Florida TaxWatch

Evaluating Hospice Certificate of Need in Florida

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Dear Fellow Taxpayer

Florida's elderly population continues to grow at a rate faster than the national average. For those who know in advance that the end of life is near, difficult decisions about medical care and other forms of support must be made. Hospice provides relief from symptoms, pain, and stress for patients diagnosed with terminal diagnoses/prognoses.

Hospice services are regulated through a process known as "Certificate of Need," designed to control costs, improve quality, and ensure access to hospice services. Florida is one of 12 states that regulate hospice through Certificate of Need. Florida ranks second nationally in terms of the number of hospice patients served, but 37th in the number of hospice providers. As a result of Certificate of Need, a smaller number of larger than average size hospices are able to provide greater access to patients.

This has prompted some to call for the repeal of Certificate of Need. Critics assert that repealing Certificate of Need will increase competition and that market forces will control costs and quality, and increase access to hospice care. During the 2017 legislative session, unsuccessful efforts were made to repeal Certificate of Need for hospice providers. Further, the Constitutionally-mandated Constitution Revision Commission considered a measure whereby the number of hospice facilities would not be limited by the granting of a Certificate of Need; however, this measure was withdrawn from consideration by the Commission (a decision which Florida TaxWatch applauds).

With the 2018 legislative session behind us, it is both appropriate and timely for TaxWatch to conduct an in-depth study of hospice care in Florida, with emphasis on the Certificate of Need process and the effects if it is repealed. TaxWatch is pleased to present this report and its findings, and looks forward to engaging policymakers and hospice regulators in discussion during the upcoming legislative session and beyond.

Sincerely,

Dominic M. Calabro

Dominic M. Calabro
President & CEO

Executive Summary

For those who know in advance that the end of life is near, decisions about medical care and other kinds of support are personal and sensitive. Central to this discussion is hospice, which is the preferred model for end of life care in the United States. Hospice services focus on palliative care, the provision of relief from symptoms, pain, and stress, with the goal of maintaining or improving the quality of life for enrollees. Hospice enrollees generate thousands of dollars in per-patient cost savings compared to individuals near the end of life who do not participate in hospice. Savings are primarily attributable to reductions in emergency care, futile care, and in-patient hospitalizations among hospice enrollees.

In Florida, the expansion of hospice programs and other health care facilities and services is guided by the "Certificate of Need" ("CON") process. Since the CON approval requires that providers enroll all eligible individuals seeking care within their assigned service area, hospices in Florida see relatively high utilization rates.

According to the 2017 Medicare Hospice Provider Report, which includes newly-released Medicare 2016 hospice patient information, Florida ranked 3rd among the 50 states and District of Columbia in terms of total hospice utilization in 2016, with more than 8.5 million patient days. Only California (10.1 million patient days) and Texas (9.4 million patient days) had higher hospice utilization than Florida. Florida had the highest overall utilization among the CON states, demonstrating that CON can be an effective means of ensuring hospice utilization.

Those who would rush to judgment and recommend that Florida, like many other states, repeal CON for hospice should consider the likely consequences: first, the demand for health care professionals trained to care for older adults continues to outpace the supply of geriatric specialists; second, the incidence of fraud is likely to increase, and Florida already leads the nation in many types of Medicaid and Medicare fraud (such as home health where no CON is required); third, the increased competition that will likely result from the repeal of CON will not reduce the costs of hospice care because most hospice services are funded by government programs (e.g., Medicare and Medicaid) that reimburse providers at a fixed per diem rate; and finally, repealing CON for hospice providers is likely to limit access for rural patients.

Characteristic of states whose hospice programs are regulated through a CON program, Florida has a large number of patients, a small number of providers, and a large patient-to-provider ratio. While much of the country has experienced explosive growth in the number of hospice providers, CON oversight has resulted in a more modest growth in the number of hospices in Florida.

Florida TaxWatch recommends the CON process be retained, and that hospice regulators continue to identify ways that Florida hospice providers can better control hospice costs, improve the quality of hospice care, and direct investments into medically-needy areas.

Introduction

From individuals seeking health services to those crafting related policies, Americans are well aware that the demand and cost for quality health care is on the rise. Among the drivers of this demand are growth in the nation's aging population and increasing life expectancy. Nationally, anticipated demographic shifts are dramatic: Between 2010 and 2050, the United States population aged 65 and older will about double, the number of those aged 80 and older will nearly triple, and the number of nonagenarians and centenarians will quadruple.[1]

At the forefront of this trend, the proportion of Florida's elderly is growing faster than the national average. While overall, the number of Americans aged 65+ will "about double" between 2010 and 2050, the number of Floridians aged 65+ is expected to *more than double* in the same period (from 3.3 million in 2010 to 7.4 million in 2050).[2] Those aged 85+ is the fastest-growing segment of Florida's elderly. They are expected to comprise 6.5 percent of the state's total population in 2050, up from 2.3 percent in 2010 (280 percent growth).[3] These numbers reflect the steady influx of retirees to the state and capture the impact of the baby boomers reaching their eighties, the age at which reliance on government services such as Medicare rises dramatically, and discussions about end of life care become critical.

For those who know in advance that the end of life is near, decisions about medical care and other kinds of support are personal and sensitive. Nonetheless, in such a vulnerable time, individuals may be empowered by choices they can make to enhance their comfort and dignity. Hospice is the primary model for end of life care in the United States. In Florida, a process to regulate the expansion of health care facilities and services commonly referred to as "Certificate of Need" ("CON") significantly shapes opportunities for hospice care providers to open, based upon need. The effects of this state regulation on hospice coverage, quality, and cost are especially salient as Florida's elderly population grows in number, proportion, and age.

