# COLORADO CENTER *for* HOSPICE & PALLIATIVE CARE

## Hospice Cost Savings

**January 2009**

### Research Indicates:

**One-third of all Medicare dollars are spent on people who are dying[1].**

### Hospice Savings in Medicare[2]

- ✓ Medicare saved $1.52 in Medicare Part A and Part B Expenditures for every Medicare dollar spent on hospice.
- ✓ Hospice saved Medicare $4,102 per patient in the last month of life, as hospice home care days often substituted for expensive hospitalizations.

### Hospice Savings in Medicare[3]

- ✓ A study of 8,700 Medicare patients indicated lower Medicare costs for patients enrolled in hospice care in a majority of cohorts.

### Hospice Savings in Medicaid[4]

- ✓ A 2003 actuary study indicated hospice saves Medicaid about $282 million / year, or approximately $7,000 per Medicaid hospice beneficiary.
- ✓ In 2004, Colorado hospices cared for ~560 Medicaid recipients. Without the Medicaid Hospice Benefit, this would increase Colorado's Medicaid spending $3.9 million.

### States Reporting Medicaid Hospice Cost Savings

- ✓ A 2008 Florida study finds that elimination of the Medicaid Hospice Benefit would actually cost Florida millions more than the state currently spends – adding to the state's budget deficit rather than reducing it.[5] Specific finds include:
  - o Eliminating the Medicaid Hospice Benefit will not save the state money, and likely will result in increased spending for mandatory services. The report conservatively estimates an additional $3.7 million in state Medicaid costs, as patients needing end-of-life care would end up in more expensive settings, such as hospital emergency rooms.
  - o Such action also will likely increase the burden on Florida counties to provide indigent care through already financially stressed indigent care programs.
  - o The loss of the service coordination, care management, and supportive services offered by hospice will increase fragmentation of care for terminally ill patients, limit their access to palliative care, and burden families and caregivers, potentially limiting their employment and educational options.
  - o The beneficiaries in Florida's Medicaid hospice program are different from the Medicare population that dominates hospice services. Florida Medicaid-only hospice patients are younger and more likely to be in the terminal stages of cancer or have HIV/AIDS related conditions than Medicare or dual Medicare/Medicaid patients. Their average length of stay in hospice is shorter, and their care is more

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[1] American Society of Clinical Oncology. Cancer care during the last phase of life. *Journal of Clinical Oncology*. 1998; 16(5):1986-1996.
[2] LEWIN-VHI. Hospice Care: An Introduction and Review of the Evidence. 1994.
[3] Pyenson B, et al. Medicare Cost in Matched Hospice and Non-Hospice Cohorts. *Journal of Pain and Symptom Management*. 2004; 28:3.
[4] Milliman USA. Value of Hospice Benefit to Medicaid Programs. 2003.
[5] Florida Hospice & Palliative Care. Cutting Medicaid Hospice Benefit Would Cost Florida More, Put Neediest Individuals At Risk. Press release 12/30/08.

Email
Info@COCHPC.org

PO Box 50888
Colorado Springs, Colorado 80949
P: (719) 594-9233 F: (719) 594-9203

Web site
www.COCHPC.org

likely to be complex and involve management of severe symptoms that, unmanaged, trigger emergency room visits and/or hospitalization.
  - The cut also would mean that Florida will lose revenue. For every dollar Florida cuts in the hospice benefit, the state will lose $1.25 in matching Federal Medicaid support.
- ✓ In 2002, The Florida Department of Health released the "Hospice Medicaid Education Project Final Report," which concluded, "The overall cost of caring for the hospice patients was 29.9% lower than non-hospice Medicaid patients with terminal conditions."[6]
- ✓ A 1995 study of the Illinois Department of Public Assistance (IDPA) found that in the last 72 days of life IDPA spending on hospice patients was $10,803 less on average than that for non-hospice patients.[7]

## The Department of Health & Human Services Encourages Hospice Utilization[8,9]

- ✓ HCFA Administrator Nancy-Ann Min DeParle cited a "disturbing misperception that hospices and beneficiaries will be penalized if a patient lives longer than six months. Nothing could be further from the truth."

## Hospice Savings in the Large Employer Market[10]

- ✓ Of 200 examined insurance carriers, 88% of them included hospice coverage.
- ✓ The estimated employer group cost for hospice coverage was only $1.18 / covered life / year.

