The Florida Hospice Model

PRESERVATION OF ACCESS AND QUALITY

Prepared by

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Executive Summary

The State of Florida has developed a Certificate of Need (CON) process for promoting orderly growth in the number of providers of hospice care for the terminally ill. One of 12 states that regulate hospice industry growth via CON, Florida uses a numeric methodology to determine the unmet need for hospice care in 27 geographical hospice service areas, while also recognizing demonstrated needs of specific population groups within those service areas.

Under this regulatory structure, Florida has evolved a model of hospice delivery that provides ready access to care, enhanced quality of care, and a variety of community services for the dying and bereaved, beyond what is required by Medicare and state hospice licensure regulations.

This position paper examines the connection between Florida's CON program for hospices and the development of its nationally respected model of hospice care. Promoting the growth of hospice programs in response to identified unmet needs – rather than allowing uncontrolled proliferation of hospice providers, as has occurred in other states – has been an essential cornerstone in building the Florida Hospice Model. In addition, the model has limited the incidence of fraud and abuse, and it ensures accountability of Florida hospices to state regulatory agencies and the communities served by the Florida hospice industry.

A close examination of hospice service utilization and quality data for Florida, in comparison with national averages and the experience of its three closest neighbors, Georgia, Alabama and Mississippi, demonstrates significant negative consequences from uncontrolled proliferation of hospice providers, when compared to the orderly growth of hospice care in Florida.

Loss of hospice CON in Florida would result in significant, uncontrolled proliferation of hospice programs and providers within the state through excessive provider supply. Hospice program supply, which has grown substantially to effectively meet the needs of Florida's terminally ill population during the past fifteen years, could be expected to increase as much as three-fold. Within just a few years, the number of Florida hospice programs could reasonably be expected to increase, absent Florida's CON program, from the current level of 68 licensed or approved programs to as many as 200.

The inevitable result, based upon the objective evidence and experience discussed in this paper, would be: 1) reduced access to care; 2) less intensive and comprehensive hospice services; 3) less investment by hospices in direct patient care; 4) generally diminished quality of care; 5) substantially increased fraud and abuse; and, 6) substantially greater workload for Florida's regulatory agencies, with resulting decreases in oversight and accountability to the communities served.

Acknowledgements

This position paper was a collaborative effort and reflects information gathered by Health Management Associates (HMA), a national health care consulting firm, from a number of sources, which are cited formally throughout the document, with input from a number of leading Florida hospice providers. Input and editing was also provided by nationally recognized End-of-Life Editor and Writer, Larry Beresford. Data compilation and analysis was provided by Jay D. Cushman, Health Planning and Development, LLC, Portland, Oregon. These sources, when considered together, provide a comprehensive picture of Florida's Hospice Model and CON program benefits.

Background

Hospice care consists of a comprehensive set of services provided to terminally ill patients and their families during the last months of life. Hospice services are accessed as an alternative to conventional medical care at a time when curative treatments offer decreasing benefits. The primary purpose of hospice is to provide medical, psychosocial, and spiritual care to terminally ill patients and their families in order to help them cope with all of the manifestations of life-limiting illness. Medicare and Medicaid beneficiaries who elect to receive hospice care choose to forego curative treatments, opting instead for hospice's medical and supportive care focused on relief of symptoms, promotion of comfort, and maximizing quality of life at a time when its duration is known to be limited.

Terminally ill persons choose hospice services for a number of reasons, including a desire to have their pain and symptoms more effectively controlled and to maintain their dignity and personal autonomy despite the challenges of living with a terminal illness. As a result, hospice patients often are able to avoid emergency room visits, hospital stays and admissions to nursing homes; and, in many cases, remain comfortably in their homes until the end of their lives. They may receive hospice care in a private residence, nursing home, assisted living facility or any other setting they call home. Hospice care is provided by an interdisciplinary team of professionals, and includes case management and coordination of care and services related to the terminal disease or condition of the patient.

Hospice care became a covered benefit under Medicare by a 1982 Act of Congress because it was viewed as a humane response to the complex needs experienced by dying patients and their families, as well as being a cost effective alternative to conventional medical care. Today there are over 3,000 Medicare-certified hospices in the United States.[1] As the Medicare Payment Advisory Commission's recent report on hospice care[2] notes, "The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package; it was a statement recognizing and respecting social values and patient preferences at the end of life."

Hospice Care Coverage

Hospice care is covered by Medicare, by most private insurance programs and, in 48 states plus the District of Columbia, by Medicaid. However, Medicare remains the primary funding source, paying for 87% of all hospice care. (See Table 1 for a summary of hospice payer sources.)

[1] Hospice Association of America. Hospice Facts and Statistics. March 2008.

[2] Medicare Payment Advisory Commission, Report to the Congress, Chapter 6, Reforming Medicare's Hospice Benefit, pp. 3, March 2009.

Because Medicare is the dominant payer for hospice care, much of the statistical analysis that follows is based exclusively upon Medicare patients.

Payer	2007	2006
Hospice Medicare Benefit	87 .0%	87 .7%
Private Insurance	4 .8%	5 .3%
Hospice Medicaid Benefit	4 .5%	4 .8%
Other Payment Sources	3 .7%	2 .2%
Source: Hospice Care in America. National Hospice and Palliative Care Organization. Released October 2008.		

Table 1: Percentage of Patient Care Days by Payer

In 2006, over 1.3 million Americans received hospice care[3] and more than 935,000 of them received Medicare-funded hospice services.[4] In Florida, more than 89,000 persons received Medicare-funded hospice care in state fiscal year 2006. Some individuals are eligible for both Medicare and Medicaid benefits and, in Florida, approximately 9,700 Medicare enrollees receiving Medicare hospice benefits also received Medicaid-funded hospice care, which was primarily payment for nursing home room and board. Another 5,900 persons not eligible for Medicare, who were primarily persons under 65 years of age, received Medicaid-funded hospice care only.[5]

Hospice patients are predominantly 65 years or older, with this age group comprising almost 83% of all hospice patients nationwide in 2006, and 70% of Floridians receiving Medicaid-funded hospice care (almost all of them dually eligible for Medicare and Medicaid).[6]

Eligibility for Hospice Care

Individuals diagnosed with a terminal illness and who have a medically determined life expectancy of six months or less, if their illness runs its normal course, are eligible to

[3] Hospice Care in America. National Hospice and Palliative Care Organization. Released October 2008.

[4] National Medicare and Florida Medicare-only data from: Medicare Hospice Utilization by State, 2006. Centers for Medicare and Medicaid Services. Florida Medicare/Medicaid and Medicaid-only data from: Analysts at the State Data Center on Aging, University of South Florida, generated 2008. Note: data from different data sources are generated at different points in time using different methodologies and, therefore, are generally representative of utilization by payor source but should not be considered accurate for other purposes.

[5] Ibid.

[6] Ibid.

receive Medicare or Florida Medicaid hospice services. Certification by two physicians of a prognosis of six months or less to live, while sometimes difficult to determine, remains an essential prerequisite for hospice care under Medicare and in Florida, under Medicaid as well[7].

The beneficiary is certified as hospice eligible for an initial 90-day period. When this period is exhausted, an eligible beneficiary may be recertified for a second 90-day period. After this second 90-day period, the patient must be recertified as still eligible for hospice care by a physician every 60 days in order to continue receiving Medicare hospice coverage. Patients may choose to revoke their hospice benefit at any time and resume regular Medicare or Medicaid coverage. They may then choose to re-elect their hospice benefit at a later date.

Scope of Services

Hospice care includes services that are reasonable and necessary for the comfort and management of a terminal illness. These services include:

- Case management and coordination of care and services related to the terminal disease or condition;
- Physician services;
- Nursing care;
- Physical therapy, occupational therapy and speech-language pathology services;
- Medical social services;
- Home health aide services;
- Homemaker services;
- Medical supplies;
- Drugs and biologicals;
- Medical appliances and equipment;
- Counseling of the patient, including psychosocial and spiritual counseling, dietary counseling, counseling of the family regarding care of the terminally ill patient and bereavement counseling; and
- Short-term inpatient care for respite, pain control and symptom management.

Medicaid hospice services and coverage mirror those available under the Medicare hospice benefit. Medicare and Medicaid both pay a daily, all-inclusive rate designed to cover all care and services necessary to manage a terminal illness for each day the beneficiary is enrolled in hospice. This per-diem rate obligates the hospice to provide

[7] Pursuant to Florida law, §400.601(10), F.S., in Florida a terminally ill person with a prognosis of one year or less is eligible for admission to hospice. However, as indicated herein, Medicaid or Medicare reimbursement for care provided is available only for those patients with prognosis of six (6) months or less.

needed services such as visits by nurses, aides, chaplains and social workers, as well as hospital care when needed, such as radiation therapy or chemotherapy, durable medical equipment, lab tests and other medical tests such as a MRI. Medicaid per-diem reimbursement rates for hospice care statutorily mirror what Medicare pays for each category of care: routine home care, continuous home care, general inpatient care and inpatient respite care.

- **Routine home care:** Routine home care is the level of care provided when the patient is in need of general care and support, and the patient's pain and symptoms can be managed through intermittent visits by hospice staff. Routine home care is provided where the beneficiary resides. That may be a home, nursing home, assisted living facility or other residential setting. Routine home care includes the full array of hospice services – scheduled visits from nurses, aides, chaplains and social workers, palliative medications related to the terminal illness, and durable medical equipment such as hospital beds, wheelchairs or oxygen. It also includes 24-hour availability of *on-call* hospice team members to respond after hours to crises, changes in care needs, and other unplanned interventions.
- **Continuous home care**: Continuous home care is the level of care provided where the beneficiary resides during a period of medical crisis. During such time-limited periods of crisis, the hospice team can provide continuous care up to 24 hours per day. Continuous home care is paid at a per-hour rate when eight or more hours of predominantly nursing care are needed on a continuous basis during a 24-hour period.
- **General inpatient care**: General inpatient care is the level of care provided when more intensive care is needed to control pain and other symptoms which cannot be managed safely in the patient's place of residence. In such cases, the patient's care is managed in an inpatient facility until the condition is stabilized or the patient dies. General inpatient care can be provided in a freestanding inpatient hospice facility, or in a Medicare-certified hospital or nursing home.
- **Inpatient respite care:** Inpatient respite care is the level of care provided to reduce stress of the primary caregiver, usually a family member, by providing the caregiver a brief period of respite from responsibilities. Access to respite care increases the likelihood that a family caregiver will remain able to fulfill this function and that a hospice patient can continue to receive care at home. Inpatient respite care may be provided in the same settings as general inpatient care, as discussed above. It is available for up to five consecutive days.

Nursing Homes and Hospice Care

Hospice coverage is also available for eligible Medicare and Medicaid beneficiaries who reside in nursing homes. For beneficiaries dually eligible for Medicare and Medicaid, Medicare reimburses the hospice for hospice services and Medicaid pays the hospice for nursing home room-and-board services, which the hospice then pays on a contractual basis to the nursing home providing the room-and-board services. Medicaid pays for the nursing home's room-and-board services just as it would were the beneficiary not also receiving hospice services. This structure is required by federal law and the payment passes through the hospice as the party responsible for managing and coordinating the hospice patient's plan of care. However, in this circumstance, the room-and-board rate is reduced to 95% of the prevailing Medicaid rate for the resident's nursing home.

For nursing home residents eligible for Medicaid but not eligible for Medicare, Medicaid reimburses the hospice both for hospice services and for room-and-board services provided by the nursing home – again, just as it would if the resident were not receiving hospice services – and the hospice passes the room-and-board payment on to the contracting nursing home.

Nursing home-based hospice care includes the provision of additional nursing care and visits, enhanced personal care and visits, additional physician services including direct patient care and palliative consultation with nursing staff, and ancillary therapies such as music therapy, massage therapy and art therapy. These additional services are critical to terminally ill patients and their families, providing psycho-social support and palliative symptom management beyond those routinely provided by a nursing home. In addition, hospices make available more intensive care, such as continuous care, which allows the patient to remain in the nursing home during periods of critical symptom management, rather than having to be relocated to a hospital or other inpatient setting. In addition, hospice care includes bereavement services for the patient and family system, continuing for a year or longer after death, and includes psycho-social support to the nursing home caregivers.

There is some confusion about this complex payment mechanism, which simultaneously covers hospice care and nursing home room-and-board services for eligible residents of nursing homes, and even some concern that hospice services and nursing home services are duplicative. However, the arrangement was developed by Congress, which determined in 1986 that terminally ill residents of nursing homes and other long-term care facilities should be equally eligible to receive comprehensive hospice care as those who continue to reside in private homes. This mechanism permits the provision of hospice's coordinated team approach to terminal care and case management while allowing long-term care facility residents to remain in the setting that has become their home until they die.

Thus, for hospice patients residing in a nursing home, the nursing home provides room and board, which includes personal and caregiver services, and the hospice provides the special professional care and management needed to manage the resident's terminal condition and maintains responsibility for coordinating the nursing home's services.

History of Certificate of Need

In 1974, Congress recognized the importance of a formal review process governing development of certain health care providers through passage of the National Health Planning and Resources Development Act of 1974. The Act mandated that all states establish a process requiring providers to obtain approval from a state health planning agency before beginning any major capital projects such as health facilities building expansions, purchase of costly medical equipment, or developing or expanding certain medical services. The Act also included federal funding for regional health planning agencies. At the time the Act was passed, there were already 25 state programs governing development of health care providers, referred to as Certificate of Need or CON programs. By 1978, 36 states had enacted CON programs.[8] The federal planning mandate was repealed in 1986, along with the related federal funding.[9]

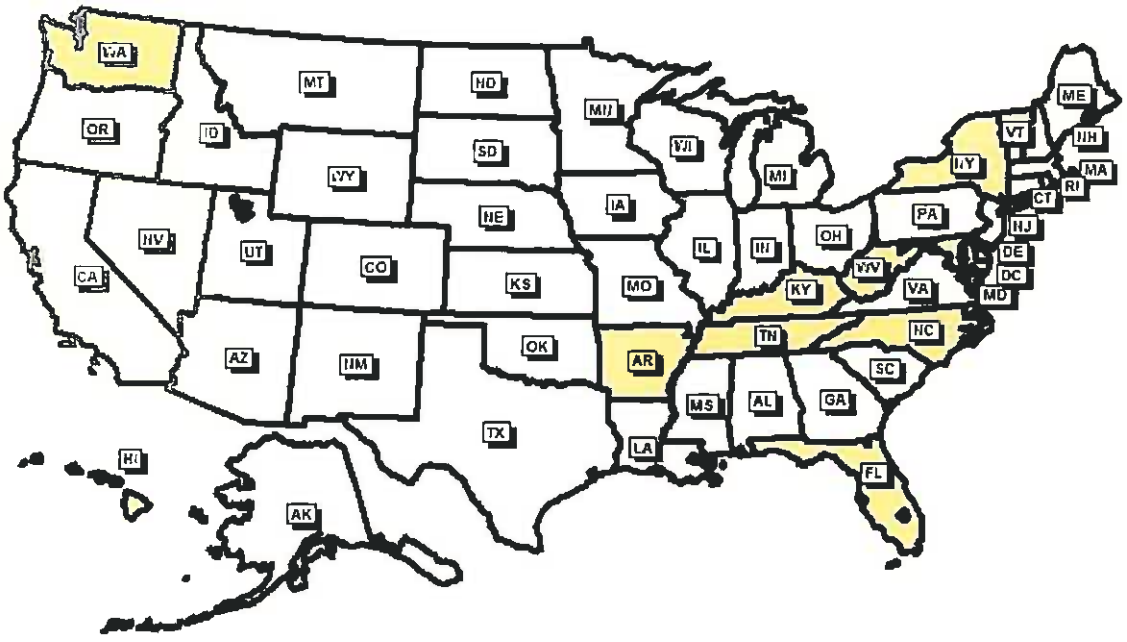

Figure 1: Eleven States with Hospice CON Requirements (yellow), February 2009

Between 1986 and 1997, a number of states implemented and/or dropped CON requirements, resulting in variation in the number of CON review programs in place. By 2006 the number of states with some form of a CON program regulating one or more

[8] National Conference of State Legislators. Certificate of Need: State Health Laws and Programs. August 21, 2008.

[9] Paul E. Parker. "Certificate of Need Regulation – A National Overview." Presentation to the Illinois Task Force on Health Planning Reform. March 10, 2008.

types of health care providers had returned to the 1978 number (36). The number of states with CON programs for hospice is 12 in 2009.[10]

Florida's Certificate of Need for Hospice Care

Florida's CON statute currently requires that any new hospice program, or any existing hospice program seeking to expand operations into a new service area, must obtain a CON from the Agency for Health Care Administration (AHCA), the state agency primarily responsible for regulating Florida's hospices and other health facilities, before it may be licensed to operate as a hospice in Florida.

Florida's CON program was enacted in 1973 and at that time regulated only hospitals and nursing homes. Hospices, and other provider types, were subjected to CON review beginning in 1980.[11] The CON program is established by and set out in Florida Statutes, Chapter 408, Part I, entitled "Health Facility and Services Planning," and in Chapter 59C, Florida Administrative Code.

Prior to 1990, the hospice CON rule regulated only the establishment of inpatient hospice beds and was deemed by AHCA to be "ineffective in controlling the increase in the number of hospices." In that year, the Florida CON program promulgated a more extensive rule regulating the establishment of new hospice programs in addition to inpatient hospice beds. In 1994, a rule change was enacted to update the hospice need methodology recognizing such planning factors as number of persons under age 65, non-cancer deaths and trends in hospice utilization.

The CON process, according to AHCA: "... is intended to help ensure that new services proposed by health care providers are needed for quality patient care within a particular region or community. The program prevents unnecessary duplication of services by selecting the best proposal among competing applicants who wish to provide a particular health service."[12] Specific objectives of the CON process are:[13]

- Preventing unnecessary capital expenditures;
- Avoiding duplication of expensive health services;
- Selecting providers with a proven quality of care record;

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[10] These states are: Arkansas, Florida, Hawaii, Kentucky, Maryland, New York, North Carolina, Tennessee, Washington, West Virginia and Vermont. In addition, the Alabama Legislature reenacted CON review of hospice programs pursuant to Act 2009-492, effective May 13, 2009.

[11] Interim Report of the Florida Certificate of Need Workgroup. December 2001. Page 9.

[12] Agency for Health Care Administration. Certificate of Need Program Overview Internet page. Accessed November 5, 2008 at: http://ahca.myflorida.com/MCHQ/CON_FA/index.shtml.

[13] Interim Report of the Florida Certificate of Need Workgroup. December 2001. Page 1.

- Evaluating impact of new providers on existing providers;
- Providing access to services by predicating CON approval on serving indigent and other underserved persons; and
- Evaluating more cost-effective service alternatives.

In hospice care, these objectives are achieved by limiting the development of new hospice programs to those service areas where access to and quality of hospice services are insufficient to meet the end-of-life care needs of the community.

Certificate of Need Procedures

Florida's hospice CON process was designed to provide an objective, numeric methodology for determining need for the development of additional hospice programs when the existing hospice providers in a specific service area are not meeting the needs of the terminally ill population. In determining need for hospice programs, AHCA uses the criteria specified in Rule 59C-1.0355(4), F.A.C., which include demographics, such as the projected numbers of cancer deaths and other deaths, service use patterns and trends, geographic accessibility to hospice services, and market economics.[14]

AHCA is required to determine the need for hospices and subsequently to publish this need (the fixed need pool) twice annually, based on service data submitted by hospices and on cancer and non-cancer death rates. For CON and planning purposes, the State of Florida is divided into 27 hospice service areas (see map on page 16; Figure 2). AHCA calculates need for each service area based on a numeric need methodology set forth in administrative rules promulgated in accordance with Florida's Administrative Procedures Act, Chapter 120 F.S.

However, a hospice provider may apply for a CON even if AHCA's numeric need methodology does not project need sufficient to justify a new hospice program. In that case, the applicant would need to provide documentation of a special need for hospice services, such as for a new hospice program to provide care to an "underserved" population. This could include underserved localities within a designated service area or underserved populations, for example, African Americans or other minority groups.[15]

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[14] Health Council of East Central Florida Brief. "Understanding Florida's Certificate of Need Program." Revised April 2007.