1 The Rising Cost of Living Longer: Analysis of Medicare Spending by Age for Beneficiaries in Traditional Medicare, The Kaiser Family Foundation. January 2015. www.kff.org/medicare/report/the-rising-cost-of-living-longer-analysis-of-medicare-spending-by-age-for-beneficiaries-in-traditional-medicare/view/footnotes/#footnote-124033-1.

2 For Florida, the graying of America presents both promises and pitfalls, Florida Trend. March 2016. www.floridatrend.com/article/19683/for-florida-the-graying-of-america-presents-both-promises-and-pitfalls.

3 Ibid.

About Hospice

Services

Central to this discussion is hospice, which provides specialized care to people at the end stages of life. Hospice eligibility is generally offered upon the exhaustion of curative treatment. This means a medical professional certifies that each patient's condition is terminal,[4] and patients waive access to life-prolonging therapies as a condition of hospice admission. Hospice services focus on palliative care, the provision of relief from symptoms, pain, and stress, with the goal of maintaining or improving the quality of life for enrollees.

In addition to medical services, hospice must provide psychosocial and end of life planning support for patients, and respite and bereavement services for their families. This includes the provision of professional healthcare chaplains who are trained to help patients and family members cope with illness.

Hospice aims to maximize patients' independence during their final days of life by physically meeting them where they are when possible. Care may take place in patients' homes, short-term institutional settings like hospitals, or long-term residential facilities such as nursing homes, as appropriate. Many hospice organizations also offer standalone, inpatient facilities.

No matter where patients are served, care is supervised by health care professionals, which by law includes interdisciplinary teams of physicians, nurses, and social workers or other psychosocial specialists, such as chaplains and spiritual counselors. In addition to professional staff, Medicare requires that volunteers provide at least 5 percent of hospice patient care hours. Volunteers may serve in companionship capacities and/or assist with some aspects of patient care. The decentralized model of care and the reliance on volunteer involvement make hospice a community-centered provider type. It is important to note that hospice provides supportive care, meaning that the bulk of routine activities associated with living or caregiving (such as dressing, washing, cooking, and transportation) falls to patients' family, friends, or an institutional organization such as an assisted living facility.

4 By Florida statutes, "terminal" means a patient's life expectancy is less than one year, given a natural progression of an illness or other condition. The federal government restricts this life expectancy to six months. See F.S. 400.601 Nursing Homes and Related Health Care Facilities, www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0400/Sections/0400.601.html.

Levels of Care

Each year, 1.6 million Americans enter hospice.[5] Hospice organizations operate on a risk-assumed, per diem payment basis,[6] and take on all care related to patients' terminal illnesses.[7] Hospice is provided at four levels of care (see Table 1) that reflect the relative intensity of services and thus, cost.[8] Almost all patients are admitted and die at the Routine Home Care level,[9] which accounts for 95 percent of hospice services nationally, though patients fluctuate between the levels as their conditions warrant.[10] All levels include visits from the interdisciplinary hospice care team, payment for medications directly related to a patient's terminal diagnosis, durable medical equipment, soft goods, and 24 hour access to "on-call" hospice nurses.

Table 1. Hospice Levels of Care

LEVEL OF CARE	FY 2017 PER DIEM PAYMENT RATE	DESCRIPTION
Routine Home Care	$190.55 (Days 1-60) $149.82 (Days 61+)	Provided within patient's residence. No time limit as long as patient continues to meet hospice admission criteria.
General Inpatient Care	$964.63	Brief inpatient care to manage acute or chronic symptom that cannot be managed in other settings. May be required for procedures necessary for pain or symptom control. May be provided in contracted hospitals.
Inpatient Respite Care	$170.97	To provide a rest period or break for the caregiver. Care will be provided for a minimum of 3 days and a maximum of 5 days per occurrence.
Continuous Home Care	$734.94	Provided at the patient's residence during a short-term, temporary period of crisis. Requires a minimum of 8 hours of care during a 24-hour day and a need for skilled nursing. Nurse (RN or LPN) present for more than 50 percent of the hours of continuous care. Certified Nursing Assistant, homemaker, companion sitter, or social worker present when no nurse present.

5 Hospice Facts and Figures, National Hospice and Palliative Care Organization. November 2014. www.nhpco.org/press-room/press-releases/hospice-facts-figures.

6 Payment rates for hospice care, the hospice cap amount, and the hospice wage index are updated annually by the federal government, adjusted for multifactor productivity and to reflect local differences in wages. See Hospice Payment System, U.S. Center for Medicaid and Medicare Services. September 2016 www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice-pay-sys-fsTextOnly.pdf.

7 Palliative Care in Florida: A Report to the Surgeon General of the Florida Department of Health by the Palliative Care Ad Hoc Committee. June 2016. Accessed via www.issuu.com/floridahealth/docs/palliative_care_in_florida__2016.

8 For more details see chart in appendix or Know the Difference: Hospice & Palliative Care, Center for Hospice Care. Accessed October 2017. www.hospicesect.org/hospice-and-palliative-care.

9 Since January of 2016, Routine Home Care payments have been made at a higher rate for the first 60 days of hospice care and a reduced rate for hospice care beyond 60 days to account for the relatively high setup costs of hospice care at the time of admission.

10 Updates to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Prices for Fiscal Year 2017, United States Department of Health and Human Services Centers for Medicare and Medicaid Services. July 2016. Accessed via www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9729.pdf.