## Hospice Under Financial Pressure in Medicare[11]

- ✓ A 2001 actuary study found that, on average, hospice costs exceed revenue by about 10-20%. The study identified two important contributors to these shortfalls:
  - The intensity of hospice services has increased dramatically resulting in an increase in the hospice cost per day. The rapid growth in prescription drug and outpatient costs has especially contributed to this increase.
  - The length of time patients actually receive hospice services has decreased, resulting in an increase in per-diem costs for each patient – while per-diem income has remained flat.
- ✓ Because hospice care saves money but is experiencing low reimbursement, hospice continues to seek appropriate Medicare / Medicaid reimbursement levels and to avoid any cuts in the existing hospice benefits.

## How Does Hospice Realize Cost Savings?[12]

- ✓ The effort to help terminally ill patients avoid unnecessary and undesirable hospitalization;
- ✓ The provision of medications, durable medical equipment, and home care visits as part of the per diem cost; and
- ✓ Extending to nursing home residents the same dignified, patient-focused end-of-life care as patients who are not in institutional settings.

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[6] Florida Department of Health. Hospice Medicaid Education Project Final Report. 2002.
[7] Illinois Department of Public Assistance Report. 1995.
[8] DeParle N. Letter to NHPCO. 2000.
[9] Scully T. Letter to NHPCO. 2002.
[10] Assistant Secretary for Planning and Evaluation (ASPE). U.S. Department of Health and Human Services. Synthesis and Analysis of Medicare's Hospice Benefit. 2000.
[11] Milliman USA. The Costs of Hospice Care: An Actuarial Evaluation of the Medicare Hospice Benefit. August 2001.
[12] Ibid.

The following selected information was downloaded from the Center to Advance Palliative Care Web site (**www.capc.org**) 7/8/09:

**MAKING THE CASE FOR PALLIATIVE CARE IN THE MIDST OF THE FINANCIAL CRISIS**

**Hospital Palliative Care teams need to be ready for the new financial realities of hospitals:**

- Hospital operating margins will shrink leading to the potential for:
- Less discretionary funding
- Hiring freezes
- Bed closure and staff layoffs
- Reduction in capital for building projects, increasing pressure on existing bed capacity
- Reluctance to embark on projects where immediate cost benefit is not apparent

**Palliative Care programs can help hospitals meet these challenges through:**

- Cost avoidance— Morrison RS et al. Arch Int Med 2008;168;1783-90.
- According to this study of eight very different hospitals:
- Hospitals saved from $279 to $374 per day per palliative care patient
- Hospitals saved $1700 to $4900 on each admission of a palliative care patient
- Significant reductions in pharmacy, laboratory and intensive care costs means savings > $1.3 million/yr for a 300-bed community hospitals
- $2.5 million/yr for the average academic medical center
- Improved through-put, especially in ICU, where LOS issues will be a major problem due to reduced hospital bed capacity - see these articles and others at http://www.capc.org/research-and-references-for-palliative-care/.
- Campbell ML. Palliative care consultation in the intensive care unit. CCM 2006;34:S355-8.also Chest 2003;123:266-71.
- Norton SA. Proactive palliative care in the ICU CCM 2007;35:1530-5.
- Integrating palliative care services starting into the emergency department and outpatient clinics for patient at risk for high cost/lengthy hospitalizations/high morbidity.

## Making the Case for Palliative Care

1. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). The SUPPORT Principal Investigators. JAMA 1995;274:1591-8.
2. Covinsky KE, Eng C, Lui LY, Sands LP, Yaffe K. The last 2 years of life: functional trajectories of frail older people. J Am Geriatr Soc 2003;51:492-8.
3. Desbiens NA, Wu AW. Pain and suffering in seriously ill hospitalized patients. J Am Geriatr Soc 2000;48:S183-6.
4. Goldsmith B, Dietrich J, Du Q, Morrison RS. Variability in access to hospital palliative care in the United States. J Palliat Med 2008;11:1094-102.
5. Hoover DR, Crystal S, Kumar R, Sambamoorthi U, Cantor JC. Medical expenditures during the last year of life: findings from the 1992-1996 Medicare current beneficiary survey. Health Serv Res 2002;37:1625-42.
6. Miller FG, Fins JJ. A proposal to restructure hospital care for dying patients. N Engl J Med 1996;334:1740-2.
7. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. JAMA 1999;281:163-8.
8. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. JAMA 2000;284:2476-82.
9. van Staa AL, Visser A, van der Zouwe N. Caring for caregivers: experiences and evaluation of interventions for a palliative care team. Patient Educ Couns 2000;41:93-105.