[15] Office of Program Policy Analysis & Government Accountability. "Florida's Certificate of Need Process Ensures Qualified Hospice Programs; Performance Reporting Is Important to Assess Hospice Quality." Report No. 06-29. March 2006. Page 2, footnote 8. Also see, Rule 59C-1.0355(4)(d), F.A.C.

Under current procedures, a new hospice program applicant must submit an application for a CON to AHCA. The application must include sufficient information to enable AHCA to determine if:

- There is a need for the project as evidenced by the availability, quality of care, efficiency, accessibility and extent of utilization of existing health care facilities and health services in the applicant's service area;
- The applicant has a history of providing quality of care;
- The applicant has the resources, including health manpower, management personnel and funds for capital and operating expenditures, sufficient for project accomplishment and operation;
- The proposal is financially feasible over both the short and long term;
- The proposed project fosters competition to promote quality and cost-effectiveness;
- The proposed costs and methods of construction are reasonable; and
- The applicant has a history of, and plans to continue, providing health services to Medicaid patients and the medically indigent.

Florida Hospice Model

Florida's hospice service delivery model is primarily a product of its hospice CON process. Florida's hospice providers have relatively large census and are primarily community-based, not-for-profit corporations. The typical Florida hospice was initially formed by community leaders and volunteers in response to recognized unmet needs within their community. These hospices were, and continue to be, committed to improving the end-of-life experience of terminally ill persons and their families through provision of the Medicare hospice benefit and by alternate forms of community service such as community grief support programs and other additional services.

Under the state's CON process, Florida has developed a hospice service model that has resulted in levels of hospice access and quality of care that are among the best in the nation. That is not to suggest that any regulatory approach to CON would achieve the same results, but since 1990 Florida has operated a well-conceived, periodically adjusted and consistently applied CON program for hospice. This process has allowed for reasonable and appropriate growth in the supply of hospice providers sufficient to meet the needs of the state's terminally ill population. In 2009, Florida has a total of 68 licensed or approved hospice programs authorized to operate in the 27 designated service areas. (See Figure 2.) The CON program has worked to prevent uncontrolled proliferation of hospices by requiring any new hospice provider (or existing hospice seeking authority to expand its services to include an additional service area) to first obtain a CON from AHCA.

The Florida CON process has been evaluated several times and has been determined to help ensure that new hospice providers have the expertise, financial resources and commitment to meet the needs of their communities.[16] The evidence that follows supports the thesis that continued access to high-quality hospice care, as reflected in the Florida Hospice Model, requires continued review of hospice need, as in the current CON process in place in the state.

[16] Office of Program Policy Analysis & Government Accountability. "Florida's Certificate of Need Process Ensures Qualified Hospice Programs; Performance Reporting Is Important to Assess Hospice Quality." Report No. 06-29. March 2006. Page 2, footnote 8.

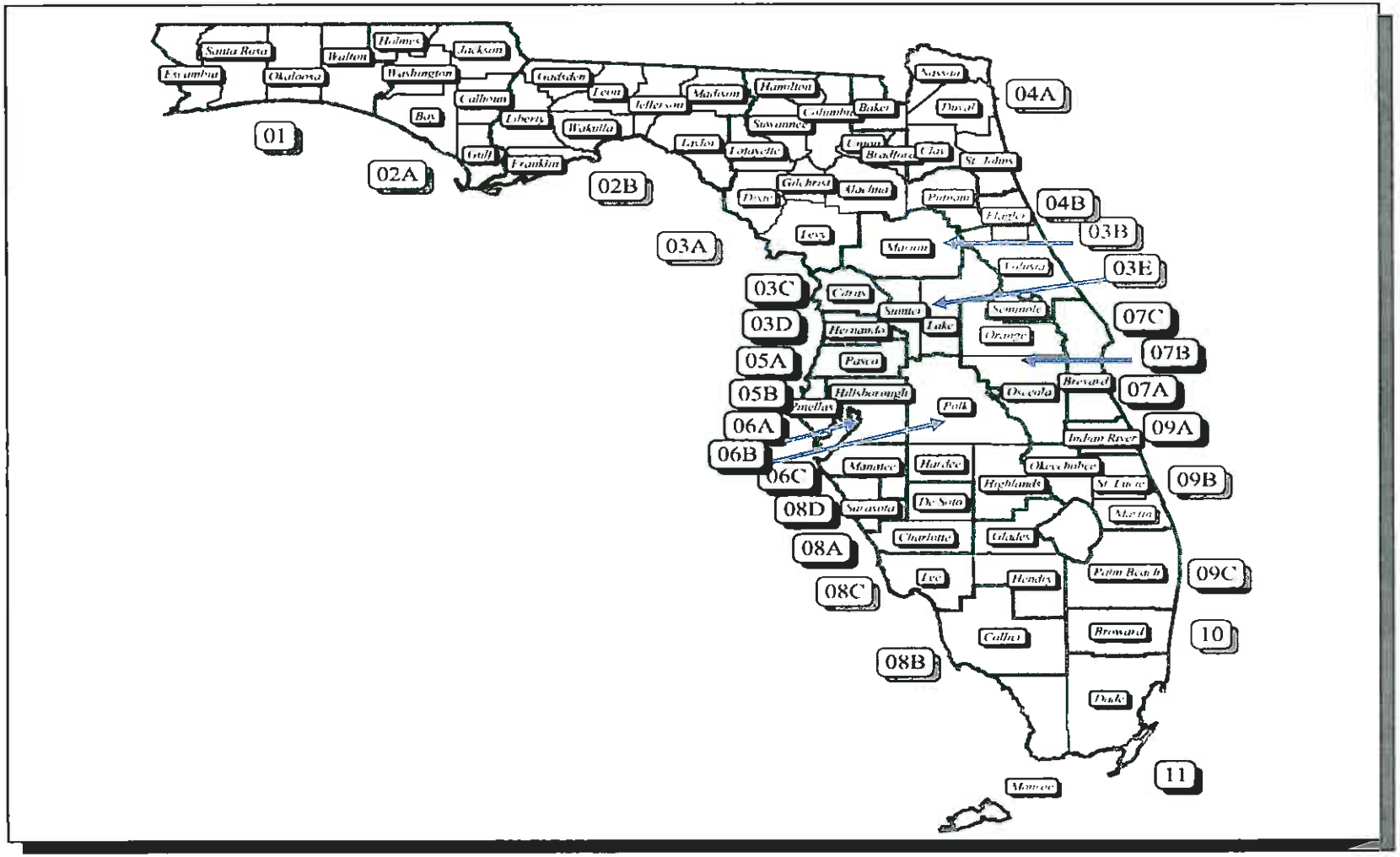

Figure 2: AHCA Hospice Service Areas

Potential Impact of Loss of Florida's Hospice CON

Florida's hospice regulation, including its CON program, has resulted in the development of hospices that provide a level of access and quality of care generally considered among the best in the nation. As will be demonstrated in the data outlined below, loss of hospice CON in Florida would likely result in a dramatic, uncontrolled proliferation of hospice programs and providers, and the development of excess provider supply, with resulting potential adverse impact on access and quality of care. Hospice program supply, which has grown substantially during the past 15 years since implementation of AHCA's current CON methodology to effectively meet the documented needs of Florida's terminally ill population, could be expected to increase as much as three-fold, resulting in unnecessary duplication of providers.

Based upon data and analysis presented herein, within just a few years after repeal of CON for hospice, the number of Florida hospice programs could reasonably be expected to increase from the current level of 68 licensed or approved programs to as many as 200. The inevitable result, based upon the objective evidence and experience discussed in this paper, would be: diminished access to care; less intensive and comprehensive hospice services; less investment by hospices in direct patient care; generally diminished quality of care; substantially increased incidence of fraud and abuse; and substantially greater workload for state regulatory agencies, resulting in decreased oversight and accountability to the communities served. These are all manifestations of uncontrolled hospice industry growth and development in states lacking Florida's approach to CON and planned growth, as will be demonstrated in the charts and graphs on the following pages.

Florida's CON program has supported the development of larger hospices, relative to states without a hospice CON requirement. The typical service area of a Florida hospice is a dominant city or town along with several small towns or communities, thus covering a single primary media market or metropolitan area. Prior to the passage of HB 1417 by the Florida legislature in 2006, Florida hospices were required to be not-for-profit corporations, except for those grandfathered in under the original state hospice licensure law. Thus, Florida hospices characteristically were relatively large, not-for-profit community-based organizations serving a single service area.

The Florida CON program has been effective in improving access to quality hospice care by creating a set of incentives for managers, administrators and leaders of hospices in Florida. With the twice-yearly publication of comprehensive utilization and death data for each of the state's 27 hospice service areas, the leaders of each Florida hospice program are given a snapshot of their organization's success in providing access to care relative to other hospices and other hospice service areas in the state. This picture provides a powerful incentive for each hospice to constantly work to increase its access and quality relative to its peers in the same and other

hospice service areas. Florida hospices know that failure to respond proactively to their community's need for access to quality end-of-life care will be identified in the twice-yearly CON calculations.

Various organizations have reviewed the success of Florida's hospice CON process since its implementation. The Florida CON Workgroup, a task force convened by Governor Jeb Bush in 2001 to review certificate of need regulation in Florida, which completed its work in 2002, recommended continued regulation of new hospice programs through CON review. Florida's Office of Program Policy Analysis and Governmental Accountability (OPPAGA), in its 2006 report, recommended that should the State Legislature decide to amend Florida laws to allow for development and licensure of for-profit hospice programs, it should simultaneously retain the requirement that new hospice programs be subject to CON review. In addition, OPPAGA found that the CON process ensures that new hospice providers have the expertise, financial resources and commitment to meet the needs of their communities.

In response, the Florida Legislature in 2006 passed HB 1417, Chapter 2006-155, Laws of Florida, which permitted licensure of for-profit hospices and further provided that no other changes be made to Florida hospice licensure and CON laws until the year 2012, in order "to protect the citizens of the State" and allow an opportunity to "correctly analyze and evaluate the impact of the act on the quality of hospice care in the State."

Beneficial aspects of the Florida hospice regulatory model and the resulting Florida hospice provider model have been previously evaluated and documented in the Brown University study of Florida hospices published in 2004.[17] The Brown researchers found that there is a distinctive Florida Hospice Model characterized by hospices that: have relatively large patient census; provide effective community outreach; achieve high hospice penetration in their service areas; provide more comprehensive and intensive hospice services; provide significant levels of charity and Medicaid care; accept patients without regard to ability to pay for hospice services; and provide other charitable non-hospice services to their communities, such as bereavement counseling and crisis intervention.

The Brown study presents responses to a 2003 survey of Florida hospices, showing that 100% had at least one service or program targeting the community-at-large, beyond what was required for Medicare certification. It also found that while hospices that were the sole providers in their service areas were twice the size of other hospice providers in the state, they had on average three times as many volunteers and spent more than four times as much on charity care – two very tangible examples of how size matters in the Florida Hospice Model.

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[17] Miller, Susan C. Ph.D., and Lima, Julie, MPH, M.A., Center for Gerontology & Health Care Research, Brown University School of Medicine. The Florida Model of Hospice Care: A Report for Florida Hospices and Palliative Care, Inc. February 2004.

The 2006 OPPAGA report further documents the ancillary services provided by Florida hospices to patients, families and the community, reflecting their commitment to serving as comprehensive end-of-life resources for their community. (See OPPAGA data in Table 2.)

Commonly Offered Ancillary Services	Percentage of Programs Offering Service
Community Bereavement Programs	93%
Massage Therapy	63%
School Bereavement Programs	60%
Pet Therapy	58%
Community-Based Crisis Intervention	54%
Financial Assistance Programs	50%
Pre-Hospice Services	47%
Music Therapy	45%

Table 2: Ancillary services provided by Florida hospices

Consistent with the Florida Hospice Model, Florida hospices also support and contribute to extensive research and teaching activities to advance the state of the art in end-of-life care. These activities have included the development of and continuing involvement with The Center for Hospice, Palliative Care & End-of-Life Studies at the University of South Florida (USF), as one example. The Center is jointly sponsored by USF, the H. Lee Moffit Cancer Center and Research Institute, and four Florida hospices – Hope Hospice and Community Services, Inc., Suncoast Hospice, HPC-LifePath Hospice, and Tidewell Hospice and Palliative Care. The Center for Hospice, Palliative Care & End-of-Life Studies at USF unites a major research university with community providers of hospice and palliative care in an equal partnership aimed at influencing policy and practice through research and education. The Center began informally in 1996, and was formally recognized by USF in 2000. The Center brings together members from hospices across West Central Florida, H. Lee Moffitt Cancer Center and Research Institute, James A. Haley Veterans Medical Center, and the University of South Florida. By facilitating collaboration among experts in end-of-life care who represent multiple disciplines, the Center is able to generate cutting-edge research that addresses issues in hospice, palliative care and end-of-life studies from a comprehensive perspective. Many Florida hospices also maintain active teaching affiliations with universities and community colleges and thus participate in training the health care system work force of tomorrow. In these and other ways,

Florida hospices contribute to the development and continuing evolution of best practices and state-of-the-art hospice care across the nation.

Growth of Hospice Provider Supply

Florida's Certificate of Need and regulatory structure has allowed for moderate and appropriate growth in the number of hospice programs over the years. Specifically, the CON process authorized development of new hospice programs where the evidence established that the needs of the community were not currently being met. The number of licensed and/or approved hospice programs has grown from 44 in 1995 to 68 in 2009, an increase in the number of operating hospice programs of 55% during a period when the number of resident deaths in Florida increased by only 14%.

In 1989, the earliest date for which information is available, and prior to implementation of hospice CON, there were 34 licensed hospices in Florida. Twenty-five of those were independent; five were hospital-based; and four were based in home health agencies.[15] By 1995, there were 45 hospices and today there are 41 licensed hospice "entities" operating 64 hospice programs (with four additional programs licensed but not yet operating). Each hospice entity may operate more than one hospice program, but CONs are required for each hospice program. Therefore, a single hospice may hold several CONs, depending on the service areas and counties in which it operates.

[15] HMA review of files made available by the Agency for Health Care Administration. December 2008.

# of Licensed or Approved Hospice Programs	1995		2009	
	Service Areas	Programs	Service Areas	Programs
1	17	17	8	8
2	4	8	10	20
3	4	12	2	6
4	1	4	4	16
5	1	5	2	10
8	0	0	1	8
	27	46	27	68

Table 3: Hospice Program Distribution 1995 and 2009

Hospice program distribution by service area varies: in 2009 there are eight service areas with one hospice program each – less than half as many single hospice provider service areas as there were in 1995 – and one service area (Service Area 11) with eight hospice programs (see Table 3).

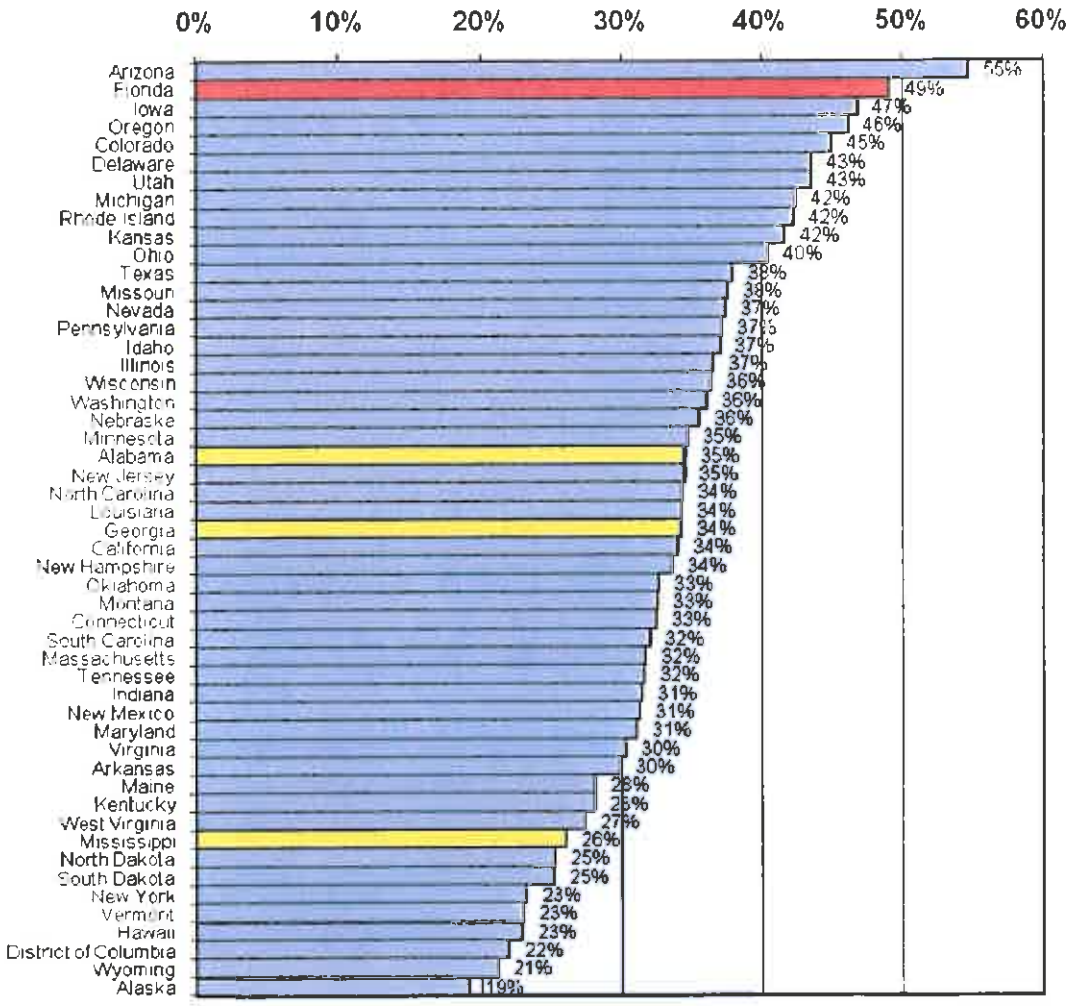
Access to Care and Hospice Penetration

Florida's hospice regulatory structure has been effective in fostering the development of a hospice service delivery system that ensures access to care and quality of care, the essential goals of any health care planning and regulatory process. The generally accepted measure of access to care for hospice services is *hospice penetration*, defined as the ratio of deaths under the care of hospice to the total number of deaths occurring in a given geographic area.

Hospice penetration is an important overall access measure, since it reflects how many terminally ill patients in a given geographical area were able to access and benefit from the support of hospice care as they were dying. Florida actually has the second highest hospice penetration rate of all 50 states[19] at about 49% (calculated as hospice deaths divided by total deaths for Medicare enrollees in 2007; see Figure 3). Only Arizona had a higher hospice penetration rate in 2007 (see Appendix II for a comparison of hospice penetration rates between Florida and Arizona).