Hospice Payments

Hospice care is paid for in full by both Medicare and Medicaid, through a Hospice Benefit for each program. Most insurance and the Veteran's Administration also cover hospice services in full or with minimal co-pays.[11] Since 98 percent of elderly Americans are Medicare beneficiaries, and nearly half of all Medicare patients who die each year do so as hospice patients, Medicare is the primary payer of hospice programs, accounting for 80 percent of all hospice billings.[12] In 2015, Medicare paid hospice providers a total of $15.9 billion for care provided, an average of $11,510 per Medicare hospice patient.[13]

Though a striking figure, there is broad recognition of the cost savings associated with hospice. Most notably, hospice enrollees are known to generate thousands of dollars in per-patient cost savings compared to individuals near the end of life who do not participate in hospice. Savings are primarily attributable to reductions in emergency care and in-patient hospitalizations among hospice enrollees.[14] In addition to considerations of quality of life, this cost saving potential is a compelling reason for policy makers to ensure that hospice is available for timely enrollment to qualified patients who desire the benefit.

Hospice Oversight

Hospice in Florida is governed by the state's Certificate of Need (CON) statute, a regulatory regime that affects a number of health care services. Under CON, major hospice investments, including new hospice establishments and the expansion of existing programs, are subject to a state review and approval process. Florida's Agency for Health Care Administration (AHCA) reviews applicant proposals from a needs formula calculation twice a year, and provides approval when the agency has identified a projected demonstrable need (i.e., patient demand) as defined by Florida Statutes.

CON legislation in Florida, as in many states, originated from the federal Health Planning Resources Development Act of 1974. The Act called for the development of state health planning agencies and enumerated regulatory functions for them. These were to include an annual review of long-range goals and short-term priorities and an application and review process for major capital projects. The original intent was to rein in growing and exorbitant health care costs by instituting a comprehensive, more uniform approach to health care delivery across both the public and private sectors.[15] Medicaid hospice benefits closely mirror hospice benefits available through Medicare. The federal Act was repealed in 1987, along with associated federal funding.

11 Know the Difference: Hospice & Palliative Care, Center for Hospice Care. Accessed October 2017. www.hospicesect.org/hospice-and-palliative-care.

12 Hospice, Inc. Huff Post. June 2014. Accessed via http://projects.huffingtonpost.com/hospice-inc.

13 Hospice Facts and Figures, National Hospice and Palliative Care Organization. November 2014. www.nhpco.org/press-room/press-releases/hospice-facts-figures.

14 See Hospice Cost.

15 Status of the Implementation of the National Health Planning and Resources Development Act of 1974. HRD-77-157: Published: Nov 2, 1978. Accessed October 2017. www.gao.gov/products/HRD-77-157.

In the time since, 14 states have repealed their CON legislation altogether (most recently New Hampshire in 2016).[16] One state, Alabama, repealed and then reinstated its CON legislation. Currently, 36 states and the District of Columbia uphold some form of CON legislation. The relative scope of specific policies varies significantly across these states, and only ten states include hospice in their CON rules. The CON laws vary significantly from state to state, making side-by-side comparisons extremely difficult. In Florida, CON regulation governs 15 forms of health facility investments,[17] placing the state's CON policy among the middle of pack in terms of scope and stringency.

Hospice Approval

Applications to establish new hospice programs can be approved in the absence of a demonstrated numeric need. In the absence of a demonstrated numeric need, applicants must demonstrate that circumstances exist to justify approval of a new hospice program.[18] Most projects are reviewed on a competitive basis.[19] Regardless of need, AHCA does not normally approve new hospice programs in a given service area unless each hospice program serving the area has been licensed and operational for at least two years.[20] Further, AHCA "generally rejects proposals for construction of freestanding inpatient hospice facilities in favor of contractual arrangements with existing hospitals or nursing homes."[21]

In the last five years, the state has received 55 applications for hospice Certificates of Need. Of these, 43 proposed establishing new hospice programs, 11 proposed additional inpatient hospice facilities, and one proposed the creation of a new service area through the partition of an existing service area. Seventeen counties across 10 different service areas were listed as prospective sites.[22] The proposal to partition an existing service area was rejected. Eight of the 11 inpatient facility proposals received approval, creating 110 new inpatient beds across the state, but no freestanding inpatient facilities received approval for construction in the last five years.

Under AHCA rules,[23] applications submitted in the same batching cycle for the same service or beds having the same CON methodology are comparatively reviewed. As a result, the ten batching cycles over this five-year period resulted in the review of 43 proposed new hospice programs and the

16 Certificate of need for hospice services, implications for elimination there of Certificate of Need State Laws, National Conference of State Legislatures. August 2016. www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

17 Increases in acute hospital bed, beds for intermediate care facilities for the developmentally disabled (ICF/DD), community nursing home care beds, long-term care hospital beds, mental health services beds, hospital-based distinct part skilled nursing unit beds, total licensed bed capacity of a health care facility, specialty burn unit beds, comprehensive rehabilitation beds, addition of beds by new construction or alteration, establishment of tertiary health services, hospice or hospice inpatient facility, inpatient health services by a health care facility, new construction or establishment of additional health care facilities, conversion from one type of health care facility to another, and establishment of a or a substantial change in such services.

18 Rule 59C-1.0355, Hospice Programs, Florida Administrative Code. Effective: 09/10/2015. Accessed October, 2017. www.flrules.org/gateway/ruleNo.asp?id=59C-1.0355.

19 Certificate of Need Program Overview, Agency for Health Care Administration. Accessed November 2017 via http://ahca.myflorida.com/MCHQ/CON_FA/.

20 Supra, see footnote 18.

21 Ibid.

22 Between 2012 and 2017, proposed sites included the following counties: Alachua, Brevard, Broward, Charlotte, Desoto, Duval, Escambia, Hernando, Hillsborough, Lake, Lee, Manatee, Miami Dade, Orange, Palm Beach, Pinellas, and Polk. Proposals included service areas 1, 3, 4, 5, 6, 7, 8, 9, 10, and 11.