## Data on the Impact of Palliative Care Services

1. Abrahm JL, Callahan J, Rossetti K, Pierre L. The impact of a hospice consultation team on the care of veterans with advanced cancer. J Pain Symptom Manage 1996;12:23-31.
2. Back AL, Li YF, Sales AE. Impact of palliative care case management on resource use by patients dying of cancer at a Veterans Affairs medical center. J Palliat Med 2005;8:26-35.
3. Bendaly EA, Groves J, Juliar B, Gramelspacher GP. Financial impact of palliative care consultation in a public hospital. J Palliat Med 2008;11:1304-8.
4. Bruera E, Neumann CM, Gagnon B, Brenneis C, Quan H, Hanson J. The impact of a regional palliative care program on the cost of palliative care delivery. J Palliat Med 2000;3:181-6.
5. Brumley R, Enguidanos S, Jamison P, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. J Am Geriatr Soc 2007;55:993-1000.
6. Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med 2008;11:180-90.
7. Higginson IJ, Finlay IG, Goodwin DM, et al. Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? J Pain Symptom Manage 2003;25:150-68.
8. Penrod JD, Deb P, Luhrs C, et al. Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. J Palliat Med 2006;9:855-60.
9. Smith TJ, Coyne P, Cassel B, Penberthy L, Hopson A, Hager MA. A high-volume specialist palliative care unit and team may reduce in-hospital end-of-life care costs. J Palliat Med 2003;6:699-705.
10. White KR, Stover KG, Cassel JB, Smith TJ. Nonclinical outcomes of hospital-based palliative care. J Healthc Manag 2006;51:260,73; discussion 273-4.

# COLORADO CENTER *for* HOSPICE & PALLIATIVE CARE

**Colorado Hospice Inpatient Facilities (N= 10)**
**7/8/09**

**Centura: Porter Hospice at the Johnson Center (Multiple Location)**
Erin Denholm
Administrator / CEO
5020 East Arapahoe Road
Centennial, CO 80122
P: 303-694-3545
E:

**Exempla Lutheran Hospice at Collier Hospice Center**
Pat Archer RN BSN MA
Administrator / Hospice Director
3210 Lutheran Pkwy.
Wheat Ridge, CO 80033
P: 303-425-8000
E: archerp@exempla.org

**Hospice & Palliative Care of Northern Colorado**
Rod McFain
Executive Director
2726 West 11th Street Road
Greeley, CO 80634-3408
P: 970-352-8487
E: rmcfain@hpcnc.org

**Hospice & Palliative Care of Western Colorado**
Christy Whitney RN MS
Administrator / President & CEO
PO Box 60307; 3090-B North 12th Street
Grand Junction, CO 81506
P: 970-241-2212
E: cwhitney@hospicewco.com

**Hospice of Larimer County dba Pathways Hospice**
Evan Hyatt
CEO
305 Carpenter Road
Fort Collins, CO 80525
P: 970-663-3500
E: evan.hyatt@pathways-care.org

**Hospice of Saint John - Lakewood**
Steven Cooper OSJ
President/CEO
1320 Everett Court
Lakewood, CO 80215
P: 303-232-7900
E: scooper@hospiceofsaintjohn.org

**HospiceCare of Boulder and Broomfield Counties**
Darla Schueth BSN MBA
Executive Director
2594 Trailridge Drive East; Ste. A
Lafayette, CO 80026
P: 303-449-7740
E: darlaschueth@hospicecareonline.org

**Pikes Peak Hospice & Palliative Care**
Martha Barton
Administrator / President & CEO
825 East Pikes Peak Ave.; Ste. 600
Colorado Springs, CO 80903-3631
P: 719-633-3400
E: mbarton@pikespeakhospice.org

**Sangre de Cristo Hospice & Palliative Care**
Joni Fair BS
President/CEO
1207 Pueblo Blvd. Way
Pueblo, CO 81005
P: 719-542-0032
E: jfair@sangredecristohospice.org

**The Denver Hospice**
Bev Sloan
Administrator / President and CEO
501 South Cherry Street; Ste. 700
Denver, CO 80246-1328
P: 303-321-2828
E: bsloan@denverhospice.org