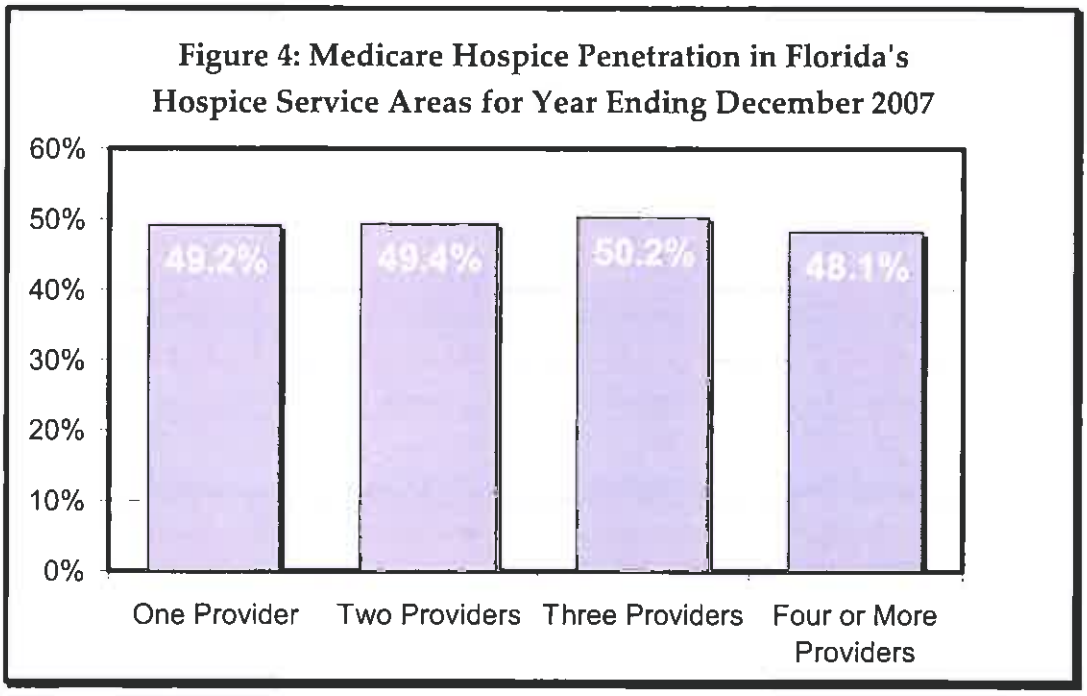
[19] Data analysis for tables 4-9 and figures 3-9 completed by Jay D. Cushman, Health Planning & Development, Portland, Oregon, based on Medicare Claims Data; Medicare Limited Data Sets, 2000-2007; and Medicare HCRIS Cost Reports for 2007.

Figure 3: Medicare Hospice Penetration in 2007: Hospice Deaths / Beneficiary Deaths



Increasing the number of hospices in a service area does not generally increase access to hospice care. Florida-specific data confirms that increasing the number of hospices in the state's service areas does not increase access to care for residents of the service area. For the year ending 2007, Florida hospice service areas with one provider had a Medicare penetration rate of 49.2%, while service areas with more than one provider had a penetration rate of 49.0% (see Figure 4.) In 2007, Miami-Dade and Monroe Counties (Service Area 11) had the greatest number of providers (seven) and a lower-than-average Medicare hospice penetration rate of 39%.

Figure 4: Medicare Hospice Penetration in Florida's Hospice Service Areas for Year Ending December 2007



State-level data, as well, demonstrate no apparent relationship between the supply of hospice providers and the rate of hospice penetration. That is, increasing the number of hospices operating in a service area fails to produce increased access or quality of service, perhaps because higher numbers of hospices, relative to the death rate, necessitate expending a greater proportion of each organization's resources on marketing and other competitive activities. For an illustration of this phenomenon, see Figure 5 depicting the 50 states and the District of Columbia for 2007. Each data point represents the supply of hospice providers and the Medicare hospice penetration for a single state. The supply of providers is measured along the horizontal axis as the number of providers per 1,000 Medicare deaths. The penetration rate measured along the vertical axis is the number of Medicare hospice deaths divided by total Medicare deaths for the state. The linear best fit line is nearly horizontal and shows that, at the state level, there is no statistical relationship between the supply of hospices and the hospice penetration rate.

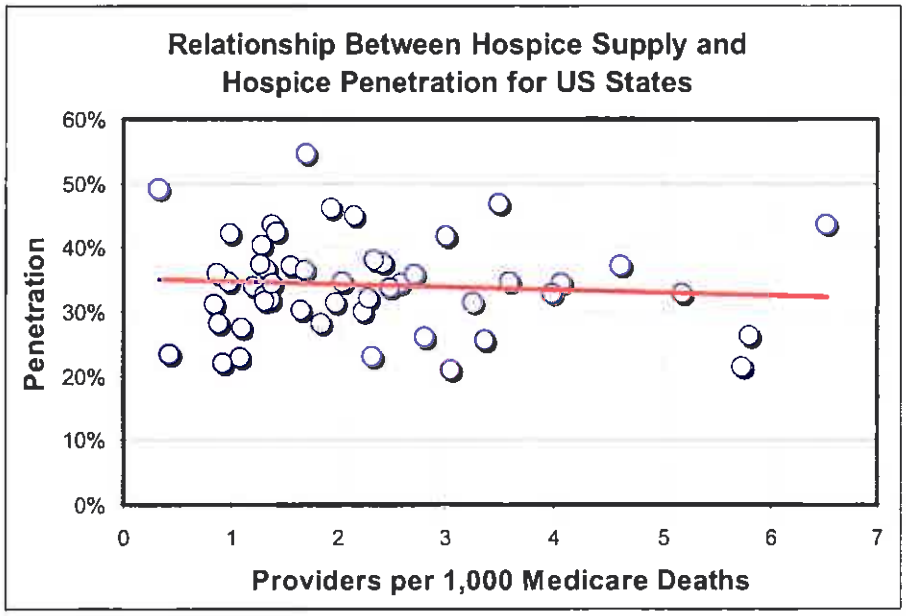


Figure 5: Lack of Statistical Relationship between Hospice Supply and Penetration

Florida's hospice utilization was compared with the national average and with the three closest states geographically – Georgia, Alabama and Mississippi – for purposes of further examining the relationship of hospice provider supply to the effective provision of hospice services as defined by hospice penetration and other measures. Table 4 and Figure 6 illustrate these comparisons both generally and for specific service delivery criteria.

The data show that the count of Medicare participating hospice providers increased in Florida by about 10% from 2000 to 2007, while in the neighboring states of Mississippi, Alabama and Georgia, the count of Medicare hospices increased by more than 100%. However, Florida's penetration rate increased more rapidly than the penetration rates of its three neighbors. This is particularly noteworthy given that a higher penetration rate is more difficult to increase than a low rate (i.e., more effort is required to increase a penetration rate from 34% to 49% than from 19% to 33%). Thus, while the supply of hospice providers remains lower in Florida, compared with its neighbors, the access to hospice services in Florida continues to be higher and to increase at a faster rate.

States	Number of Medicare Certified Hospice Providers		
	2000	2007	% Increase
Florida	39	43	10%
United States	2,224	3,211	44%
Mississippi	45	121	169%
Alabama	65	128	97%
Georgia	73	126	73%
Three State **Subtotal**	183	375	105%

States	Medicare Hospice Penetration		
	2000	2007	Increase
Florida	34%	49%	16%
United **States**	21%	36%	15%
Mississippi	13%	26%	13%
Alabama	20%	35%	14%
Georgia	21%	34%	14%
Three State Subtotal	19%	33%	14%

Table 4: Supply of hospice providers for 2000 and for 2007

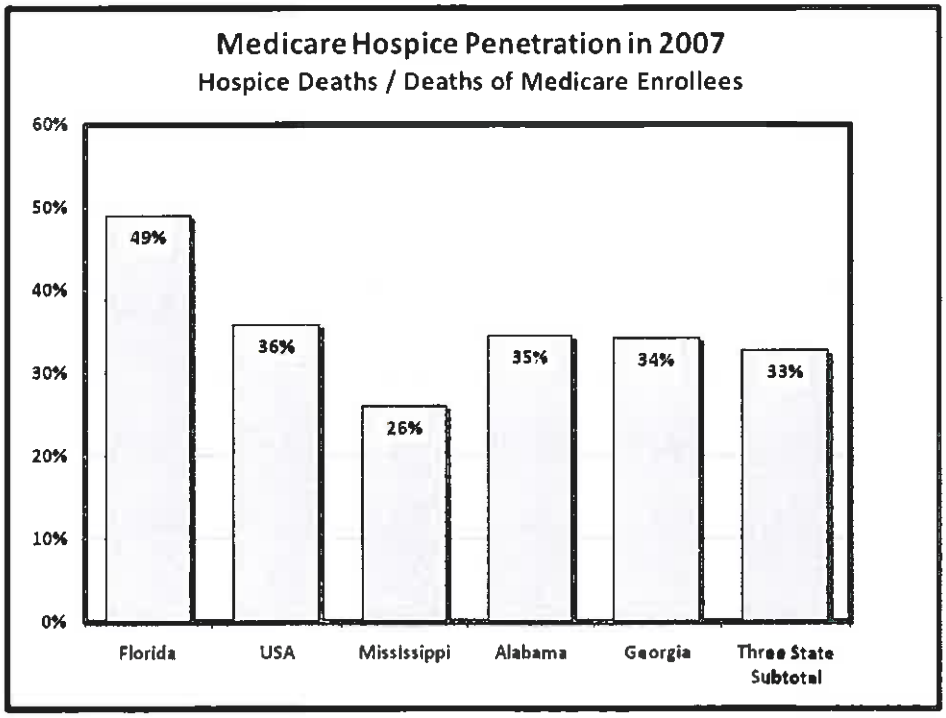


Figure 6: Medicare Hospice Penetration 2007

These comparisons highlight the important differences between Florida, with its robust and effective CON program, and its neighboring states (which collectively represent nearly equivalent numbers of total Medicare deaths), while demonstrating the negative consequences for access from uncontrolled proliferation of hospice programs in the absence of CON constraints.

These conclusions are confirmed by the Brown study described above, which further cites Light,[20] who argues that "pernicious competition" – i.e., competition arising from imperfectly competitive markets, where weaker parties can be exploited – creates a potential for market failure to cause harm to the community from poor quality of care. In hospital markets, the preponderance of research suggests that more provision of charity care for the poor occurs in markets with lower, rather than higher, rates of competition. Hospice is a classic example of the potential for pernicious competition, since neither the hospice concept nor indicators of hospice quality are widely understood by the public, and because dying patients generally access the service under stress, and thus are highly vulnerable to exploitation.

The data, both comparing Florida to neighboring states and national averages and, within the state, between service areas, clearly demonstrate that increasing the number of providers, relative to the dying population, does not result in increased access. However, there are other, more negative, consequences of the proliferation of providers, as will be outlined below. These include quality concerns such as inappropriate admissions, violations of Medicare's aggregate, per-patient ceiling on reimbursement, and provision of less care at the patient's bedside.

[20] Light, D. Cost containment and the backdraft of competition policies. *International Journal of Health Services;* 31 (4): 681-708, 2001.

Services to Persons Not Eligible for Hospice Care – Relation to Supply of Hospices

The uncontrolled proliferation of hospice providers in a state can have adverse consequences for the quality of hospice care delivered in the state. Medicare eligibility for hospice services is based on the presence of a terminal illness and a life expectancy of six months or less. Medicare patients must be re-certified as terminally ill each 60 days after two initial 90-day benefit periods. If a patient does not meet the eligibility criteria (even after a lengthy stay), that patient must be discharged alive from hospice care. This does not mean that patients automatically exhaust their hospice benefits after six months on service and must be discharged; only that they need to continue presenting with clinical evidence of a prognosis of six months or less to live in order to continue qualifying for hospice care, and if not, then they should be discharged.

States with a high supply of hospice providers tend to exhibit a higher rate of these live discharges. In the states with the highest supply of hospices, almost one-third of the Medicare patients who were discharged in 2006 were alive at the time of discharge, compared with Florida hospices, which have a live discharge rate below the national average. It may be reasonably inferred that in those states, a relatively higher proportion of patients were admitted who were not eligible for hospice care under Medicare guidelines. Some patients may be discharged simply because terminal disease does not always follow a normal trajectory. A patient may be discharged alive from hospice when that patient no longer desires hospice care or desires to switch hospices, or when the hospice decides the patient no longer meets the guidelines for terminal illness.

However, in states that have both dramatically higher live discharge rates and a higher-than-average supply of hospice providers (as shown in Table 5), the higher live discharge rate suggests evidence of an inability to meet patient needs or to comply with Medicare's patient eligibility guidelines for hospice care, and merits further study and analysis.

States	Medicare Hospice Patients Served in 2007	Live Discharges of Medicare Hospice Patients in 2007	Live Discharge Percentage for 2007
Florida	100,197	15,479	15%
United States	1,054,118	176,118	17%
Mississippi	18,052	7,858	44%
Alabama	30,864	10,765	35%
Georgia	31,304	7,997	26%
Three State Subtotal	80,220	26,620	33%

States	Medicare Hospice Patients Served in 2000	Live Discharges of Medicare Hospice Patients in 2000	Live Discharge Percentage for 2000
Florida	60,927	5,827	10%
United States	570,771	83,445	15%
Mississippi	6,651	2,248	34%
Alabama	12,391	2,528	20%
Georgia	15,374	2,711	18%
Three State Subtotal	34,416	7,487	22%

Table 5: 2007 Live Discharge Rate

The Medicare Payment Advisory Commission also found evidence of inappropriate utilization of the Medicare hospice benefit among some providers who admitted significant numbers of patients that MedPAC believed were not eligible for hospice care. In fact, MedPAC proposed in March of 2009 to reform the hospice payment system and require greater accountability from hospices. Regardless of the reasons, a higher live discharge rate is an indication of disruptions of services and interruptions in care for patients with life-threatening illnesses and their families – disruptions which the Medicare hospice benefit was intended to help prevent. More specifically, the data show:

- In 2007, the national average for live discharge rates was 17% – measured as live discharges among Medicare patients divided by Medicare patients served.
- For Florida the live discharge rate was just 15%.
- The live discharge rates for Georgia, Alabama and Mississippi were 26%, 35% and 44%, respectively. (See Table 6 and, for a graphic presentation of the live discharge data, Figure 7.)

2007	Florida	United States	Mississippi	Alabama	Georgia	3-State Total
Medicare Enrollment	3,285,590	45,440,759	492,842	830,035	1,169,638	2,492,515
Medicare Enrollee Deaths	131,513	1,875,451	20,861	35,630	48,805	105,296
Medicare Hospice Providers	43	3,211	121	128	126	375
Medicare Hospice Deaths	64,596	673,321	5,435	12,310	16,719	34,464
Medicare Hospice Penetration	49%	36%	26%	35%	34%	33%
Percentage (Live Discharge Rate)	15%	17%	44%	35%	26%	33%
% of Providers Over Medicare Cap (Est.)	**2%**	**8%**	**38%**	**28%**	**10%**	**25%**

Table 6: State Comparative Data (2007)

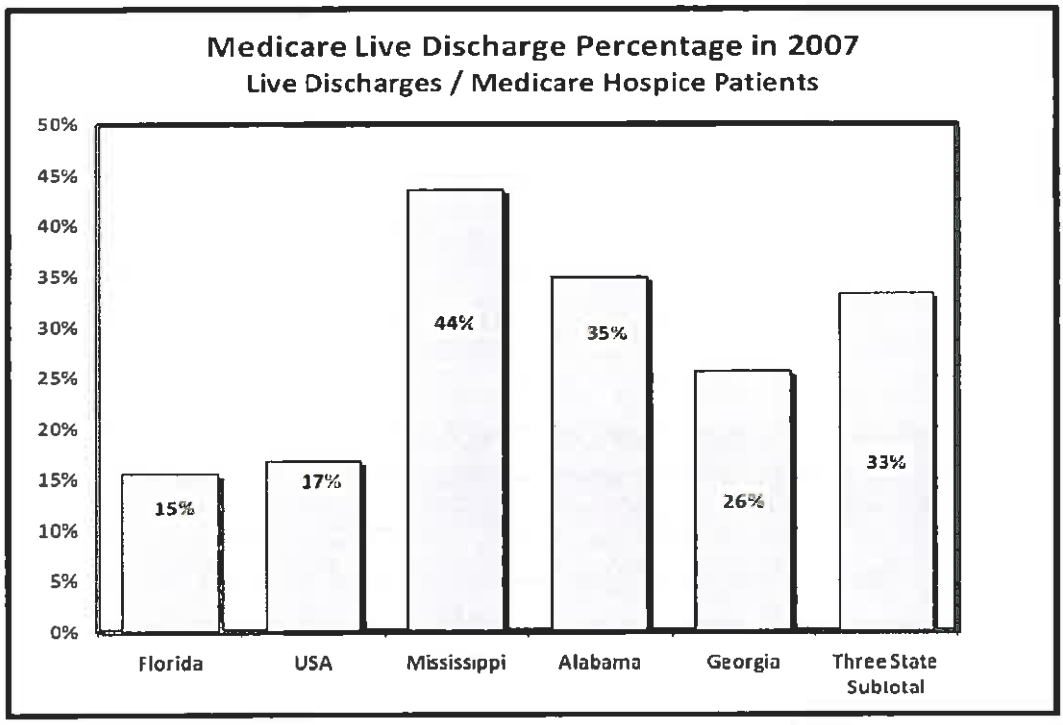


Figure 7: Live Discharge Rate

Overcharging Medicare for Hospice Services

Medicare has established a reimbursement cap that limits the total amount that it will pay a hospice program each year. This is a per-beneficiary, lifetime ceiling on hospice reimbursement, aggregated and averaged for all Medicare patients served by a particular hospice over the course of a year. The amount of the reimbursement cap for a particular provider is derived from the total number of beneficiaries served by the hospice who were not previously served by another Medicare-certified hospice. The purpose of the reimbursement cap is to ensure that the hospice benefit is cost-effective overall from the standpoint of the Medicare program.

If Medicare determines it has paid a hospice program more than is allowed by the reimbursement cap (i.e., more than the aggregated, average per-patient limit), the hospice program must pay back the amount of overpayment. In some instances such a repayment can affect the financial viability of the hospice program. For example, a North Alabama hospice program (Good Samaritan Hospice) filed for bankruptcy protection in February 2009, following notice by the Centers for Medicare and Medicaid Services of overpayments exceeding $5 million resulting from claims that it exceeded the hospice cap rate.[21]

States such as Florida's closest neighbors, with a much higher supply of hospice providers relative to the number of Medicare deaths, also exhibit a much higher level of reimbursement cap violations. These differences are particularly striking when compared to Florida. Table 7 shows how over time the number of cap violations has grown concurrent with rapid growth of providers in states without CON reviews and with the resulting oversupply of hospice providers.

[21] "Hospice provider in the Shoal files for bankruptcy." February 18, 2009. WAFF48 News. Retrieved March 9, 2009 from: http://www.waff.com/Global/story.asp?S=9862038.

States	Count of Medicare Provider #s in 2007	Estimated Count of Providers That Violated Their Reimbursement Caps in 2007	Percentage Violating Cap in 2007
Florida	43	1	2%
United States	3,211	268	8%
Mississippi	121	46	38%
Alabama	128	36	28%
Georgia	126	12	10%
Three State Subtotal	375	94	25%

States	Count of Medicare Provider #s in 2000	Estimated Count of Providers That Violated Their Reimbursement Caps in 2000	Percentage Violating Cap in 2000
Florida	39	0	0%
United States	2,224	35	2%
Mississippi	45	5	11%
Alabama	65	4	6%
Georgia	73	1	1%
Three State Subtotal	183	10	5%

Table 7: Medicare Cap Violations

High rates of cap violations are indicative of a hospice system that is not meeting the goals of the Medicare program to provide a cost-effective alternative to conventional medical care for the terminally ill. High rates of cap violations also suggest evidence of a hospice system where providers risk financial instability or insolvency related to an oversupply of providers. Such provider instability may result in disruption to the lives of patients brought about by poor enrollment decisions and poor cap management by the hospices in states with an oversupply of providers.

