the general supervisory services of the program medical director and team physician's participation in the development of the patient's plan of care. Home or inpatient physician visits made by a hospice physician are reimbursed outside the per-diem rate.

TABLE 3A - Appendix II
Medicaid Decedents Age 64 or Younger
Claims by Type of Provider (January 1 to June 31, 1999)
N=45

PROVIDER TYPE	CLAIM
Hospital	\$189,332
Home and Community Based Care	\$103,695
Pharmacy	\$53,122
Nursing Home	\$45,893
Other Claims	\$23,230
Physician	\$25,022
Home Health	\$14,298
Ambulance / Van	\$12,047
TOTAL CLAIMS	\$466,637

Table 3B
Medicaid Decedents Ages 64 or Younger,
Claims by ICD-9 (January 1 to June 31, 1999)
N= 45

ICD-9 GROUP	CLAIMS
Mental Disorders	\$106,091
Disease of the Respiratory System	\$106,071
Neoplasms	\$59,021
Disease of the Circulatory System	\$52,931
No Primary Diagnosis	\$52,650
Other	\$84,346
OTHER:	
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	\$22,041
Symptoms, Signs, and Ill-Defined Conditions	\$19,486
Infectious and Parasitic Diseases	\$13,496
Disease of the Genitourinary System (Renal Failure)	\$6,934
Disease of the Musculoskeletal System and Connective Tissue	\$4,728
Disease of the Blood and Blood Forming Organs	\$4,598
Disease of the Nervous System and Sense Organs	\$4,143
Disease of the Digestive System	\$3,973
Injury and Poisoning	\$2,838
Endocrine Nutritional and Metabolic Diseases and Immunity Disorders	\$2,032
Diseases of the Skin	\$54
Congenital Anomalies	\$22
OTHER TOTAL	\$84,346
TOTAL CLAIMS	\$461,108

Table 3C
Medicaid Decedents Ages 65 or Older,
Claims by Type of Provider (January 1 to June 30, 1999)
N= 202

Provider	Claims
Nursing Homes	\$1,781,215.85
Pharmacy	\$243,218.01
HCBC	\$79,754.89
Hospital	\$41,131.89
Mental Health	\$34,473.95
Other	\$19,978.65
Home Health Agency	\$17,549.26
Physician	\$8,546.21
TOTALS	\$2,225,868.71

TABLE 3D
Medicaid Decedents Ages 65 or Older,
Claims by ICD-9 (January 1 to June 31, 1999)
N= 202

ICD-9 GROUP	CLAIMS
Mental Disorders	\$538,185.58
Disease of the Circulatory System	\$465,066.95
No Primary Diag	\$209,634.23
Disease of the Nervous System and Sense Organs	\$202,463.91
Endocrine Nutritional and Metabolic Diseases and Immunity Disorders	\$127,312.83
Disease of the Respiratory System	\$115,269.90
Neoplasms	\$100,303.22
Disease of the Musculoskeletal System and Connective Tissue	\$96,174.75
Symptoms, Signs, and Ill-Defined Conditions	\$92,528.87
Injury and Poisoning	\$82,671.43
Disease of the Digestive System	\$51,214.02
Diseases of the Skin	\$40,725.10
Disease of the Genitourinary System (Renal Failure)	\$28,692.28
Supplementary Classification of Factors Influencing Health Status and Contact With Health Services	\$13,632.06
Congenital Anomalies	\$13,518.97
Infectious and Parasitic Diseases	\$4,893.76
Disease of the Blood and Blood Forming Organs	\$98.55
TOTALS	\$2,182,386.41

TO:

FROM: Ann Blair, Executive Director, NH Hospice Organization
Shawn V. LaFrance, Project Director, NH Partnership for End-of-Life Care

DATE: September 8, 2000

SUBJECT: New Hampshire Hospice Survey

The New Hampshire Hospice Organization and the Foundation for Healthy Communities/NH Partnership for End-of-Life Care is examining the potential creation of a Medicaid hospice benefit in New Hampshire. We are seeking your help in gathering some basic information to assess need, estimate cost and project utilization. Thank you.

Instructions:

Survey responses should only include data from **Fiscal Year 1999**. All information will be handled with strict confidentiality. Results will be summarized for the state and will not report data for any specific organization.

Please return your survey by Monday, September 18, 2000 by Fax to 225-4346. If you have any questions about the survey, contact Shawn LaFrance at (603) 225-0900 or slafrance@nhha.org or Ann Blair at NHHO (603) 225-0900 or hosp@nhho.org. Thank You.