23 Rule Chapter 59C-1.008 (Certificate of Need Applications Procedures), Florida Administrative Code.

approval of new hospice programs in the seven areas that showed a need. If and when approved, the state requires that new hospices provide care to all eligible individuals in their designated service area, and prohibits the provision of care outside of said boundaries. Because CON averts over-saturation of markets, it contributes to hospice programs being able to build state-of-the-art in-patient units funded by local community philanthropy.

Hospice Coverage

Currently, 47 organizations provide hospice care to about 125,000 patients across Florida. Hospice organizations operate within state-designated service areas, geographic regions consisting of a specified county or counties, making up 27 service areas in all.[24] As previously stated, for the 15 health services under CON, AHCA reviews all proposals for new or expanding programs and grants approval based on a criterion of "need." For hospices, need may be demonstrated in one of two ways.

Numeric need is demonstrated when a service area's projected number of unserved patients who would elect hospice is 350 or greater.[25] Such projected numbers of unserved patients are identified by projecting deaths in each service area[26] as a proportion of the service area's total population. The projection factors in current numbers of resident cancer deaths of those under age 65, cancer deaths at age 65 and over, deaths under age 65 from all causes except cancer, and deaths age 65 and over from all causes except cancer, and weighs these causes of death based on differences in the likelihood of hospice utilization for each group. If the product of this calculation reflects a growth of 350 or more potentially unserved patients, numeric need is established. Stated more simply, numeric need is formed on the basis of an anticipated rise in demand for hospice that may strain the capacity of existent hospice organizations in a given service area. When numeric need is demonstrated in a service area, AHCA will consider proposals for new hospice programs in that area, and will select one.[27]

Applicant organizations may also receive a Certificate of Need by way of a second means, "Approval Under Special Circumstances." In the absence of numeric need, applicants must demonstrate that circumstances exist to justify the approval of a new hospice, with evidence that a specific terminally ill population is not being served and/or that one or more counties within the service area of a licensed hospice program is underserved. For example, an applicant organization could attempt to demonstrate that a particular racial or ethnic group was underserved in a service area, or that an especially remote part of a particular service area was underserved. Then, AHCA may consider proposals to service that specific, underserved population. Approval Under Special Circumstances is thus a caveat created to ensure coverage for populations who otherwise may be underserved by established hospice providers.[28]

24 Certificate of Need (CON) Program Overview: Hospice. Florida Agency for Health Care Administration. Accessed November 2017, http://ahca.myflorida.com/MCHQ/CON_FA/. For map: https://ahca.myflorida.com/MCHQ/CON_FA/maps/images/hospice.jpg

25 Rule 59C-1.0355, Hospice Programs, Florida Administrative Code. Effective: 09/10/2015. Accessed October 2017. www.flrules.org/gateway/ruleNo.asp?id=59C-1.0355.

26 Based on a 3-year average resident death rate for that service area.

27 For the purpose of a succinct overview, a simplification of the numeric need formula is presented here. For a complete description of the weights and figures included in this calculation, please see Hospice Programs Rule 59C-1.0355, available via www.flrules.org/Gateway/View_notice.asp?id=16383414.

28 Statutory provision is a rare, third means by which a hospice organization may be granted a CON. This means has only be utilized once in Florida.

Analysis

Beneficiaries

Nationally, Florida ranks second in the number of annual hospice beneficiaries (patients),[29] with a little more than 125,000 individuals in the state receiving end of life care through hospice each year.[30] This puts Florida just behind California, which served 128,635 hospice beneficiaries in 2014, and ahead of Texas, which served 106,601 that year. These three states care for significantly greater numbers of hospice enrollees than other states, comprising 26 percent of all hospice beneficiaries in the country. By comparison, Pennsylvania, ranked fourth nationally in number of annual enrollees, cared for just 68,255 hospice patients in 2014.

Hospice Providers

Though second in number of hospice patients, Florida ranks 37th in number of hospice providers. Neither California nor Texas has CON policies in place, and Florida's 43 hospice providers in 2014 paled in comparison to the number of providers in those states: California boasted 612, and Texas, 500.[31] This difference reflects a national pattern: states that oversee hospice through Certificate of Need legislation average only 46 service providers per state, compared to an average of 94 providers among the 38 states without this kind of regulation. Though dramatic, the difference is unsurprising; limits on new hospice entrants is a direct goal and product of CON policies that are intended to control costs and ensure high rates of utilization.

Still, of the ten hospice CON states, three claim more providers than Florida: North Carolina (78), Tennessee (57), and New York (45). None of these states cared for even 50,000 individuals in 2014. In contrast, Florida, with the second-largest population of hospice enrollees in the country, is served by relatively few, but very large, hospices.

In the last decade, while much of the country has witnessed explosive growth in the number of hospice providers, CON oversight has resulted in a more modest growth rate for Florida. The 2006 Florida Legislature authorized for-profit entities to operate hospice programs in the state. Prior to that, Florida was the only state in the country to bar for-profit hospice providers. Since the legislative change, for-profit hospice organizations in Florida have grown steadily in number, nearly doubling their market share in recent years, from 17 percent in 2009 to 31 percent in 2015. Though the extent of the growth is different in Florida (because of CON legislation), the rise of for-profit hospices in this state is consistent with growth patterns elsewhere, and suggests that, among potential providers, there is great interest in serving the state.

29 Based on the most recent available data (2014) for Medicare-eligible recipients (98 percent of all hospice beneficiaries nationally).

30 Specifically, 120,517 in 2014, compared to 125,618 in 2016.

31 Medicare Provider Utilization and Payment Data: Hospice Providers. U.S. Center for Medicaid and Medicare Services. September 2017. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html.