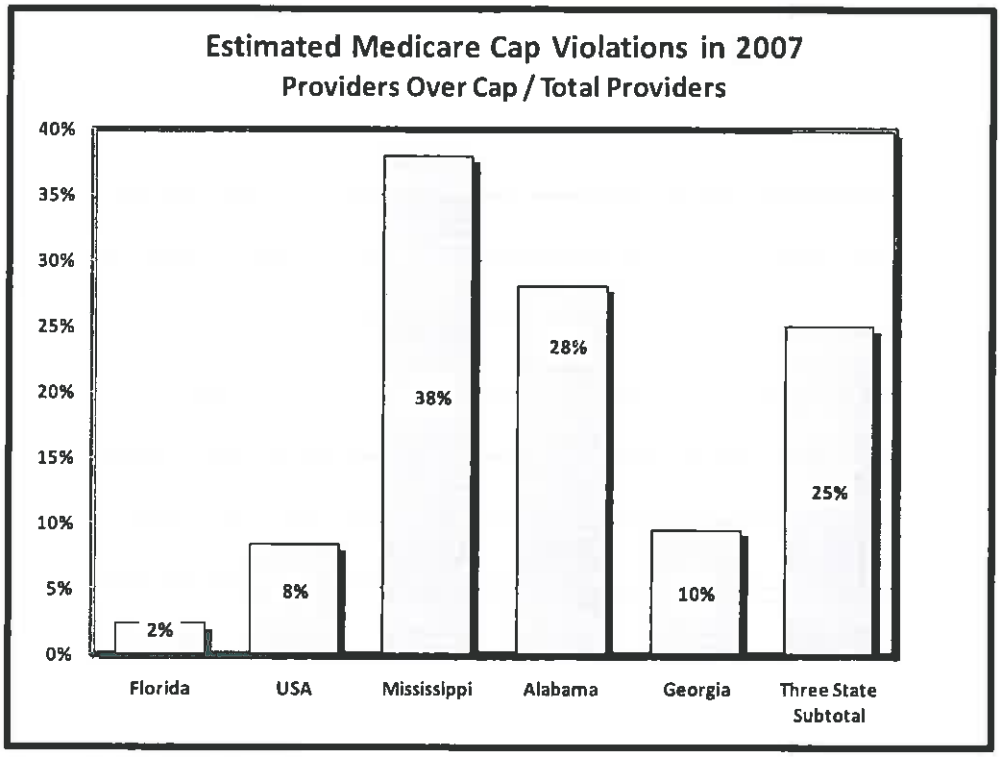


Figure 8: Medicare Cap Violations

The relatively larger hospices in Florida are consistently cited with far fewer Medicare cap violations than their neighboring states with no CON program, and than the nation as a whole. This is yet another indicator of the advantages of the Florida Hospice Model, which is a product, to a substantial degree, of the Florida hospice CON process.

Quality of Care

One might suppose that in the presence of more hospice providers the intensity of hospice care delivery (that is, the total amount of services delivered directly to the patient's bedside, as reflected in average expenditures on direct patient care) would be higher. In fact, the opposite is true: in the presence of a higher number of providers, the average amount of care delivered per patient day decreases. Payment for Medicare hospice services is based on pre-set, per-diem rates, with Florida hospices paid approximately the same daily reimbursement rates (with minor regional adjustments) as their peers in Georgia, Alabama and Mississippi. If expenditures per day are lowered by reducing services, revenues per day remain at the same level and provider profits are increased.

The following tables and figures show data from Medicare Cost Reports for 2007 that depict average hospice expenditures per day in Florida and its neighbors, showing that Florida, with fewer hospice programs, spends more at the patient's bedside than the national average and

significantly more than the neighboring states with higher numbers of hospice providers, relative to death rates.

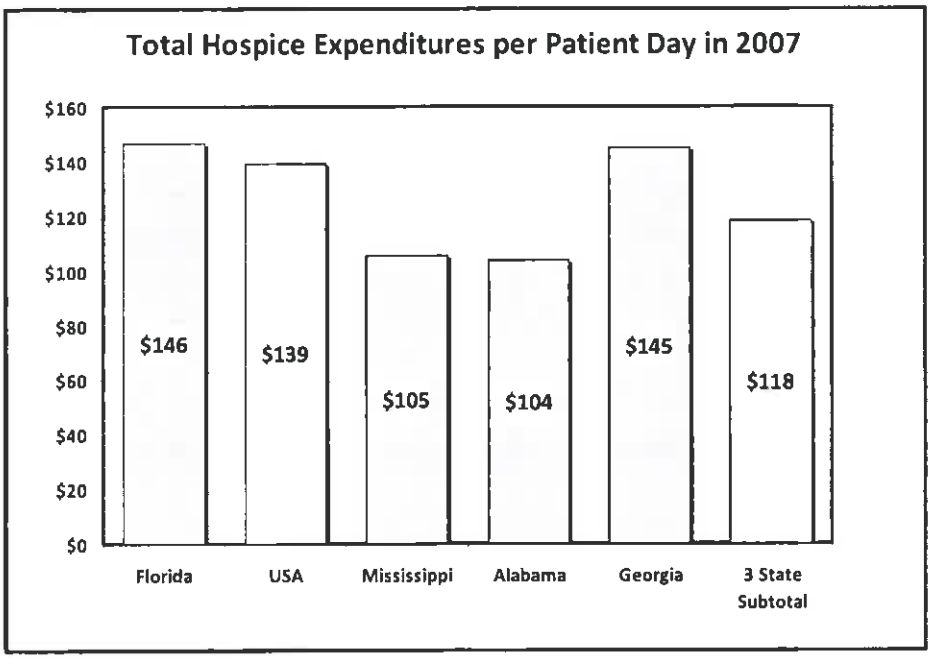


Figure 9: 2007 Total Hospice Expenditures per Patient Day

One might conjecture that these higher total average expenditures per patient day in Florida include greater administrative expenditures, but in fact Florida hospices, as shown in Table 8, spend a lower percentage of their budgets on administrative and general expenses.

State	Administrative & General	Inpatient Services	Visiting Services	Other	Non-Reimbursable	Total Costs Per Patient Day
Florida	29%	12%	43%	14%	2%	100%
USA	35%	8%	42%	13%	2%	100%
Mississippi	40%	5%	41%	13%	1%	100%
Alabama	36%	5%	43%	15%	1%	100%
Georgia	36%	8%	44%	11%	1%	100%
3 State Subtotal	37%	6%	43%	13%	1%	100%

Table 8: 2007 Expenditure Proportions

Table 9 (on the following page) elaborates on this essential fact of CON versus uncontrolled proliferation of hospice programs, showing comparative average per-day expenditures for a number of specific services provided under hospice care by Florida and its neighbors. These results confirm that proliferation of hospice programs does not lead to enhanced care delivered at the patient's bedside.

The average amount spent per patient per day, on average, on the provision of these various facets of hospice care is one of the most powerful proxies for the quality of hospice services, since these are what make the service an invaluable benefit to dying patients. The money spent on these services reflects an ability to maximize quality of life at a most difficult time of life for patients and families. States like Florida, with fewer hospices relative to death rates, are able to make a greater investment in direct patient care, such as visiting services (which includes nursing care), physician services, physical, occupational, and speech therapies, and inpatient services.

Table 9: Comparative Hospice Expenditures

	Florida	USA	Three Neighboring States			
			Mississippi	Alabama	Georgia	3 State Subtotal
Hospice Utilization Statistics						
Average # of Hospice Providers per 1,000 Deaths	0.3	1.7	5.8	3.6	2.6	3.6
Penetration -- Hospice Deaths / Enrollee Deaths	49%	36%	26%	35%	34%	33%
% of Patients Discharged Live in 2006	15%	17%	44%	35%	26%	33%
% of Providers Estimated to Exceed Reimbursement Cap	2%	8%	38%	28%	10%	25%
Inpatient Days as Percent of Total Patient Days	4.6%	3.1%	2.2%	2.0%	5.9%	3.4%
Hospice Expenditures per Patient Day						
Administrative & General	$42	$48	$42	$37	$52	$43
Inpatient Services	$17	$11	$6	$5	$12	$7
Visiting Services	$64	$59	$43	$45	$63	$50
Other Services	$20	$18	$14	$16	$17	$15
Non-Reimbursable Services	$4	$3	$1	$1	$1	$1
Total Expenditures	$146	$139	$105	$104	$145	$118
Palliative Radiation Therapy and Chemotherapy	$1.93	$0.31	$0.01	$0.06	$0.09	$0.06
Physician Services	$4.86	$2.34	$1.00	$1.00	$2.55	$1.52
Medical Social Work	$5.26	$6.03	$3.48	$4.30	$5.28	$4.42
Bereavement and Volunteer Services	$1.63	$1.55	$0.38	$0.69	$0.98	$0.71

States like Georgia, Alabama and Mississippi, which are marked by significantly higher numbers of hospice providers relative to total Medicare deaths, representing uncontrolled proliferation of hospice programs, by contrast make significantly smaller investments in direct patient care.

Further confirmation of these results comes from a study of California hospices, which found that larger hospices and hospices that were part of a chain were significantly less likely to restrict access to hospice care because the patient either lacked a caregiver in the home, was unwilling to forgo admission to a hospital, or was receiving tube feedings, radiotherapy and transfusions at the time of admission.[22] In other words, these larger hospices tended to utilize their economies of scale in order to make a greater commitment to ensuring access to hospice care for patients who were more costly to care for.

These findings confirm that Florida hospices, and hospices in states with larger hospices, are able to commit more resources and a higher proportion of their per-diem patient revenues to direct patient care than those in a market environment characterized by an oversupply of hospice programs and proliferation of providers. Additionally, they are more willing and/or able to accept patients who require more care, or more complex care, than are smaller hospices.

Thus, the data show that the CON regulation of Florida hospices has resulted both in more patients being served (greater penetration with greater access to care), and in provision of a higher intensity of hospice care per patient – in other words, higher quality of care for dying patients. Not only has Florida's CON process supported greater access to and appropriateness of hospice services, but it has also enhanced the quality of hospice services, resulting in hospice care delivery that generally exceeds the US averages and those of its three neighboring states.

[22] Miller, Susan C. Ph.D., and Lima, Julie, MPH, M.A., Center for Gerontology & Health Care Research, Brown University School of Medicine. The Florida Model of Hospice Care: A Report for Florida Hospices and Palliative Care, Inc. February 2004.

Provider Oversupply and Fraud and Abuse

In the real world, there is no alternate model of a state that is just like Florida, yet lacks its hospice CON program, to illustrate what would ensue by eliminating the CON regulation of hospice services. But based on comparisons of Florida with its neighboring states, eliminating CON in Florida would likely result in an uncontrolled proliferation of hospice programs.

When Florida deregulated home health care and eliminated CON requirements for home health agencies in 2000, a similar kind of proliferation of home health care providers followed. The number of freestanding home health agencies in the nation today is about the same as in 1996 – just before the interim payment system for home health services was implemented by Medicare.

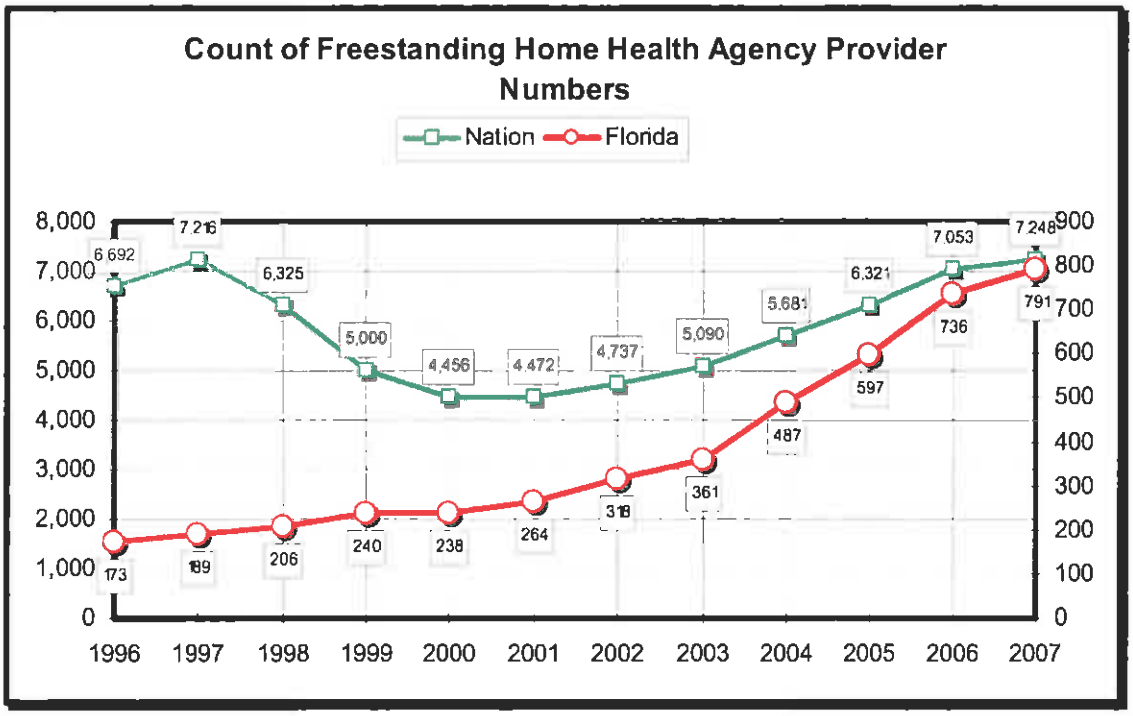


Figure 10: Count of Freestanding Home Health Agency Providers

But in Florida, by contrast, following elimination of the home health CON program, the number of freestanding home health providers in the state *has more than tripled* (see Figure 10). In Miami-Dade County alone, the number of licensed home health agencies increased by 435% between 1999 and 2007.

The Florida Senate's Interim Project Report 2008-135, released in November 2007, identified many problems associated with this proliferation, including "possible quality-of-care problems and Medicaid fraud." With the dramatic increase in the number of home health agencies came increased demands and stresses on the resources of licensing and regulatory agencies. At the

same time, home health agency fraud and abuse skyrocketed. Medicaid Program Integrity investigators found that a number of problem or fraudulent activities resulted, including but not limited to:

- Patients being served by more than one home health agency at the same time;
- Alteration and changing of patient records;
- Inappropriate billing of services, including billing for home health aide services when less costly housekeeping or companionship services were provided instead;
- Home health agencies with no active patient caseload of their own acting as "staffing pools" for other home health agencies; and
- Patient brokering and prohibited payments to physicians for referrals.[23]

What can be inferred from the experience of home health agencies in Florida, where elimination of CON led to these serious problems with fraud and abuse? If extrapolated to hospice, their near neighbor in the health delivery continuum, could an uncontrolled proliferation of hospice programs in Florida lead to similar problems with Medicare fraud and abuse if the hospice CON program were eliminated?

If Florida's CON for hospice programs were eliminated, based on the experience of Florida's closest neighbors, Georgia, Alabama and Mississippi, it is reasonable to expect that the number of hospice providers would exceed 200 within a few years. Such a proliferation could create the same kinds of problems that have affected Florida's home health sector, or the hospice sector in those neighboring states, with uncontrolled proliferation of providers resulting in a likely infusion into the state of new for-profit providers that may increase the incidence of adverse consequences, including fraud and abuse.

As shown in the data presented here, a dramatic increase in the number of hospice providers would not improve access to services, but it would likely diminish quality of care and lead to increased fraud. As with Florida's home health agencies, an oversupply of hospices has been shown to be associated with various problems in service delivery, including more restricted access and diminished quality of care. In addition, hospice fraud and abuse have begun to appear in markets characterized by provider oversupply.

As one example, the United States Department of Justice recently reported that SouthernCare, Inc., an Alabama-based hospice chain, and its shareholders have agreed to pay the government a total of $24.7 million to settle allegations that the hospice company submitted false claims to the government for patients treated by its hospice facilities. The government "...investigation

[23] Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2006-2007. p. 37, Agency for Health Care Administration, Medicaid Fraud Control Unit, December 2007.

showed a pattern and practice to falsely admit patients to hospice care who did not qualify and to bill Medicare for that care."[24]

Alabama recently reenacted CON regulation of hospice programs, and other states served by SouthernCare do not provide for CON regulation of hospice providers. Alabama had 120 Medicare certified hospice providers in 2006, while Florida today has 68 licensed or approved hospice programs authorized to serve its 27 hospice service areas.

In AHCA's 2006-2007 report on fraud and abuse, it concludes:

> While CON has been criticized as a barrier to free market activity in the health care sector, the Agency is beginning to see signs that the lack of a barrier may be making it too easy for poorly qualified providers to deliver lower-quality home health services. There has been a substantial increase in the number of federal conditions of participation not met by Medicare certified home health agencies since the elimination of the CON requirement. Although there was an increase of 109% in the number of Medicare-certified home health agencies from 2001 through 2006, the number of federal conditions of participation not met increased by 1,100%.[25]

In other words, violations of core Medicare quality requirements for home health agencies increased 10 times as fast as the number of providers when the door was opened for the uncontrolled proliferation of home health agencies. Hospices are similar to home health agencies in that the development of a hospice program does not require significant capital investment, such as design, construction and facility costs. Further, in areas where CON has been eliminated or does not exist, the dramatic proliferation of providers has often followed, sometimes overwhelming state regulatory agencies with new applications for licensure and certification. Continued regulation of Florida hospices through CON review eliminates the potential for the development of provider oversupply, which occurred subsequent to the elimination of CON for Florida home health agencies.

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[24] "Alabama-Based Hospice Company Pays U.S. $24.7 Million to Settle Health Care Fraud Claims." United States Department of Justice Press Release. January 15, 2009. Retrieved March 9, 2009 from: http://www.usdoj.gov/opa/pr/2009/January/09-civ-043.html.

[25] Annual Report on the State's Efforts to Control Medicaid Fraud and Abuse FY 2006-2007, p. 37. Agency for Health Care Administration, Medicaid Fraud Control Unit, December 2007.

The Importance of Continuing Hospice CON

In 2000, the Maryland Health Care Commission considered elimination of hospice CON but concluded that the process should be continued. As noted above, in 2009, Alabama reenacted CON for hospice programs in order to control unnecessary proliferation of provider supply and the associated adverse consequences. There is at present no national trend toward elimination of CON, although some state legislatures are reported to have a "perennial debate" regarding the need for CON.[26]

Reasons commonly cited for continuation of CON include:

- CON helps to preserve high-quality hospice care;
- There is little or no market incentive for hospice providers to offer services in remote and sparsely populated parts of the state now served by local hospices with strong community ties. Growth in hospice services resulting from deregulation is more likely to be pursued by large hospice chains and to take place in communities where there is already intense competition;
- An excessive supply of hospice providers within service areas already served by multiple hospice programs will result in competition for the same dollars and some or all of those providers could become insolvent.

The American Health Planning Association (AHPA) is the professional group representing state agencies responsible for regulation and planning. It identifies three additional factors that suggest the continued need for CON programs.[27]

- CON programs limit health care spending by promoting appropriate competition while maintaining lower costs for treatment services.
- CON programs are related to improved quality of care.
- CON programs help state agencies identify areas that are underserved and to distribute care to these areas.

In summary, an excess supply of hospice providers does not correlate with a positive impact on access or service availability. However, an oversupply of hospice providers is associated with negative outcomes such as lower levels of hospice expenditures per patient day, higher rates of

[26] Maryland Health Care Commission. "An Analysis and Evaluation of Certificate of Need Regulation in Maryland Hospice Services: Response to Written Comments on the Staff Recommendation." December 12, 2000. Also, Maryland Health Care Commission. "Certificate of Need – Update on Implementation of Recommendations: -- 2005 Certificate of Need Task Force - Comprehensive Evaluation Required by Chapter 702 of 1999." October 1, 2008.

[27] National Conference of State Legislators. Certificate of Need: State Health Laws and Programs. August 21, 2008.

live discharges and higher rates of reimbursement cap violations – all significant quality concerns.

An uncontrolled proliferation of hospices in Florida, which would likely follow if CON for hospice were eliminated, would not increase access to care but would be likely to lower quality of care, result in higher rates of admissions of persons not eligible for hospice care, and lead to higher rates of Medicare cap violations, with resulting financial instability in the hospice sector. In addition, proliferation of providers would result in substantially increased costs of regulation to Florida's and the nation's regulatory agencies. That problem would be compounded dramatically should the elimination of CON for hospice result in a significant addition of new hospice programs and providers in Florida.