New Hampshire Partnership for End-of-Life Care

... a group of organizations that helps people to plan for their health care, talk about their choices and have them respected.

NEW HAMPSHIRE HOSPICE SURVEY
FISCAL YEAR 1999

- 1. Medicare Certified
 Yes
 No

- 2. Accredited by JCAHO
 Yes
 No

- 3. Accredited by CHAP
 Yes
 No

The following data is **ONLY** for patients billed under your **Hospice Provider Number**.

(Please do **NOT** include Bridge, Pre-Hospice, etc.)

(Note: If all data is not available, complete what is possible.)

- 4. **TOTAL NUMBER of PATIENTS SERVED in FY 1999** _____

- 5. Of the total number of patients served, how many were:
Age 65 or Older _____
Age 64 or Younger _____ (Of these, how many
were Age 18 or Younger?) _____

- 6. In FY 1999, How many of your patient's diagnosis were:
Cancer _____
Non-Cancer _____

- 7. In FY 1999, What was your hospice's:
Average Length of Stay _____
Average Daily Census _____
Median Length of Stay _____

- 8. In FY 1999, What was your hospice's cost per patient for:
Average Length of Stay _____
Average Daily Cost _____

- 9. How many volunteers does your hospice have? _____

- 10. Do you provide community bereavement programs?
 Yes
 No

Contact Name _____ Phone # _____

**Please fax back to the NH Partnership for End-of-Life Care
at (603) 225-4346 by Monday, September 18, 2000.**

New Hampshire
Medicaid-Hospice Survey Form

Instructions:

The New Hampshire Hospice Organization, New Hampshire Partnership for End-of-Life Care, and the New Hampshire Department of Health and Human Services are seeking your help collecting some basic data to assess the need for a Medicaid hospice benefit in New Hampshire.

This survey is focused on collecting data on hospice patients that are age 64 and younger. Survey responses will only include data from January 1 - December 31,1999. Your response is essential, regardless of your patient volume under the age 65 during the required time period. All information will be handled with strict confidentiality and reports will not attribute specific data to any patient or organization.

Please return your completed survey no latter than Wednesday July 12, 2000 so that we will be able to report results at the July 18, 2000 meeting of the Hospice Care Coordinators. Questions you may have about the survey or project can be answered by contacting Shawn LaFrance or Denny Roberge at (603) 225-0900 or by sending e-mail to roberge@nhha.org. Your participation is most important. Thanks.

New Hampshire Partnership for End-of-Life Care

... a group of organizations that helps people to plan for their health care, talk about their choices
and have them respected.

New Hampshire
Medicaid-Hospice Survey Form

#1.

How many patients received hospice care services that were age 64 or younger between January 1 - December 31, 1999? _____

#2.

Identify the source of reimbursement for care you provided for the patients identified above:

_____ **Privately Insured (eg . Blue Cross/Blue Shield)**

_____ **Medicare (eg. disabled)**

_____ **Medicaid (including Medicaid bridge/transitional/supportive patients)**

_____ **HCBC (Home and Community-Based Care Program)**

_____ **Free Care (Uninsured)**

_____ **Other (Please specify) _____**

_____ **Total Patients (*Total should equal the number reported in question #1*)**

#3.

For the 'Free Care' patients identified above, please estimate how many might have been eligible for Medicaid but were not enrolled? _____

#4.

How many patients received hospice care services who were age 65 or older between January 1 - December 31, 1999 that were not eligible for Medicare? _____

#5.

How many hospice qualified patients received service between January 1 - December 31, 1999 that were covered by Medicaid and in a nursing home? _____

#6.

Do you have a written policy for providing access to hospice care services for low income/uninsured persons?

Yes

No

#7.

How do you pay for hospice care operating expenses incurred in providing services to free care (low income/uninsured) patients? *(Check all that apply)*

- Memorial donations
- United Way
- Annual Campaign
- Other (Please specify)

#8.

Any other comments on the issue of creating a Medicaid hospice benefit in New Hampshire? _____

Organizational Information:

Organization Name _____ Date _____

Organization Address _____

Contact Person _____ Telephone _____

e-mail _____

Is your organization Medicare certified ?

- YES
- NO

PLEASE FAX TO DENNY ROBERGE BY Wednesday July 12, 2000
FAX # (603) 225-4346