Overall Hospice Utilization

Under the state's current CON restrictions, existing hospice providers benefit from the limited number of hospice providers. Since the CON approval requires that these providers enroll all eligible individuals seeking care within their assigned service area, hospices in Florida see relatively high utilization rates. Utilization is a central concern for hospices generally, because of the risk-assumed, per diem reimbursement model under which they operate. High utilization is one way providers can mitigate some operational risk. It can help hospices offset costs associated with providing rural, indigent, and other more expensive kinds of care.

One measure of hospice utilization is the number of Medicare beneficiaries served by hospice out of all Medicare beneficiaries in a given state.[32] By this measure, Florida ranked tenth in 2014, with 3.03 percent of all Medicare beneficiaries in the state having received hospice care.[33] That year, the national average by this measure was 2.59 percent, against which Florida's utilization appears relatively high (17 percent higher).

According to the 2017 Medicare Hospice Provider Report, which includes newly-released Medicare 2016 hospice patient information, Florida ranked 3rd among the 50 states and District of Columbia in terms of total hospice utilization in 2016, with more than 8.5 million patient days. Only California (10.1 million patient days) and Texas (9.4 million patient days) had higher hospice utilization than Florida. Florida had the highest overall utilization among the CON states, demonstrating that CON can be an effective means of ensuring hospice utilization. The top 10 states in terms of hospice utilization, and their CON status, are identified in Table 2.

Table 2. Overall Hospice Utilization (2016)

State	Utilization Patient Days	Hospice CON State
California	10,087,919	No
Texas	9,411,486	No
Florida	**8,529,487**	**Yes**
Ohio	4,756,725	No
Pennsylvania	4,304,891	No
Georgia	3,809,296	No
Michigan	3,372,970	No
North Carolina	3,177,420	Yes
Illinois	2,987,002	No
Alabama	2,817,976	No
Source: 2017 Medicare Hospice Provider Report		

A more-detailed, site-specific analysis of hospice utilization is presented in a later section of this report.

32 Since Medicare beneficiaries represent 98 percent of all hospice patients, and since Medicare is the largest payer of hospice care, Medicare figures are typically used in calculating utilization.

33 State by State Hospice Utilization, Healthcare Market Resources, Inc. 2017. Accessed via www.healthmr.com/wp-content/uploads/2017/03/STATE-BY-STATE-HOSPICE-UTILIZATION-2006-2015.pdf.

Hospice Quality

As of 2016, all 45 Florida hospices met the state's standard mandatory outcome measure: that 50 percent or more of patients who reported severe pain (greater than five on a 0-10 scale) at the time of admission subsequently reported a reduction in pain (to five or less on the same scale) by the end of the fourth day of care in a hospice program.[34]

In fact, Florida hospices reported that, on average, 82 percent of patients admitted in pain subsequently reported this reduction by the end of the fourth day in a hospice program.[35] This is one piece of promising evidence of quality hospice provision in the state. Hospice quality is also reflected in the data annually submitted to the U.S. Centers for Medicare & Medicaid Services (CMS). These data include information ranging from patients' primary diagnoses at the time of admission to patients' length of stay and level of services rendered.

Since reimbursement is at a per diem rate, hospice organizations tend to rely on patients with longer life expectancies to offset the costs of those who require more resource-intensive care. The median length of hospice stay is comparable between CON and non-CON states, at 65 and 63 days respectively.[36] Similarly, the proportion of patients in hospice for 60 or more care days is comparable (43 percent in CON states, 42 percent in others). Individuals who received seven or fewer care days, however, made up about 23 percent of all hospice patients in CON states, compared to 11 percent in non-CON states.[37]

In Florida, 31 percent of patients receive hospice care for seven days or fewer, a proportion more comparable to other CON states like New York (32 percent) than non-CON states like Georgia (25 percent), Texas (25 percent), and California (23 percent). At the same time, 46 percent of patients enrolled in hospice care in Florida received care for more than 60 days in 2014. This put the state above the national median for this metric (42 percent), but well behind Alabama (62 percent), and other non-CON states like Texas (56 percent), Georgia (56 percent), Louisiana (52 percent), and California (49 percent), which more frequently cared for patients for longer spells.

Like utilization rates, patient length of stay may have important implications for hospice viability. This is because hospice care costs are "U-shaped" over time, with setup costs in the first week of care and costs in the last days before death higher for each patient than the care provided in between (mainly due to the increased frequency of nurse and physician visits at the time of hospice admission and in the last days of life). As shown above, Florida has high percentages of hospice patients at both ends of the "U-shaped" curve, where the costs are the highest.

Another measure to consider is the proportion of live patient discharges. Sometimes patients elect to discontinue hospice after admission. Since physicians confirm patients' terminal diagnoses

34 Hospice Demographics and Outcome Measures 2016 Report, Florida Department of Elder Affairs. Accessed October 2017. http://elderaffairs.state.fl.us/doea/Evaluation/2016_Hospice_Report_Final.pdf.

35 Ibid

36 The median is used in many figures here to reduce the distortion of figures caused by an outlier among either CON or non-CON state groupings.

37 Median, against total hospice patients.

prior to hospice admission, live discharges are not generally indicative of a sudden turnaround in patient condition. Rather, live discharges usually reflect dissatisfaction with hospice care, patient hospitalization, or sometimes (in Florida) a patient move or transfer to somewhere beyond a hospice's service area (e.g., "snowbirds" returning home).