Future Challenges

The Medicare Payment Advisory Commission (MedPAC) recently published a report recommending significant changes to the hospice reimbursement system directed at addressing some of the problems alluded to herein, including issues commonly associated with provider oversupply. MedPAC found that hospices exceeding the Medicare per-patient cap are more likely to be smaller, newer and for-profit than those hospices not exceeding the cap. MedPAC also found that newer hospices, which are characteristically smaller and for-profit, may be pursuing a business model that aims to maximize profit by maximizing length of stay through sometimes inappropriate marketing or admission practices. MedPAC also noted that some smaller hospices, such as those in non-CON regulated states, may have to "merge with larger ones to better manage costs and achieve a sufficient base to manage risk."[28] MedPAC's findings support the conclusion that America needs fewer but larger hospices, like those that have emerged under hospice CON regulation in Florida – in other words, hospices representative of the Florida Hospice Model.

Recommendations

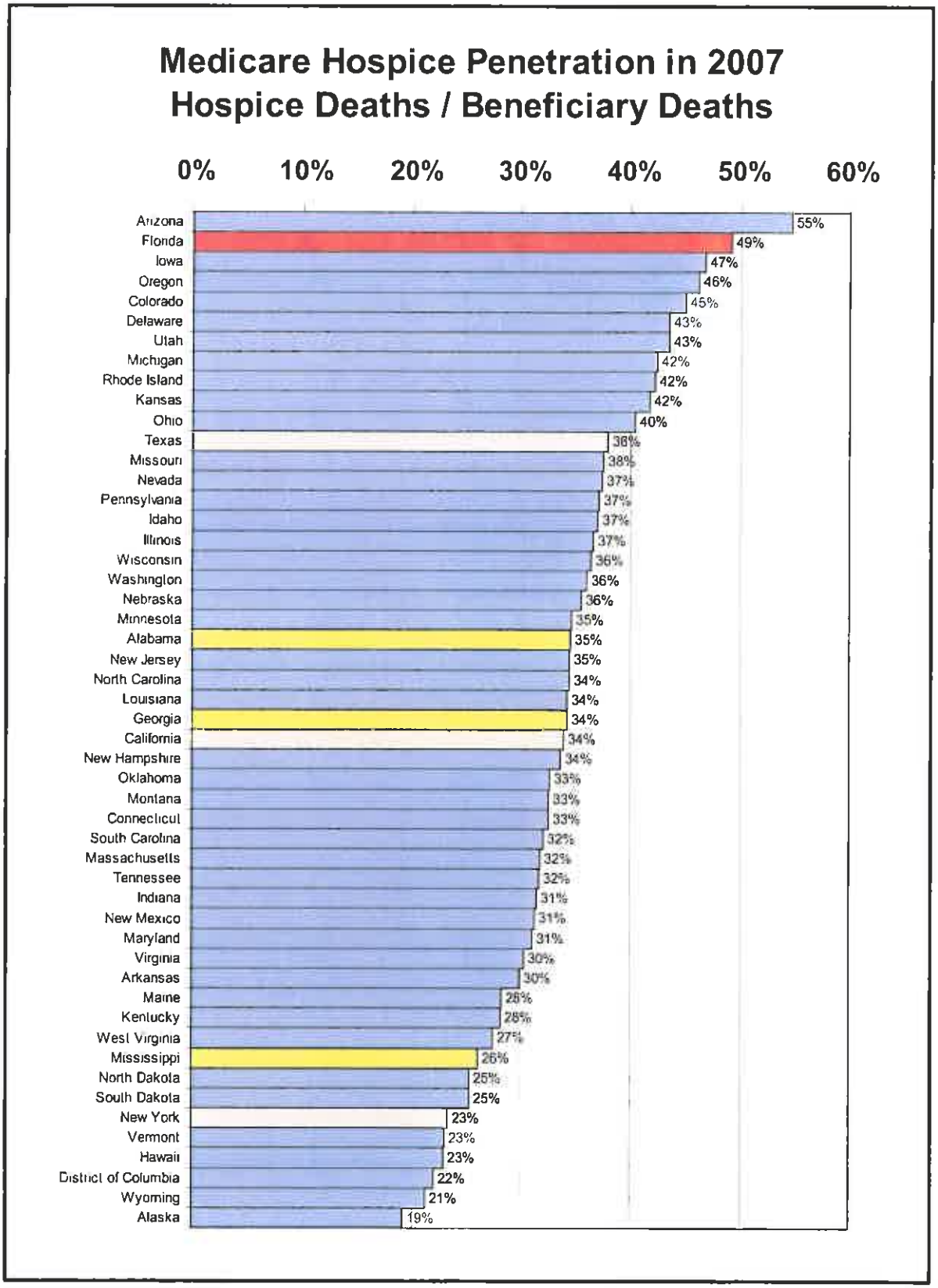
Consistent with the recommendations of the Governor's Task Force, OPPAGA and AHCA, the Florida Legislature should maintain a CON process for hospice programs that preserves the Florida Hospice Model and the level of access and quality of care that is characteristic of the Florida Hospice Model.

AHCA should act to ensure that the CON need methodology and regulations foster and preserve the Florida Hospice Model, while allowing for appropriate provider entry and authorization of additional hospice programs where the level of access and quality of care of existing hospice programs in a service area is inadequate or insufficient to meet the needs of the community.

[28] Medicare Payment Advisory Commission, Report to the Congress, Chapter 6, Reforming Medicare's Hospice Benefit, pp. 356-358, 362, 365-367. March 2009.

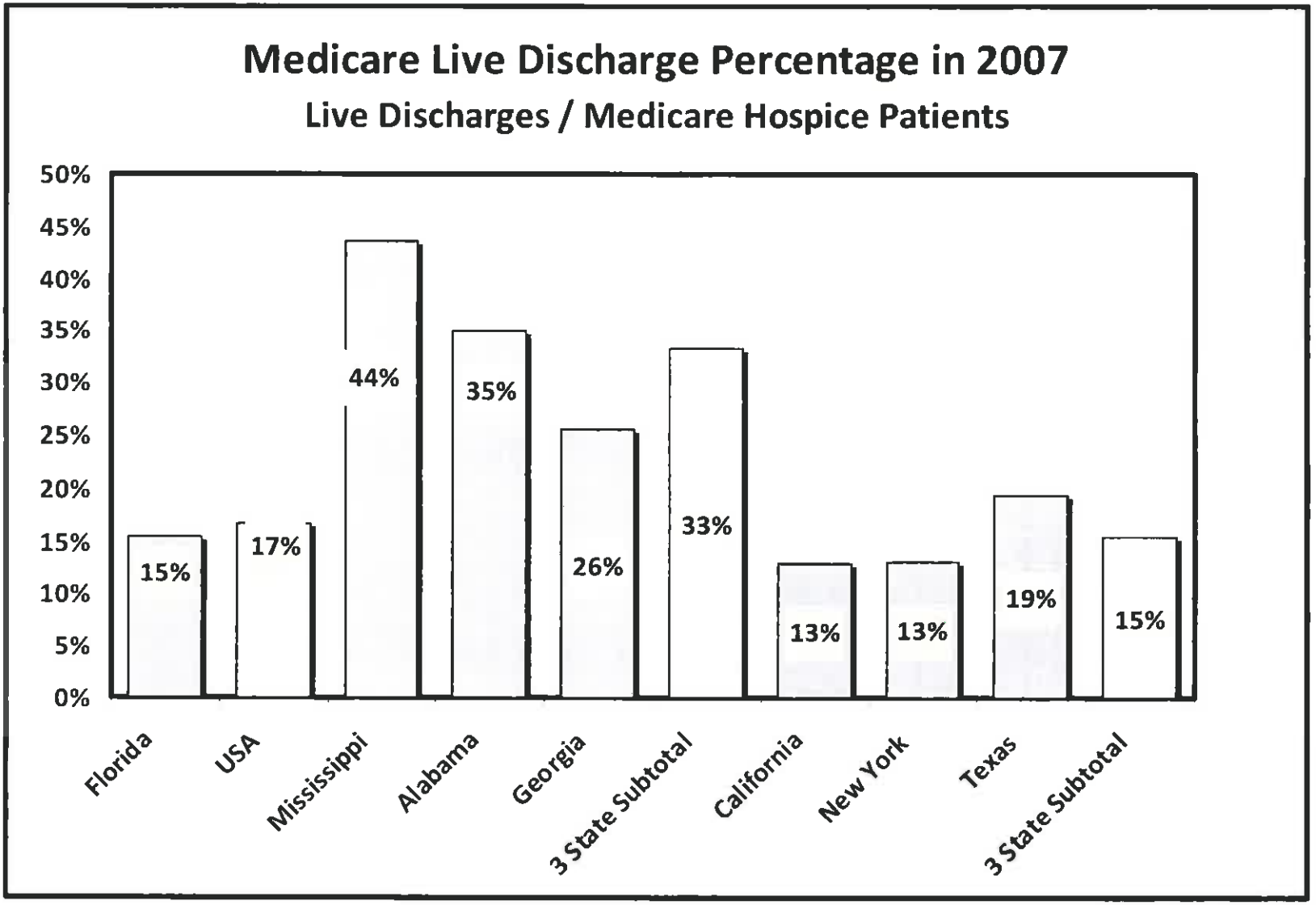
APPENDIX I
ADDITIONAL STATE COMPARISONS

In order to confirm the findings set forth in the main paper, which includes Southeastern state regional peer group comparisons, the reviewers also compared Florida, the fourth largest of the fifty states by population, with the three largest states – California, New York and Texas. The findings set forth in the following pages confirm that the Florida Hospice Model is effective in ensuring hospice services among the very best in the nation.


Medicare Hospice Penetration in 2007
Hospice Deaths / Beneficiary Deaths
0%
10%
20%
30%
40%
50%
60%
Arizona 55%
Florida 49%
Iowa 47%
Oregon 46%
Colorado 45%
Delaware 43%
Utah 43%
Michigan 42%
Rhode Island 42%
Kansas 42%
Ohio 40%
Texas 38%
Missouri 38%
Nevada 37%
Pennsylvania 37%
Idaho 37%
Illinois 37%
Wisconsin 36%
Washington 36%
Nebraska 36%
Minnesota 35%
Alabama 35%
New Jersey 35%
North Carolina 34%
Louisiana 34%
Georgia 34%
California 34%
New Hampshire 34%
Oklahoma 33%
Montana 33%
Connecticut 33%
South Carolina 32%
Massachusetts 32%
Tennessee 32%
Indiana 31%
New Mexico 31%
Maryland 31%
Virginia 30%
Arkansas 30%
Maine 28%
Kentucky 28%
West Virginia 27%
Mississippi 26%
North Dakota 25%
South Dakota 25%
New York 23%
Vermont 23%
Hawaii 23%
District of Columbia 22%
Wyoming 21%
Alaska 19%

States	Count of Medicare Participating Hospices 2007	Count of Deaths of Medicare Beneficiaries in 2007	Count of Medicare Participating Hospices per 1,000 Deaths
Florida	43	131,513	0.33
United States	3,211	1,875,451	1.71
Mississippi	121	20,861	5.80
Alabama	128	35,630	3.59
Georgia	126	48,805	2.58
Three State Subtotal	375	105,296	3.56
California	212	176,526	1.20
New York	50	118,601	0.42
Texas	281	119,908	2.34
Three Big State Subtotal	543	415,035	1.31

States	Count of Medicare Participating Hospices 2000	Count of Deaths of Medicare Beneficiaries in 2000	Count of Medicare Participating Hospices per 1,000 Deaths
Florida	39	130,862	0.30
United States	2,224	1,855,013	1.20
Mississippi	45	21,305	2.11
Alabama	65	34,268	1.90
Georgia	73	46,119	1.58
Three State Subtotal	183	101,692	1.80
California	163	171,454	0.95
New York	54	122,974	0.44
Texas	137	111,640	1.23
Three Big State Subtotal	354	406,068	0.87


Medicare Live Discharge Percentage in 2007
Live Discharges / Medicare Hospice Patients
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
15%
17%
44%
35%
26%
33%
13%
13%
19%
15%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

States	Count of Medicare Participating Hospices in 2007	Count of Deaths of Medicare Beneficiaries in 2007	Count of Hospice Deaths of Medicare Beneficiaries in 2007	Penetration Hospice Deaths/Total Deaths for 2007
Florida	43	131,513	64,596	49%
United States	3,211	1,875,451	673,321	36%
Mississippi	121	20,861	5,435	26%
Alabama	128	35,630	12,310	35%
Georgia	126	48,805	16,719	34%
Three State Subtotal	375	105,296	34,464	33%
California	212	176,526	60,025	34%
New York	50	118,601	27,590	23%
Texas	281	119,908	45,493	38%
Three Big State Subtotal	543	415,035	133,108	32%

States	Count of Medicare Participating Hospices in 2000	Count of Deaths of Medicare Beneficiaries in 2000	Count of Hospice Deaths of Medicare Beneficiaries in 2000	Penetration Hospice Deaths/Total Deaths for 2000
Florida	39	130,862	43,889	34%
United States	2,224	1,855,013	384,119	21%
Mississippi	45	21,305	2,678	13%
Alabama	65	34,268	6,958	20%
Georgia	73	46,119	9,520	21%
Three State Subtotal	183	101,692	19,156	19%
California	163	171,454	35,368	21%
New York	54	122,974	18,020	15%
Texas	137	111,640	26,442	24%
Three Big State Subtotal	354	406,068	79,830	20%

States	Medicare Hospice Patients Served in 2007	Live Discharges of Medicare Hospice Patients in 2007	Live Discharge Percentage for 2007
Florida	100,197	15,479	15%
United States	1,054,118	176,118	17%
Mississippi	18,052	7,858	44%
Alabama	30,864	10,765	35%
Georgia	31,304	7,997	26%
Three State Subtotal	80,220	26,620	33%
California	87,219	11,299	13%
New York	36,495	4,773	13%
Texas	77,542	14,974	19%
Three Big State Subtotal	201,256	31,046	15%

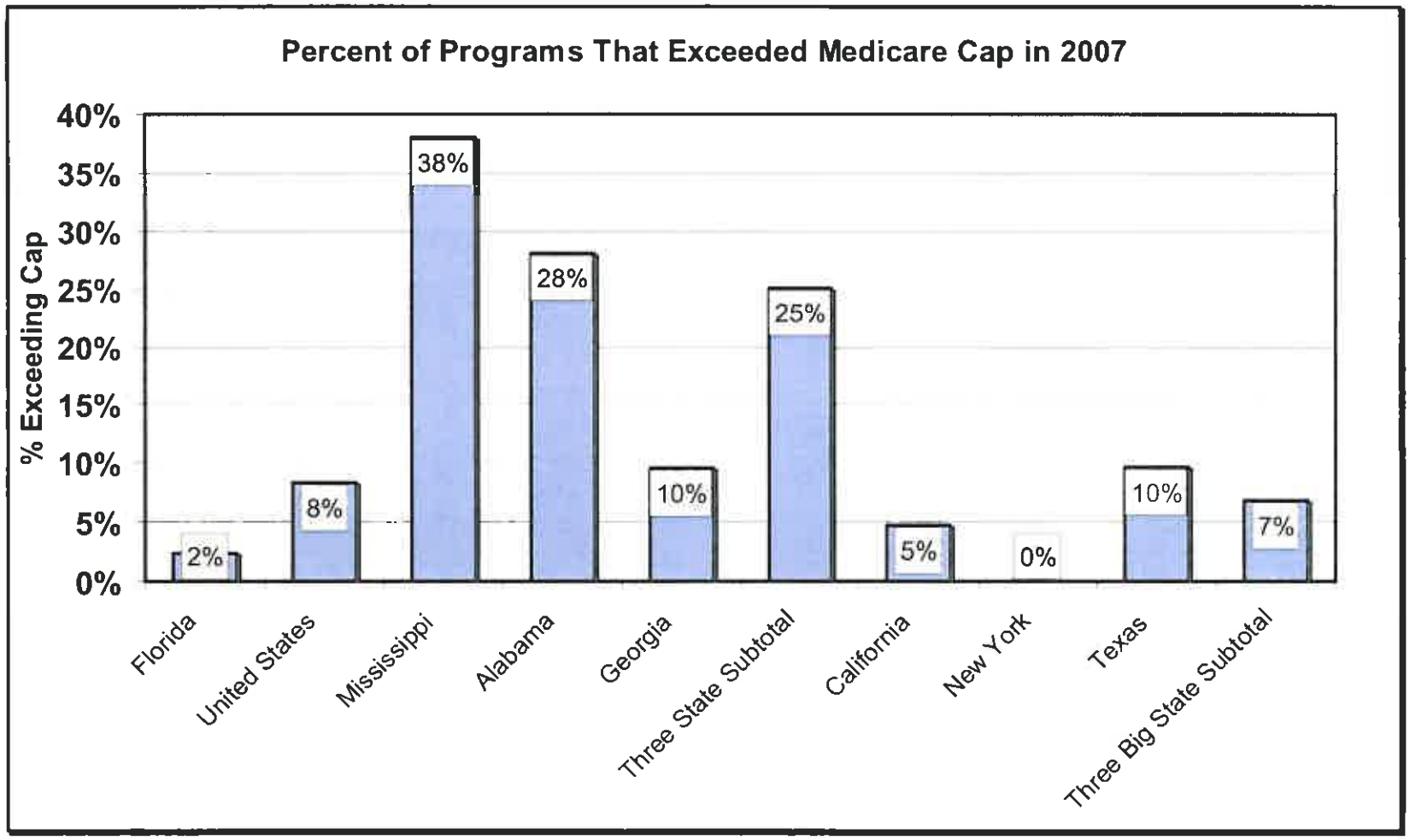
States	Medicare Hospice Patients Served in 2000	Live Discharges of Medicare Hospice Patients in 2000	Live Discharge Percentage for 2000
Florida	60,927	5,827	10%
United States	570,771	83,445	15%
Mississippi	6,651	2,248	34%
Alabama	12,391	2,528	20%
Georgia	15,374	2,711	18%
Three State Subtotal	34,416	7,487	22%
California	53,792	8,613	16%
New York	24,221	2,580	11%
Texas	43,045	8,465	20%
Three Big State Subtotal	121,058	19,658	16%

2007	Florida	United States	Mississippi	Alabama	Georgia	3- State Total
Medicare Enrollment	3,285,590	45,440,759	492,842	830,035	1,169,638	2,492,515
Medicare Enrollee Deaths	131,513	1,875,451	20,861	35,630	48,805	105,296
Medicare Hospice Providers	43	3,211	121	128	126	375
Medicare Hospice Deaths	64,596	673,321	5,435	12,310	16,719	34,464
Medicare Hospice Penetration	49%	36%	26%	35%	34%	33%
Percentage (Live Discharge Rate)	15%	17%	44%	35%	26%	33%
% of Providers Over Medicare Cap in 2007 (Est.)	**2%**	**8%**	**38%**	**28%**	**10%**	**25%**

2007	Florida	United States	California	New York	Texas	3- State Total
Medicare Enrollment	3,285,590	45,440,759	4,585,778	2,978,073	2,856,978	10,420,829
Medicare Enrollee Deaths	131,513	1,875,451	176,526	118,601	119,908	415,035
Medicare Hospice Providers	43	3,211	212	50	281	543
Medicare Hospice Deaths	64,596	673,321	60,025	27,590	45,493	133,108
Medicare Hospice Penetration	49%	36%	34%	23%	38%	32%
Percentage (Live Discharge Rate)	15%	17%	16%	11%	20%	16%
% of Providers Over Medicare Cap in 2007 (Est.)	**2%**	**8%**	**5%**	**0%**	**10%**	**7%**

States	Count of Medicare Provider #s in 2007	Estimated Count of Providers That Violated Their Reimbursement Caps in 2007	Percentage Violating Cap in 2007
Florida	43	1	2%
United States	3,211	268	8%
Mississippi	121	46	38%
Alabama	128	36	28%
Georgia	126	12	10%
Three State Subtotal	375	94	25%
California	212	10	5%
New York	50	0	0%
Texas	281	27	10%
Three Big State Subtotal	543	37	7%

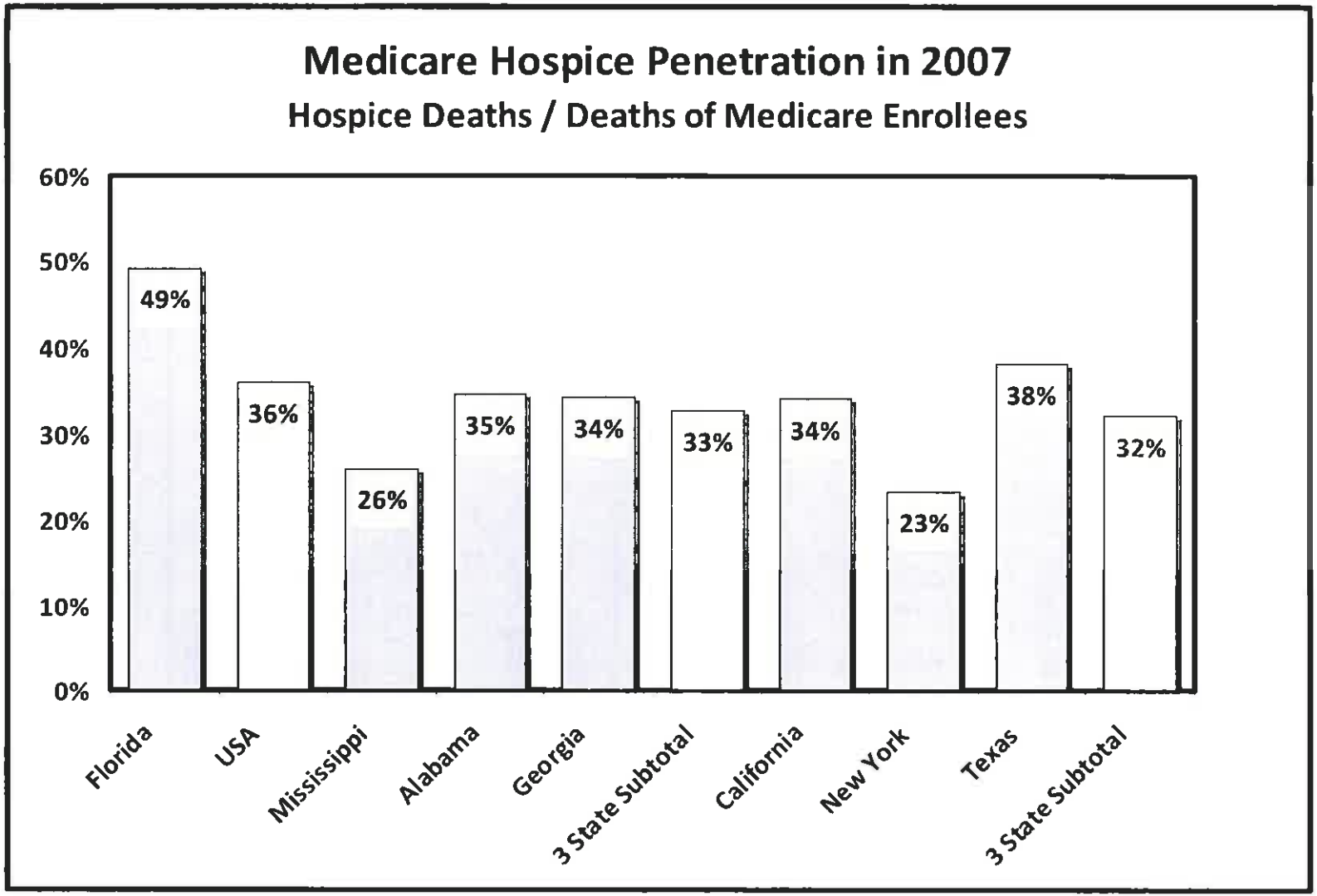
States	Count of Medicare Provider #s in 2000	Estimated Count of Providers That Violated Their Reimbursement Caps in 2000	Percentage Violating Cap in 2000
Florida	39	0	0%
United States	2,224	35	2%
Mississippi	45	5	11%
Alabama	65	4	6%
Georgia	73	1	1%
Three State Subtotal	183	10	5%
California	163	6	4%
New York	54	0	0%
Texas	137	2	1%
Three Big State Subtotal	354	8	2%

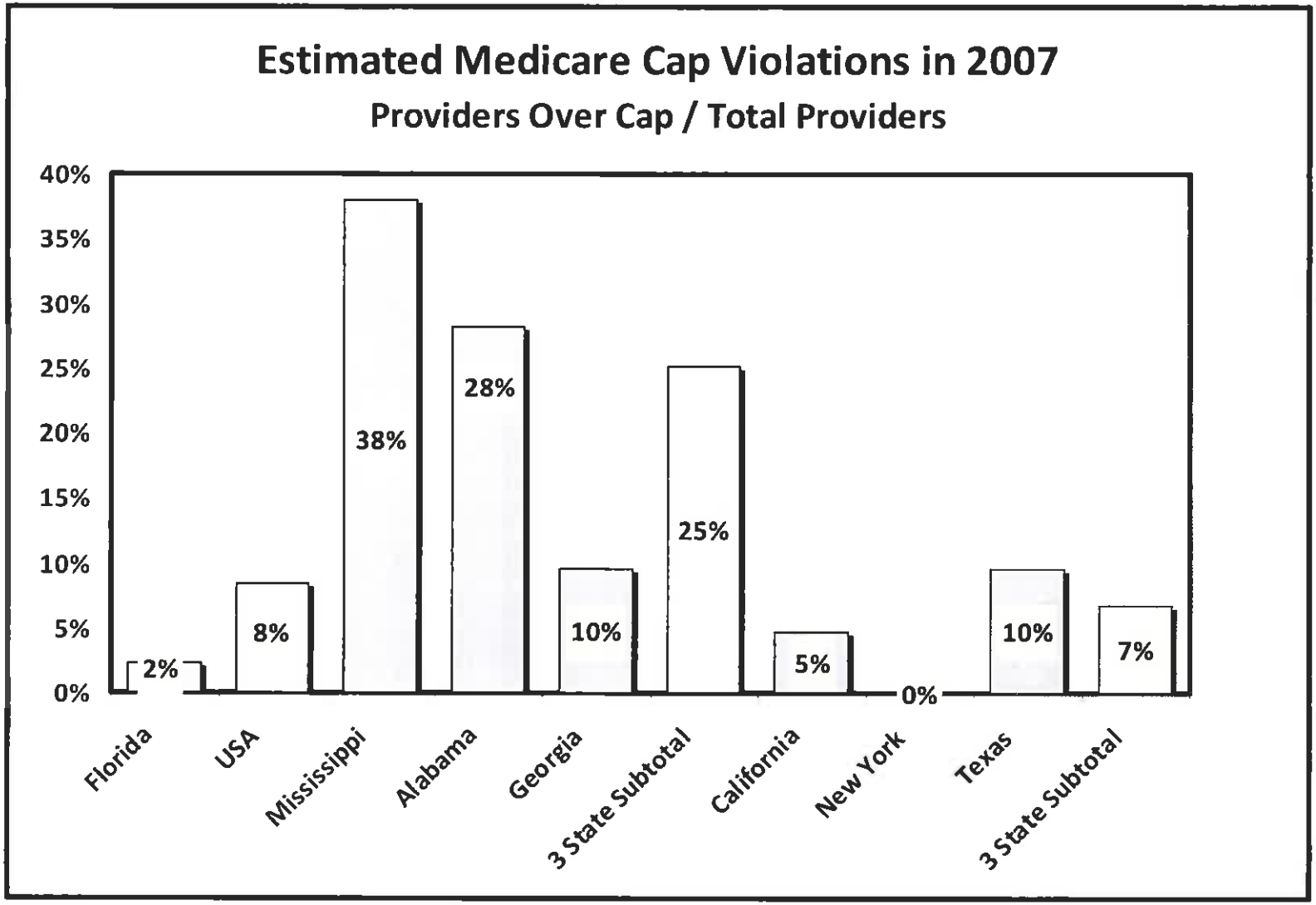

Percent of Programs That Exceeded Medicare Cap in 2007
% Exceeding Cap
40%
35%
30%
25%
20%
15%
10%
5%
0%
2%
8%
38%
28%
10%
25%
5%
0%
10%
7%
Florida
United States
Mississippi
Alabama
Georgia
Three State Subtotal
California
New York
Texas
Three Big State Subtotal

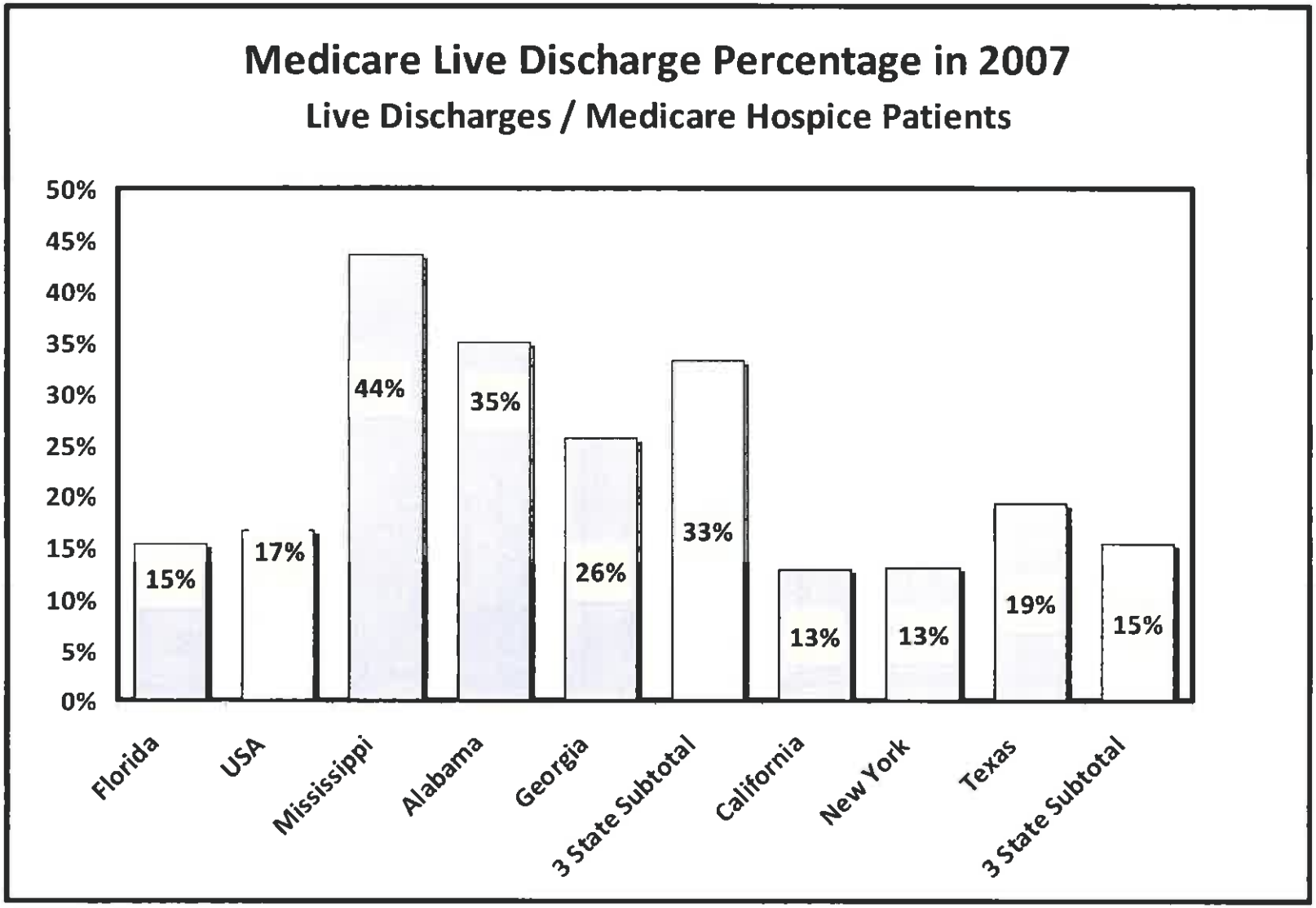
State	Administrative & General	Inpatient Services	Visiting Services	Other	Non-Reimbursable	Total Expenditures Per Patient Day	Radiation and Chemo	Physician Services	Medical Social Services Expenditures per Patient Day	Bereavement and Volunteer Expenditures per Patient Day	% GIP Days
Florida	$41.79	$17.43	$63.70	$19.95	$3.61	$146.49	$1.93	$4.86	$5.26	$1.63	4.6%
USA	$48.29	$10.70	$58.98	$18.18	$2.85	$138.97	$0.31	$2.34	$6.03	$1.55	3.1%
Mississippi	$42.39	$5.64	$43.09	$13.70	$0.69	$105.50	$0.01	$1.00	$3.48	$0.38	2.2%
Alabama	$37.26	$4.99	$44.66	$15.67	$1.37	$103.94	$0.06	$1.00	$4.30	$0.69	2.0%
Georgia	$51.81	$11.88	$63.06	$16.58	$1.30	$144.64	$0.09	$2.55	$5.28	$0.98	5.9%
3 State Subtotal	$43.46	$7.47	$50.43	$15.46	$1.17	$117.99	$0.06	$1.52	$4.42	$0.71	3.4%
California	$66.16	$5.74	$74.25	$18.58	$3.41	$168.14	$0.07	$3.03	$8.53	$1.61	1.7%
New York	$49.71	$24.93	$80.52	$27.03	$4.43	$186.63	$0.23	$4.17	$8.43	$2.75	4.3%
Texas	$48.33	$7.15	$55.08	$17.16	$2.31	$130.03	$0.12	$2.58	$4.31	$0.93	2.0%
3 State Subtotal	$56.02	$9.07	$66.73	$19.15	$3.07	$154.04	$0.12	$2.99	$6.67	$1.47	2.2%

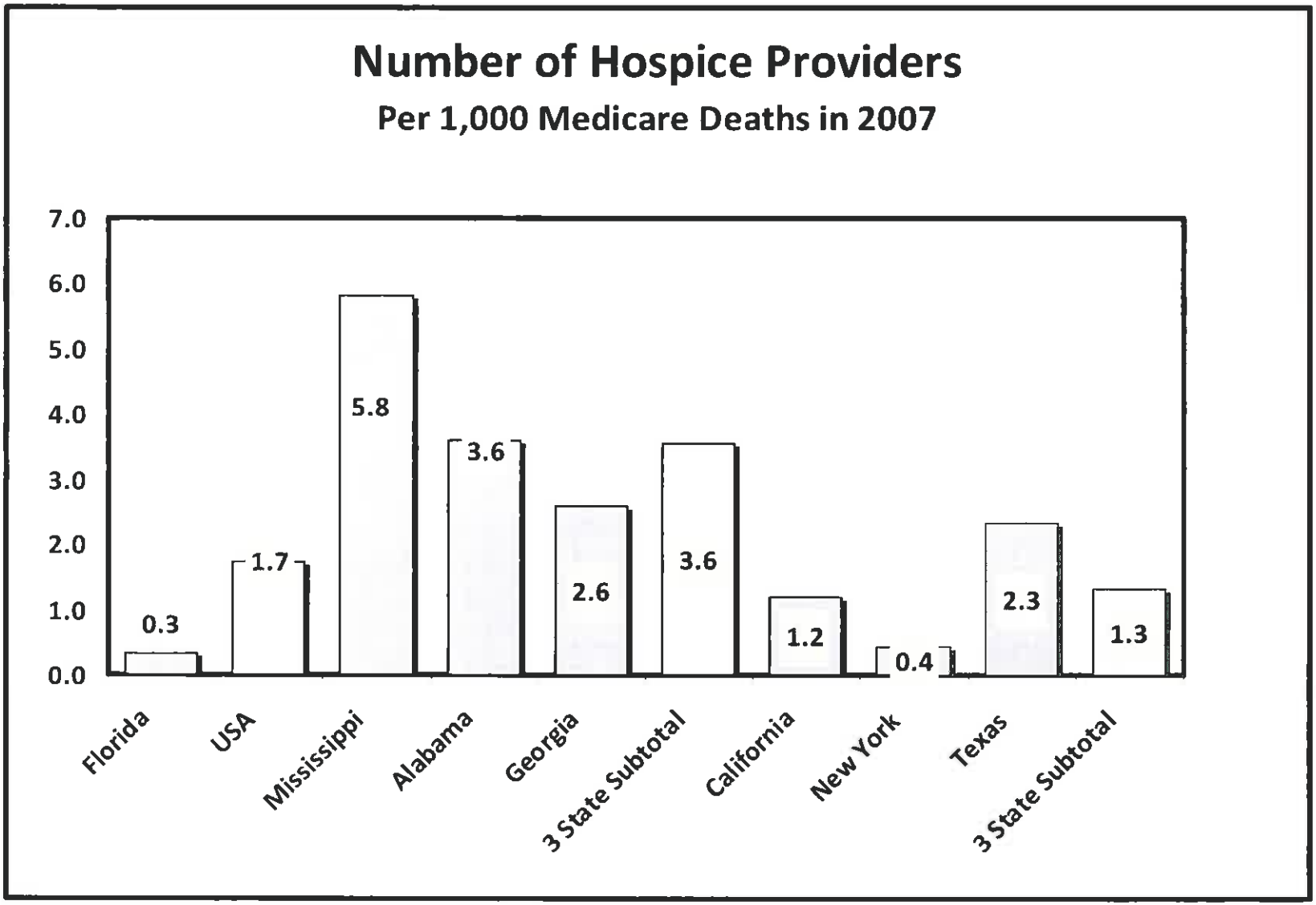
State	Administrative & General	Inpatient Services	Visiting Services	Other	Non-Reimbursable	Total Hospice Costs Per Patient Day
Florida	29%	12%	43%	14%	2%	100%
USA	35%	8%	42%	13%	2%	100%
Mississippi	40%	5%	41%	13%	1%	100%
Alabama	36%	5%	43%	15%	1%	100%
Georgia	36%	8%	44%	11%	1%	100%
3 State Subtotal	37%	6%	43%	13%	1%	100%
California	39%	3%	44%	11%	2%	100%
New York	27%	13%	43%	14%	2%	100%
Texas	37%	5%	42%	13%	2%	100%
3 State Subtotal	36%	6%	43%	12%	2%	100%