In 2014, about 11 percent of all admitted patients were discharged alive in CON states, 12 percent in non-CON states. Florida's proportion of live discharges was slightly lower at 10 percent, differentiating it from Georgia (15 percent), California (15 percent), and Texas (13 percent), and even other CON states like Alabama (18 percent) and South Carolina (20 percent). In sum, though proportionately more patients have short hospice stays in Florida, proportionately fewer patients leave hospice once admitted. Research indicates that patients residing in markets with more hospital beds and greater hospice capacity enroll in hospice earlier (farther from death), which can enhance patient quality of life and contribute to significantly to care cost savings.[38]

Site of Service

The greatest divergences in hospice provision between CON states and non-CON states arise in the nature and context of specific care services. Site-of-service, the location where the majority of a patient's care takes place, is one aspect of hospice provision that CON policies seem to affect. Site-of-service is not a perfect correlate to the level of hospice care provided. For instance, an individual can receive Continuous Home Care, a relatively intensive level of hospice care, in a private home or residential facility and, conversely, receive Inpatient Respite Care, a relatively low level of care, in an inpatient hospice bed (as the name implies).

Still, the location where the majority of a patient's care takes place can be a useful proxy for the intensity of care because it is unlikely that a patient will receive Continuous Home Care or Inpatient Respite Care for the majority of their time in hospice. Both of those are services designed to be of limited duration, the former provided at the patient's residence during a short-term, "temporary period of crisis," and the latter to provide a rest period or break for the patient's primary caregiver.[39]

Hospice CON policies have an observable impact on the preponderance of inpatient care. Fourteen percent of Medicare beneficiaries receive the majority of their hospice care days in an inpatient setting, compared to nine percent of beneficiaries in states without hospice CON.[40] That is 44 percent more inpatient care utilization in hospice CON states. The reason for this difference is unclear. It may be an illustration of Roemer's Law: "in an insured population, a [hospice] bed built is a filled bed." That is, providers in CON states may encourage hospice patients to utilize inpatient care more frequently, simply because inpatient facilities are at their disposal. Alternatively, states without CON oversight may have hospice patients in need of inpatient care who are unable to access it due to a limited or uneven distribution of inpatient facilities across a state or region. In this latter case, the

38 Impact of Individual and Market Factors on the Timing of Initiation of Hospice Terminal Care. May 2000.

39 The relative intensities of these levels of care is also reflected in their respective Medicare reimbursement rates. See the chart on page 6 for more information.

40 Based on the number of distinct Medicare beneficiaries receiving the majority of their hospice care days in a hospice-contracted bed in a hospital or other inpatient hospice facility, as opposed to a home setting, such as a private residence or non-contracted bed in a nursing home or assisted living facility.

relatively low proportion of inpatient stays reported by non-CON states may be a reflection of a deficit in supply, to the detriment of hospice patients.

Specific Service Utilization

Inpatient Care

Inpatient care can also be analyzed in terms of its utilization relative to other forms of hospice services. According to the 2017 Medicare Hospice Provider Report, hospices nationwide reported a total of 1,446,135 inpatient days of hospice service in 2016. Almost 20 percent (288,540 days) were provided by hospices in Florida, making Florida by far the leading inpatient hospice state in the country. Inpatient hospice care represents 3.4 percent of the total number of hospice days in Florida in 2016.[41] The top 10 states, in terms of inpatient hospice days in 2016 and CON status, are identified in Table 3. It is important to note that three of the top five states are CON states, demonstrating that CON can be an effective means of ensuring inpatient hospice utilization.

Table 3. Inpatient Hospice Utilization 2016 (Top 10 States)

	State	Utilization Patient Days	Hospice CON State		State	Utilization Patient Days	Hospice CON State
1	**Florida**	**288,540**	**Yes**	6	Georgia	62,163	No
2	Ohio	105,703	No	7	Pennsylvania	56,649	No
3	Texas	94,955	No	8	Illinois	53,138	Yes
4	North Carolina	89,942	Yes	9	California	39,960	No
5	New York	82,781	Yes	10	Arizona	37,810	No

Source: 2017 Medicare Hospice Provider Report

Nonetheless, Florida, Texas, and California are comparable in proportions of hospice patients with a primary diagnosis of cancer, those most likely to need inpatient care. These patients embody 28 percent of all hospice patients in Florida, 29 percent in California, and 25 percent in Texas. In short, patient diagnoses cannot account for the drastic variation in inpatient care provided across these states with relatively similar hospice populations. Inpatient units are funded by their communities through community fundraising. No government or public funds are required. This robust level of community fundraising helps explain Florida's high level of inpatient care. Without CON, it would be very difficult to raise the millions of private dollars, because of the multiple providers.

Continuous Home Care

According to the 2017 Medicare Hospice Provider Report, hospices nationwide reported a total of 226,354 continuous home care days of hospice service in 2016. More than 56 percent (127,224 days) were provided by hospices in Florida, making Florida by far the leading continuous home care hospice state in the country, and demonstrating that CON can be an effective means of ensuring continuous care hospice utilization. Continuous home care represents 1.5 percent of the total number of hospice days in Florida in 2016.[42] The top 10 states, in terms of continuous care hospice days in 2016 and CON status, are identified in Table 4.

41 288,540 inpatient hospice days divided by 8,529,487 total hospice days equals 3.38 percent.

42 127,224 continuous care hospice days divided by 8,529,487 total hospice days equals 1.49 percent.

Table 4. Continuous Home Care Hospice Utilization 2016 (Top 10 States)

	State	Utilization Patient Days	Hospice CON State		State	Utilization Patient Days	Hospice CON State
1	**Florida**	**127,224**	**Yes**	6	Illinois	4,586	No
2	California	33,856	No	7	New York	3,339	Yes
3	Texas	23,648	No	8	Connecticut	2,434	No
4	Ohio	12,147	No	9	New Jersey	2,260	No
5	Georgia	4,627	No	10	Pennsylvania	1,937	No

Source: 2017 Medicare Hospice Provider Report

Inpatient Respite Care

According to the 2017 Medicare Hospice Provider Report, hospices nationwide reported a total of 307,719 inpatient respite care days of hospice service in 2016. Approximately 7 percent (23,495 days) were provided by hospices in Florida, ranking Florida 3rd among the 50 states and District of Columbia. Only Texas (31,599 days) and Ohio (25,087 days) had greater inpatient respite care utilization than Florida in 2016. Inpatient respite care represents less than one percent of the total number of hospice days in Florida in 2016.[43] The top 10 states, in terms of inpatient respite care hospice days in 2016 and CON status, are identified in Table 5.