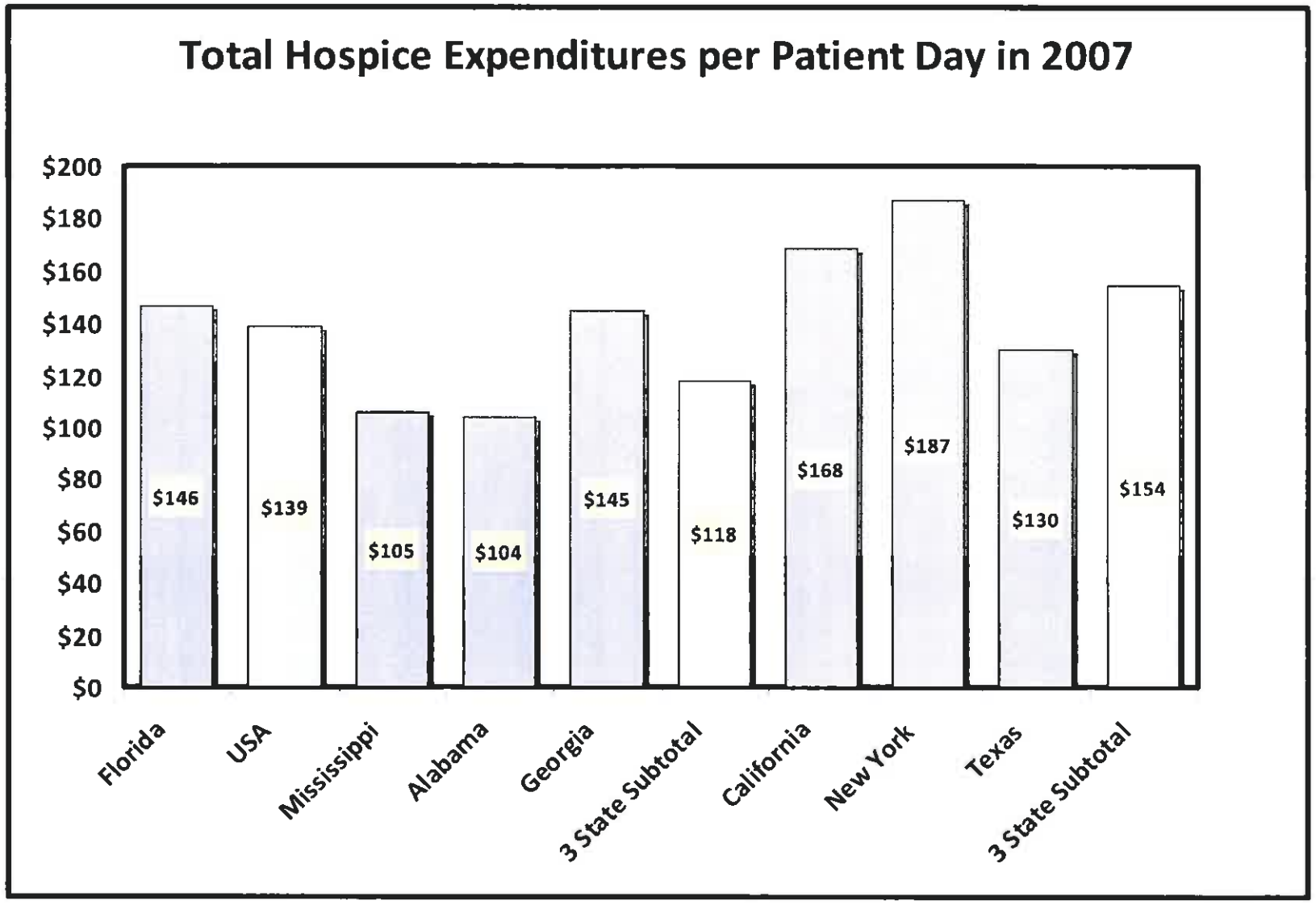
	Florida	USA	Three Neighboring States				Three Other Large States			
			Mississippi	Alabama	Georgia	3 State Subtotal	California	New York	Texas	3 State Subtotal
Hospice Utilization Statistics										
Average # of Hospice Providers per 1,000 Deaths	0.3	1.7	5.8	3.6	2.6	3.6	1.2	0.4	2.3	1.3
Penetration -- Hospice Deaths / Enrollee Deaths	49%	36%	26%	35%	34%	33%	34%	23%	38%	32%
% of Patients Discharged Live in 2006	15%	17%	44%	35%	26%	33%	13%	13%	19%	15%
% of Providers Estimated to Exceed Reimbursement Cap	2%	8%	38%	28%	10%	25%	5%	0%	10%	7%
Inpatient Days as Percent of Total Patient Days	4.6%	3.1%	2.2%	2.0%	5.9%	3.4%	1.7%	4.3%	2.0%	2.2%
Hospice Expenditures per Patient Day										
Administrative & General	$42	$48	$42	$37	$52	$43	$66	$50	$48	$56
Inpatient Services	$17	$11	$6	$5	$12	$7	$6	$25	$7	$9
Visiting Services	$64	$59	$43	$45	$63	$50	$74	$81	$55	$67
Other Services	$20	$18	$14	$16	$17	$15	$19	$27	$17	$19
Non-Reimbursable Services	$4	$3	$1	$1	$1	$1	$3	$4	$2	$3
Total Expenditures	$146	$139	$105	$104	$145	$118	$168	$187	$130	$154
Palliative Radiation Therapy and Chemotherapy	$1.93	$0.31	$0.01	$0.06	$0.09	$0.06	$0.07	$0.23	$0.12	$0.12
Physician Services	$4.86	$2.34	$1.00	$1.00	$2.55	$1.52	$3.03	$4.17	$2.58	$2.99
Medical Social Work	$5.26	$6.03	$3.48	$4.30	$5.28	$4.42	$8.53	$8.43	$4.31	$6.67
Bereavement and Volunteer Services	$1.63	$1.55	$0.38	$0.69	$0.98	$0.71	$1.61	$2.75	$0.93	$1.47

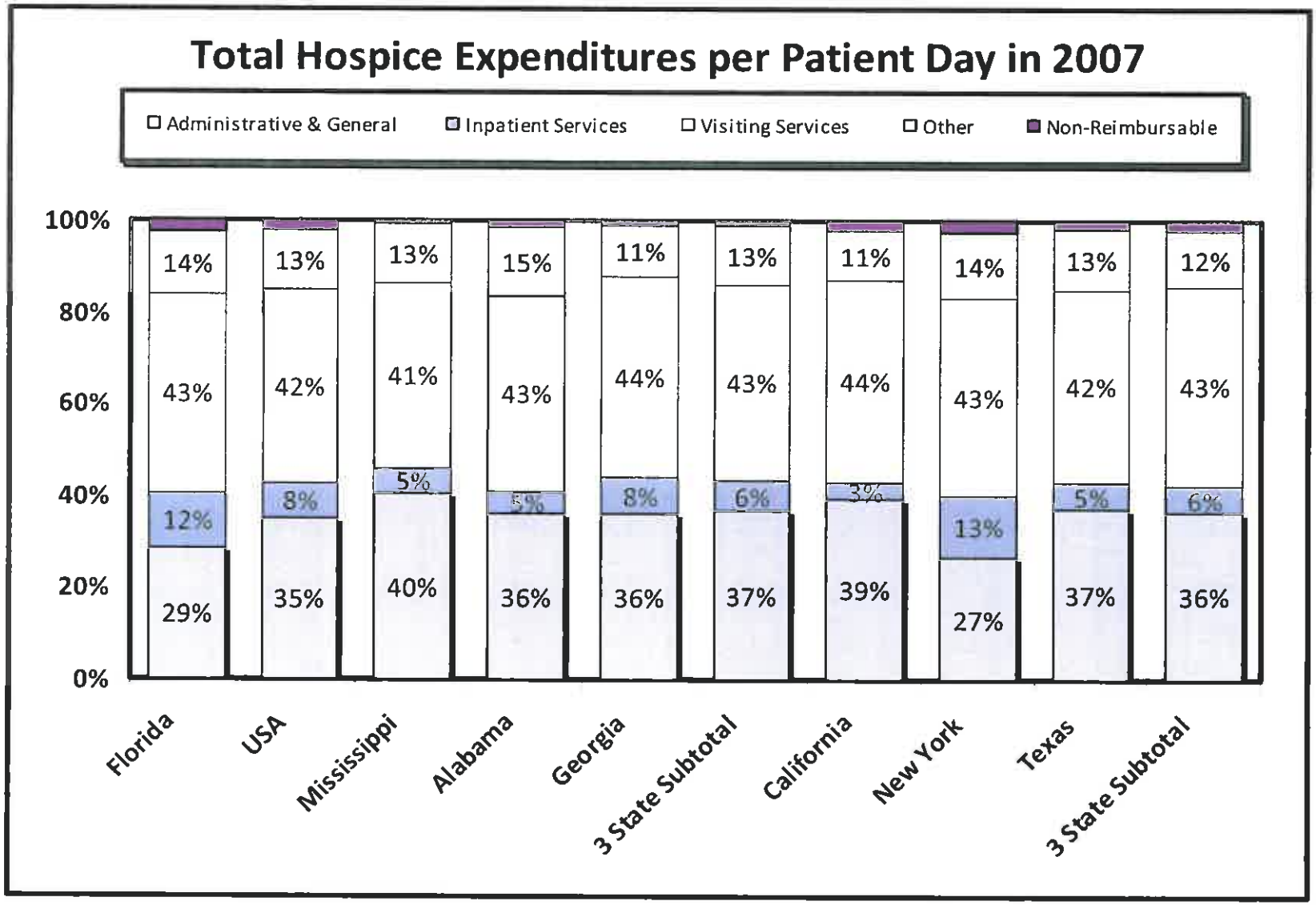

Medicare Hospice Penetration in 2007
Hospice Deaths / Deaths of Medicare Enrollees
60%
50%
40%
30%
20%
10%
0%
49%
36%
26%
35%
34%
33%
34%
23%
38%
32%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

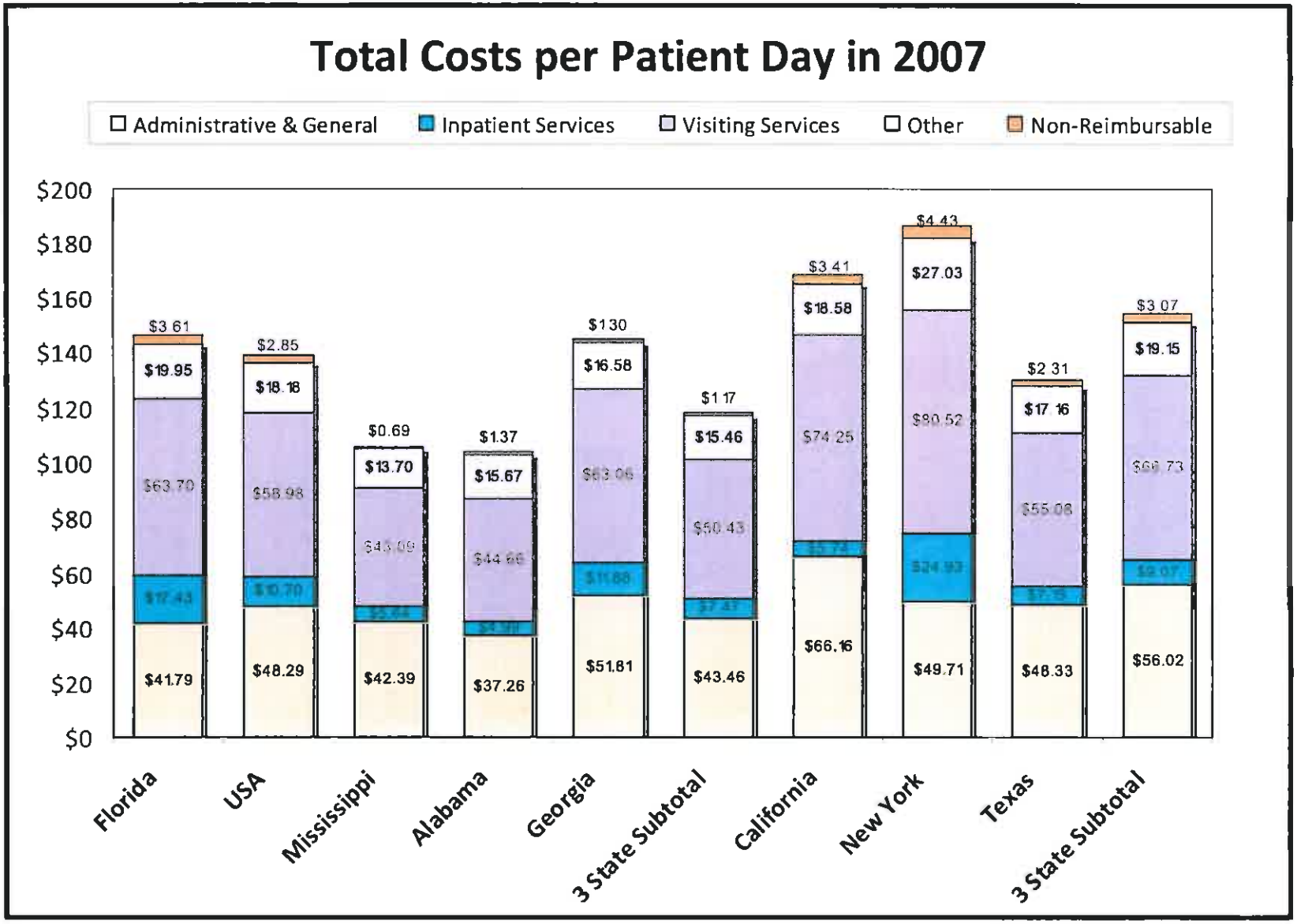

Estimated Medicare Cap Violations in 2007
Providers Over Cap / Total Providers
40%
35%
30%
25%
20%
15%
10%
5%
0%
2%
8%
38%
28%
10%
25%
5%
0%
10%
7%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

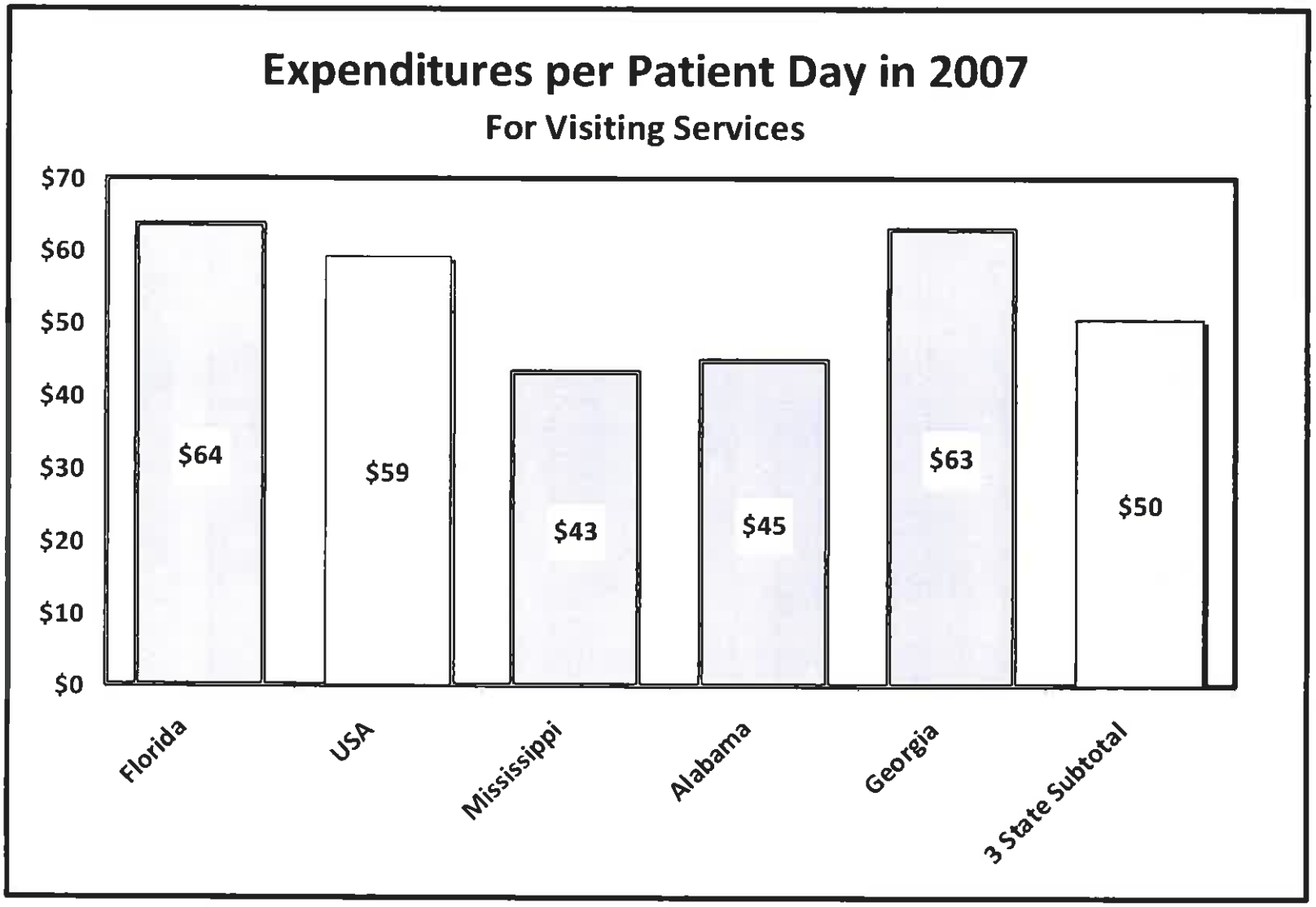

Medicare Live Discharge Percentage in 2007
Live Discharges / Medicare Hospice Patients
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
15%
17%
44%
35%
26%
33%
13%
13%
19%
15%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

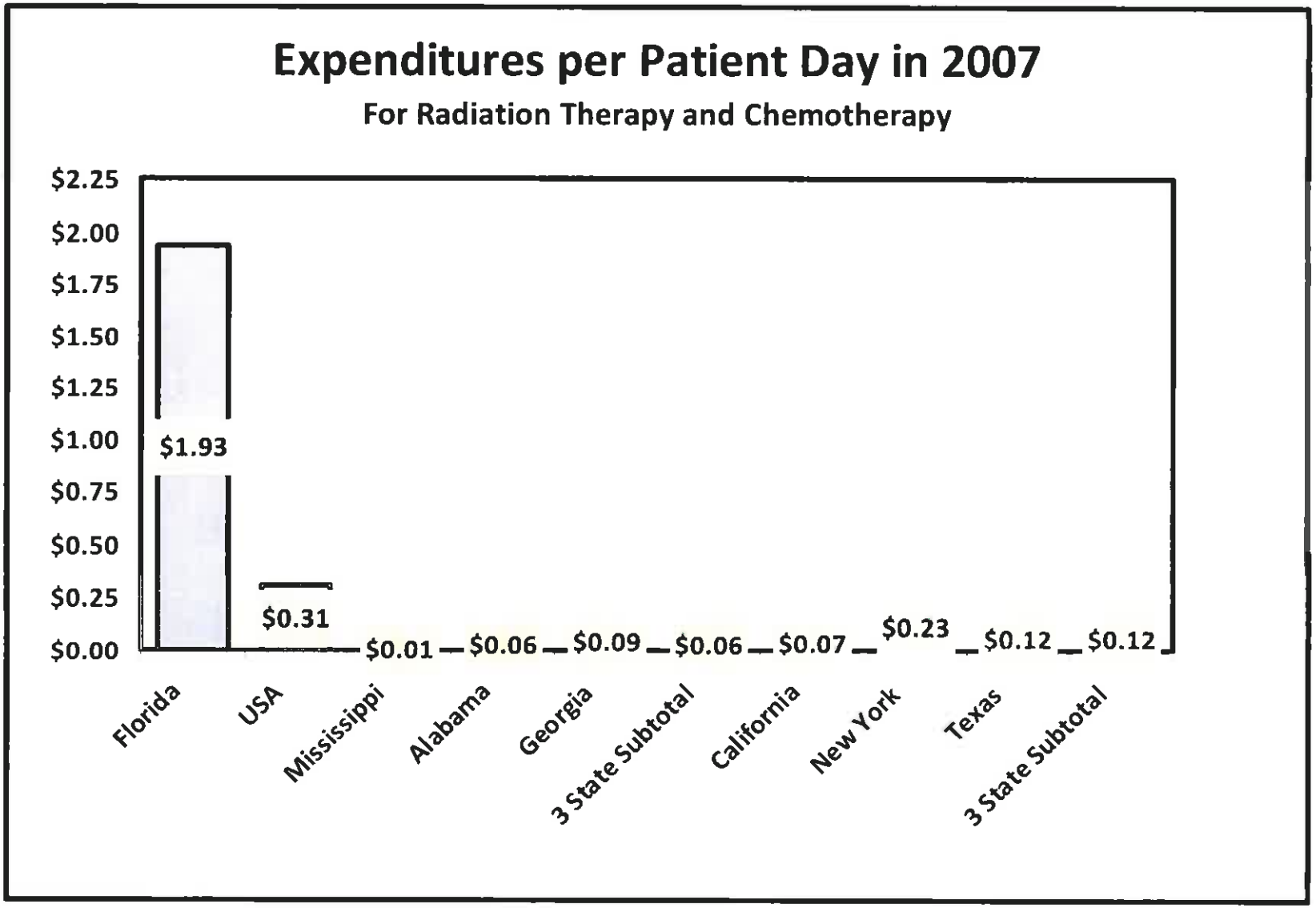

Number of Hospice Providers
Per 1,000 Medicare Deaths in 2007
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
0.3
1.7
5.8
3.6
2.6
3.6
1.2
0.4
2.3
1.3
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