Table 5. Inpatient Respite Care Hospice Utilization 2016 (Top 10 States)

	State	Utilization Patient Days	Hospice CON State		State	Utilization Patient Days	Hospice CON State
1	Texas	31,599	No	6	Michigan	13,812	No
2	Ohio	25,087	No	7	North Carolina	13,252	Yes
3	**Florida**	**23,495**	**Yes**	8	California	12,394	No
4	Georgia	17,527	No	9	Alabama	11,608	No
5	Pennsylvania	16,921	No	10	Arizona	11,423	No

Source: 2017 Medicare Hospice Provider Report

Routine Home Care

According to the 2017 Medicare Hospice Provider Report, hospices nationwide reported a total of 96,402,263 routine home care days of hospice service in 2016. Approximately 8.4 percent (8,090,2285 days) were provided by hospices in Florida, ranking Florida 3rd among the 50 states and District of Columbia. Only California (10,001,709 days) and Texas (9,261,284 days) had greater routine home care utilization than Florida in 2016. Routine home care represents almost 95 percent of the total number of hospice days in Florida in 2016.[44] The top 10 states, in terms of routine home care hospice days in 2016 and CON status, are identified in Table 6.

43 23,495 inpatient respite care hospice days divided by 8,529,487 total hospice days equals 0.27 percent.

44 8,090,228 routine home care hospice days divided by 8,529,487 total hospice days equals 94.9 percent.

Table 6. Routine Home Care Hospice Utilization 2016 (Top 10 States)

	State	Utilization Patient Days	Hospice CON State		State	Utilization Patient Days	Hospice CON State
1	California	10,001,709	No	6	Georgia	3,724,979	No
2	Texas	9,261,284	No	7	Michigan	3,322,831	No
3	**Florida**	**8,090,228**	**Yes**	8	North Carolina	3,073,616	Yes
4	Ohio	4,613,788	No	9	Illinois	2,922,513	No
5	Pennsylvania	4,229,384	No	10	Alabama	2,788,205	No

Source: 2017 Medicare Hospice Provider Report

Physician Services

Physician services is another area of stark contrast between states with and without hospice CON regulation. Physician services identifies the total number of hospice care physician services provided to patients, in this case annually and by state. In 2014, about 14,801 physician services were provided to roughly 26,227 hospice patients in each CON state, while about 6,894 physician services were provided to some 17,886 patients in each state without hospice CON.[45] Put another way, the patient-to-physician service ratio among CON states is 0.56, compared to 0.39 across other states.

Here again, Florida is a significant outlier, with physicians in the state having provided 310,050 physician services to Florida enrollees in 2014, significantly more than any other state. Florida has very large and sophisticated hospice programs because of CON, and can offer a wide array of services. For many patients who have no primary physician, the hospice doctor becomes the primary physician. The next-leading state in physician services was North Carolina, which provided 69,779 physician services in that year, followed by California, with 68,843 (recall that California is the only state with more hospice enrollees than Florida).

Skilled Nursing Visits

Florida similarly stands apart with regard to another care service, that of skilled nursing visits. Nursing visits are measured by the average number of hours of this care provided per day. Nationally, states averaged 0.3 hours of skilled nursing per day in 2014 and, altogether, the states with hospice CON oversight averaged 0.32 hours per day in that year. By contrast, Florida provided 0.7 hours of skilled nursing per day. Wyoming, Connecticut, and Ohio provided the next-most amount of skilled nursing, at 0.49, 0.43, and 0.41 hours per day, respectively.

As with site of service, neither the average age of Florida's hospice patient population, nor the primary diagnoses of patients upon hospice admission, reflects the kind of drastic deviation the state sees from national trends in service provision. As with inpatient care, one possible explanation is that hospice CON regulations ensure more uniform coverage for hospice services, and thus make them more available to patients who are in need. The implication of this conclusion is that other states, especially those without CON legislation, have an uneven distribution of providers and many

45 8,090,228 routine home care hospice days divided by 8,529,487 total hospice days equals 94.9 percent.

patients who are need of (but are unable to receive) more intensive services because of asymmetries in service provision (that hospice CON regulation rectifies in Florida).

There is one more standalone feature of Florida's hospice services that warrants mention, that is the scale of available pediatric hospice care. Though only about two-tenths of hospice patients in Florida are younger than 19 years of age, 24 percent of the state's hospices are prepared to meet their needs with a designated pediatric program and specialized clinical staff.[46] Nationally, only about 8 percent of hospices have pediatric programs.[47] Thus, Florida's capacity to care for chronically and terminally ill young people is about 500 percent greater.[48]

One reason for Florida's expansive pediatric program is that, as previously described, the state's hospice organizations are much larger than those in other states. Through economies of scale, Florida's organizations are better able to absorb the costs associated with pediatric programs. Because of the limited number of providers and their relatively broad reach, Florida is also able to leverage better coverage for pediatric patients around the state.

Florida was the first state to develop and implement an innovative model of care that provides wrap-around services from diagnosis onward for individuals under 21 years of age.[49] Other states have subsequently developed sophisticated models for the provision of pediatric hospice care, including several states that do not regulate hospice through a CON process. Still, Florida's CON oversight is at least partially responsible for the pediatric hospice coverage which spans 34 counties and 11 of the state's 27 service areas and is unparalleled anywhere in the country.