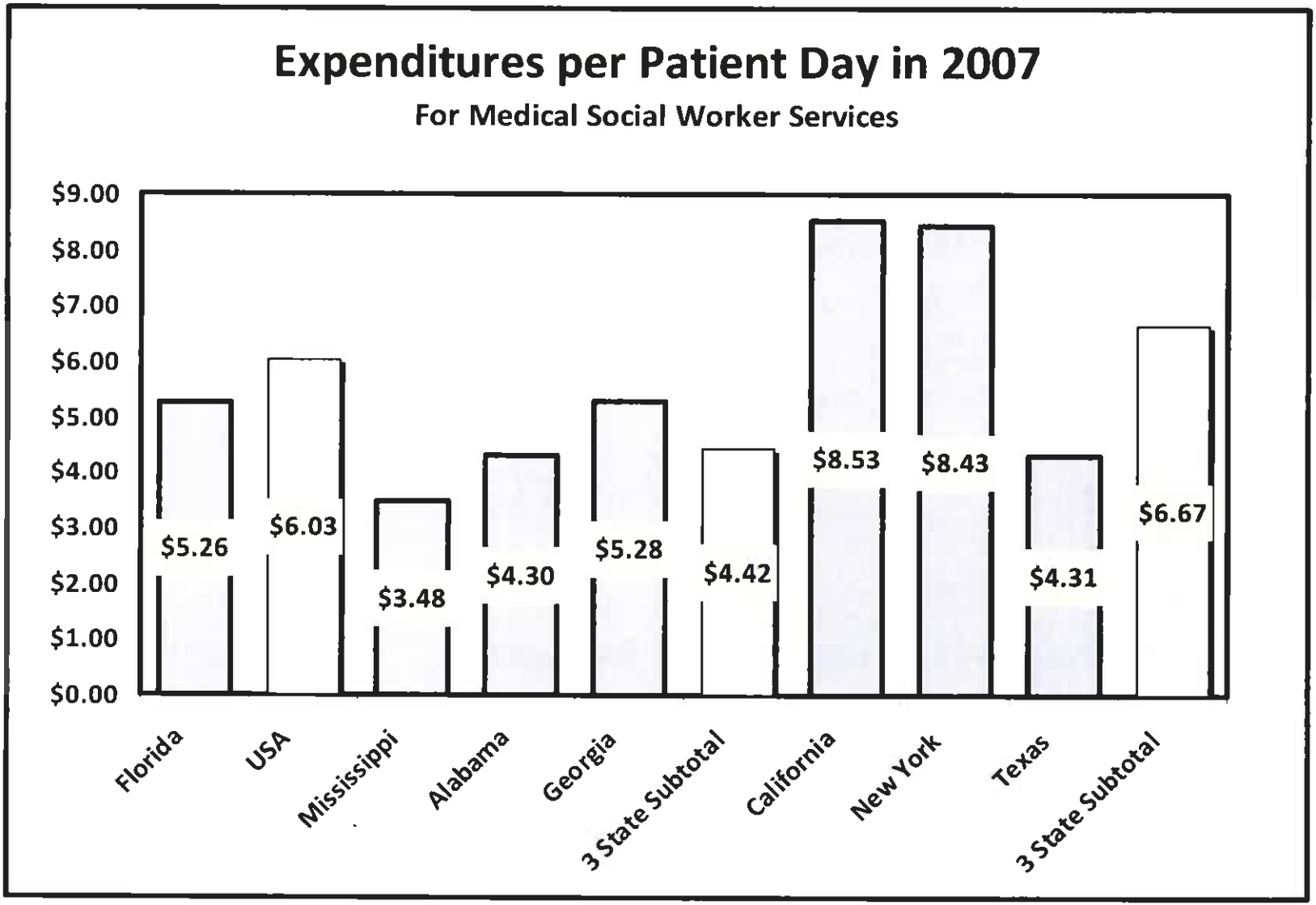

Total Hospice Expenditures per Patient Day in 2007
$200
$180
$160
$140
$120
$100
$80
$60
$40
$20
$0
$146
$139
$105
$104
$145
$118
$168
$187
$130
$154
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

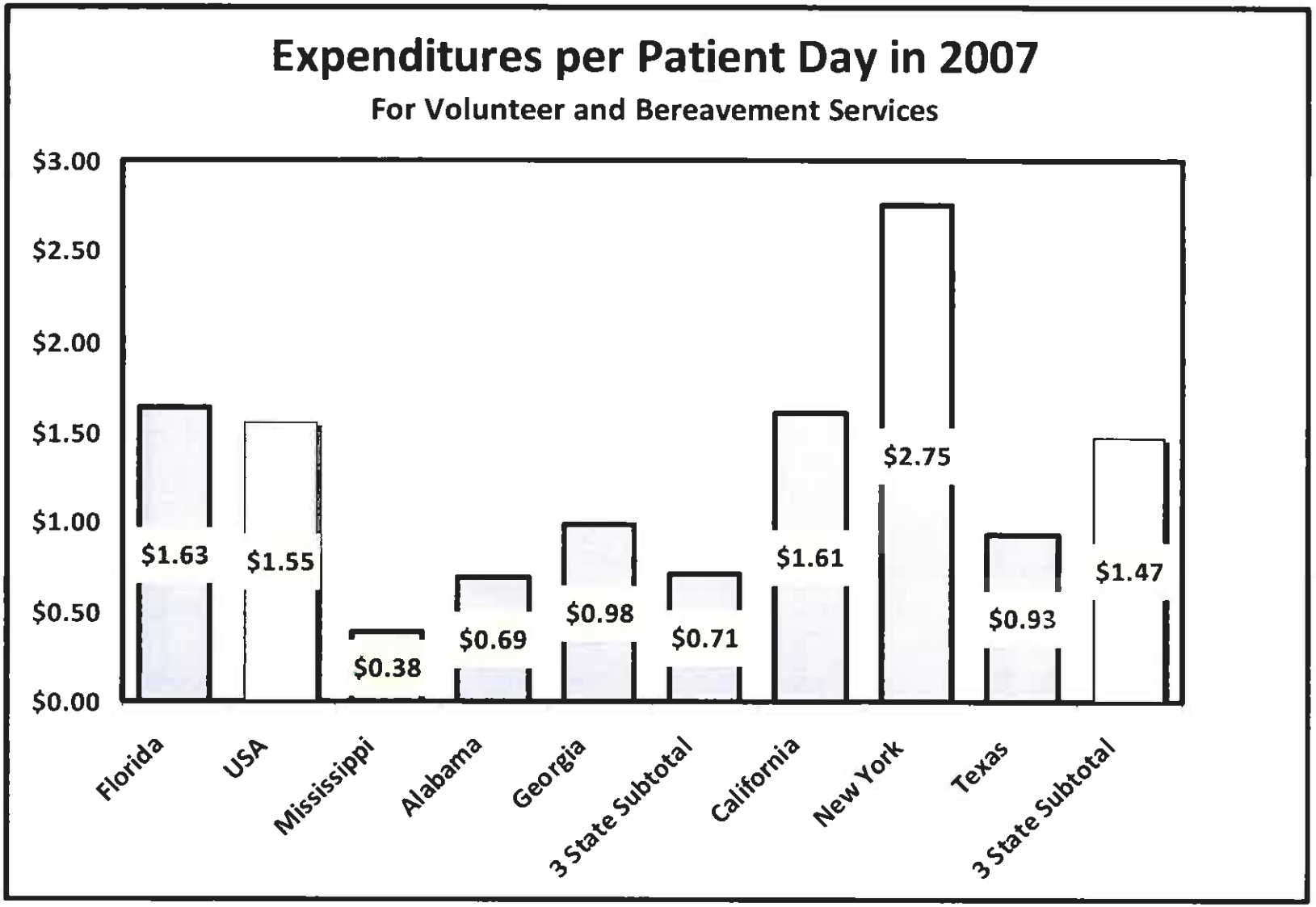

Total Hospice Expenditures per Patient Day in 2007
Administrative & General
Inpatient Services
Visiting Services
Other
Non-Reimbursable
100%
80%
60%
40%
20%
0%
14%
43%
12%
29%
13%
42%
8%
35%
13%
41%
5%
40%
15%
43%
5%
36%
11%
44%
8%
36%
13%
43%
6%
37%
11%
44%
3%
39%
14%
43%
13%
27%
13%
42%
5%
37%
12%
43%
6%
36%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

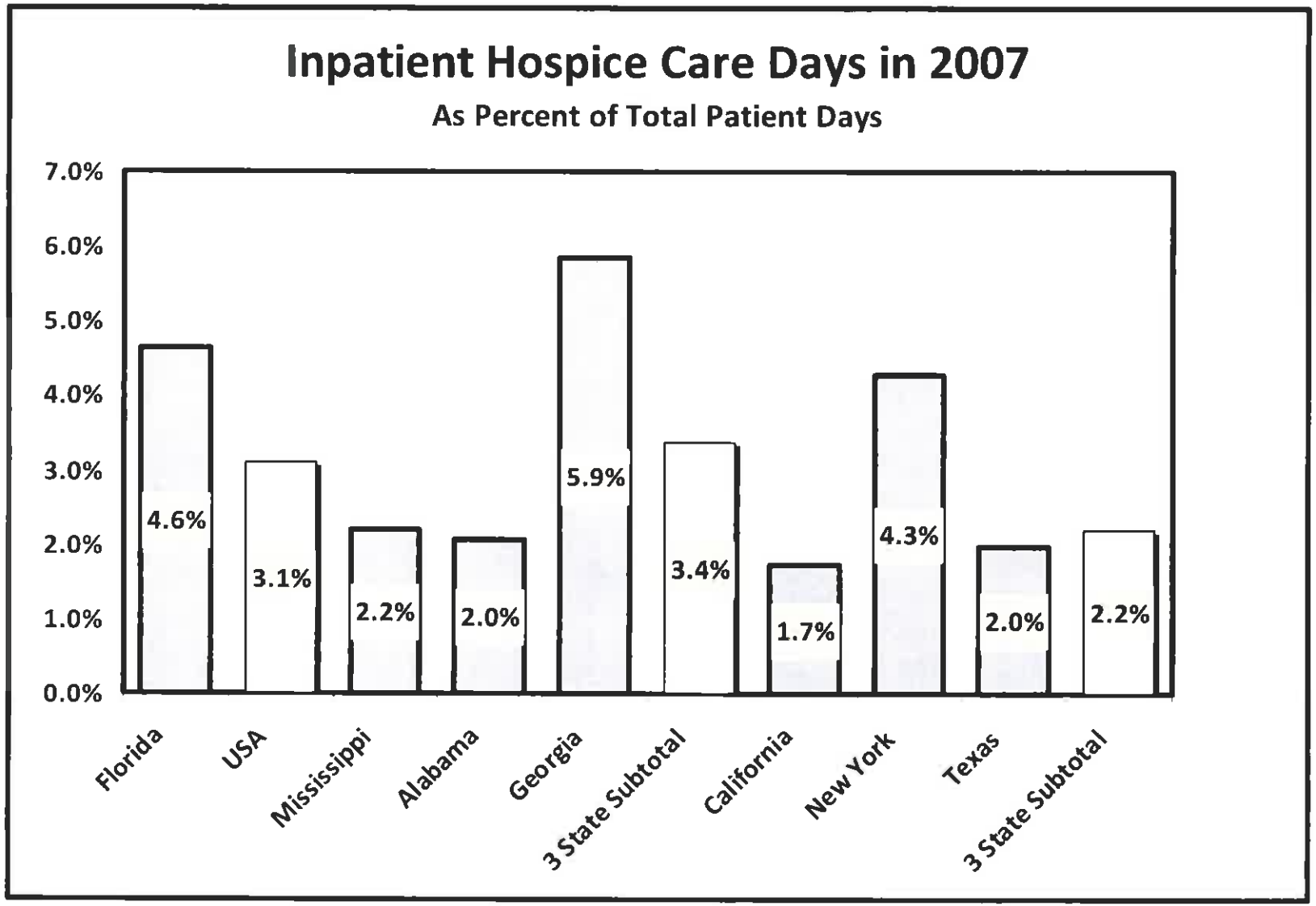

Total Costs per Patient Day in 2007
Administrative & General
Inpatient Services
Visiting Services
Other
Non-Reimbursable
$200
$180
$160
$140
$120
$100
$80
$60
$40
$20
$0
$3.61
$19.95
$63.70
$41.79
$2.85
$18.18
$58.98
$48.29
$0.69
$13.70
$43.09
$42.39
$1.37
$15.67
$44.66
$37.26
$1.30
$16.58
$63.06
$51.81
$1.17
$15.46
$50.43
$43.46
$3.41
$18.58
$74.25
$66.16
$4.43
$27.03
$80.52
$49.71
$2.31
$17.16
$55.08
$48.33
$3.07
$19.15
$69.73
$56.02
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal


Expenditures per Patient Day in 2007
For Visiting Services
$70
$60
$50
$40
$30
$20
$10
$0
$64
$59
$43
$45
$63
$50
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal


Expenditures per Patient Day in 2007
For Radiation Therapy and Chemotherapy
$2.25
$2.00
$1.75
$1.50
$1.25
$1.00
$0.75
$0.50
$0.25
$0.00
$1.93
$0.31
$0.01
$0.06
$0.09
$0.06
$0.07
$0.23
$0.12
$0.12
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal


Expenditures per Patient Day in 2007
For Medical Social Worker Services
$9.00
$8.00
$7.00
$6.00
$5.00
$4.00
$3.00
$2.00
$1.00
$0.00
$5.26
$6.03
$3.48
$4.30
$5.28
$4.42
$8.53
$8.43
$4.31
$6.67
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal


Expenditures per Patient Day in 2007
For Volunteer and Bereavement Services
$3.00
$2.50
$2.00
$1.50
$1.00
$0.50
$0.00
$1.63
$1.55
$0.38
$0.69
$0.98
$0.71
$1.61
$2.75
$0.93
$1.47
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal


Inpatient Hospice Care Days in 2007
As Percent of Total Patient Days
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
4.6%
3.1%
2.2%
2.0%
5.9%
3.4%
1.7%
4.3%
2.0%
2.2%
Florida
USA
Mississippi
Alabama
Georgia
3 State Subtotal
California
New York
Texas
3 State Subtotal

APPENDIX II
FLORIDA AND ARIZONA COMPARISONS

FLORIDA AND ARIZONA COMPARISONS

In 2007, Florida ranked second in hospice penetration among all states. The leading state was Arizona. A closer comparison of the two states shows that, for all counties with fewer than 15,000 Medicare deaths, Florida had a higher rate of hospice penetration in 2007.

Florida's most populous county, Miami-Dade County, accounted for only 10 percent of Florida's Medicare deaths in 2007. However, Arizona's largest county, Maricopa County, accounted for over half of the Medicare deaths in Arizona.

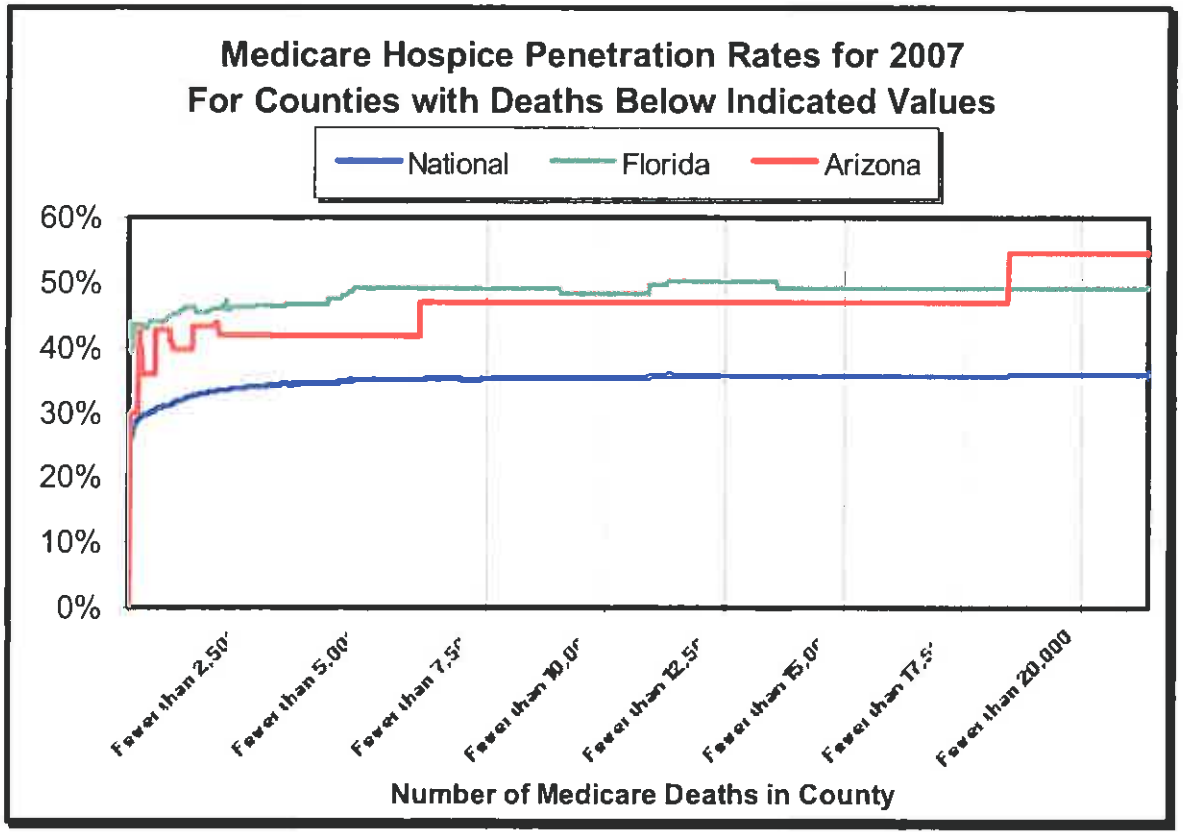
As shown in the following table, if these two largest counties are excluded from the calculations, the penetration rate in the remaining Florida counties exceeds the penetration rate in Arizona's remaining counties. Miami-Dade County has a lower-than-average penetration rate for Florida. The penetration rate for Florida, even including Miami-Dade County, is higher than the penetration rate for Arizona – excluding Maricopa County.

Medicare Hospice Penetration in 2007

Statewide	Arizona	Florida
Medicare Enrollees	883,257	3,285,590
Medicare Deaths	34,021	131,513
Medicare Hospice Deaths	18,581	64,596
Hospice Penetration	55%	49%
Hispanic Penetration Rate	44%	41%
Largest County	**Maricopa**	**Miami-Dade**
Medicare Enrollees	466,797	360,388
Medicare Deaths	18,478	13,588
Medicare Hospice Deaths	11,260	5,258
Hospice Penetration	61%	39%
Hispanic Penetration Rate	49%	36%
Other Counties	**Arizona**	**Florida**
Medicare Enrollees	416,460	2,925,202
Medicare Deaths	15,543	117,925
Medicare Hospice Deaths	7,321	59,338
Hospice Penetration	47%	50%
Hispanic Penetration Rate	40%	49%

In comparison to Miami-Dade County, Maricopa County has a more homogeneous elderly population and is less ethnically diverse. Over 60 percent of the elderly population of Miami-Dade County is of Hispanic ethnicity, but less than 10 percent of the elderly population of Maricopa County is Hispanic. Thirteen percent of the elderly population of Miami-Dade County is African-American, but less than three percent of the elderly population of Maricopa County is African-American.

The Medicare hospice penetration rate for Florida counties in 2007 was higher than for all Arizona counties over a wide range of county population sizes – excluding only Maricopa County, the most populous county in Arizona (see the following chart).



This chart compares the Medicare hospice penetration rates for Florida, Arizona and the nation for a range of county sizes. In general, hospice penetration increases with the number of deaths in a county. For all ranges of counties shown in the chart, Florida has a higher penetration rate than Arizona – until the largest county in Arizona is considered.