Provider Performance

In 2014, the federal government enacted the "Improving Medicare Post-Acute Care Transformation Act of 2014" (IMPACT Act) which, among other things, created greater oversight and increased transparency requirements for the hospice community.[50] The Act mandates that Medicare-certified hospice providers are surveyed at least once every three years, and establishes a CMS medical review triggered by a percentage threshold for patients receiving care for more than 180 days. Hospice surveys may take the form of standard certification surveys, complaint-driven surveys, and federal monitoring surveys.

In Florida, the CON regulation and the relatively small number of hospices means that the state can readily survey hospices within these requirements. In fact, even prior to the federal mandate, Florida surveyed each hospice at least once every two years.[51] Between January of 2004 and October of 2014,

46 Partners In Care, Together For Kids Program Directory. June 2016. Accessed October 2017 via www.floridahealth.gov/programs-and-services/childrens-health/cms-specialty-programs/partners-in-care/_documents/09-16%20Program%20Directory.pdf.

47 Coverage of Palliative and Hospice Care for Pediatric Patients with a Life-Limiting Illness: A Policy Brief. U.S. National Library of Medicine, National Institutes of Health. September 2013.

48 Nationally, only 8 percent of hospices provide pediatric services. See: Pediatric Hospice and Palliative Care: A Little Knowledge Goes a Long Way, Hospice Analytics. 2015. Accessed via www.nationalhospiceanalytics.com/library/documents/Pediatric_Hospice_newsletter_article_Lindley_CO.pdf.

49 Partners in care: together for kids: Florida's model of pediatric palliative care. U.S. National Library of Medicine, National Institutes of Health. November 2008. Accessed via www.ncbi.nlm.nih.gov/pubmed/19021484/.

50 Frequently Asked Questions Regarding Hospice Licensure, Florida Agency for Health Care Administration. Accessed November 2017. http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/Hospice/Hospice_FAQs.shtml.

51 Ibid.

Florida's hospices underwent a total of 554 surveys, an average of 11.79 surveys per provider.[52] In that period, nationally, states provided an average of 290 surveys, or 3.24 per provider, meaning Florida conducted about 363 percent more surveillance of its providers than other states.

To put this difference in perspective, consider that Florida performed nearly twice as many surveys as New York, the next-leading state in hospice surveillance, which averaged of 6.14 surveys per provider between January of 2004 and October of 2014. In general, states that regulate hospice through CON legislation provide a higher level of oversight,[53] in part because the smaller number of providers make doing so more feasible. Between January of 2004 and October of 2014, states with hospice CON conducted an average of 4.28 surveys per provider, compared to 2.91 surveys per provider in states without hospice CON. These surveys can be further analyzed by considering their findings and purpose.

CMS maintains three survey classifications: standard/certification, complaint, and federal monitoring surveys. Surveys are conducted by state inspectors, and sometimes yield deficiencies (violations), which range from organizational environment, to staff training, to rights of patients. This information is reported to CMS at the provider level, and can be aggregated for cross-state analysis. Here, the survey data are examined for the last ten years using the most recent available data, which span from January of 2004 and October of 2014. Dividing the total number of deficiencies reported by state by the total number of surveys conducted per state yields a ratio that can be useful for understanding differences among states in terms of state oversight and provider performance.

Of the 554 surveys Florida conducted between 2004 and 2014, 473 deficiencies were identified, a ratio of 0.9 deficiencies per survey. By this measure, Florida ranks 7th nationally, with only six states identifying fewer provider deficiencies per survey. In all, states with hospice CON identify on average two deficiencies per survey, slightly fewer than the 2.5 deficiencies per survey reported by non-CON states. California and Texas, Florida's peers in terms of hospice population size, encountered more deficiencies per survey, 1.2 in Texas and two deficiencies per survey in California. Florida's limited number of providers and historically proactive role in surveillance (features of its hospice CON legislation) may account for some of this difference. Examining survey findings by type can yield more insight into hospice performance within and across states.

Government certification surveys ensure that hospices are performing in accordance with regulatory requirements, while complaint surveys are conducted when formal complaints have been filed against providers. Between 2004 and 2014, Florida conducted 136 standard or certification surveys of its 47 hospice providers and identified 183 deficiencies, or a deficiency to survey ratio of 1.35. Compared to the national average of 3.01 deficiencies per certification survey, Florida's providers demonstrated relative conformation to regulatory requirements.

52 Based on CMS data, Medicare Provider Utilization and Payment Data: Hospice Providers. U.S. Center for Medicaid and Medicare Services. September 2017. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html.

53 Between January 2004 and October 2014, CON states conducted an average of 4.28 surveys per provider, 32 percent more than the national average. However, this average is skewed by Florida's anomalous surveillance rates. Excluding Florida, CON states averaged 3.6 surveys per provider in that time period, only 11 percent more than non-CON states.

States with even fewer reports of deficiency per certification survey are a mix of hospice CON and non-CON states, including Utah (non-CON, 0.8 deficiencies per certification survey), Louisiana (non-CON, 0.89), Kentucky (CON, 0.95) and Tennessee (CON, 1.33). On the whole, states with hospice CON average slightly fewer deficiencies per certification survey than non-CON states, 2.63 and 3.1 respectively. Non-CON Texas just trailed Florida by this measure, with 1.56 deficiencies per certification survey, Georgia's ratio was 2.36, and California's was 2.62, figures that far exceeded the performance of providers in some hospice CON states, including North Carolina (3.28), Alabama (4.5), and New York (5.26 deficiencies per certification survey). These ratios illustrate that, while CON may have some influence, the legislation is not a cure-all for ensuring regulatory compliance among hospice providers.

Another consideration for provider performance is the absolute number of complaints reported. Between 2004 and 2014, Florida received 416 complaints, putting it 4th nationally in terms of number of complaints, behind only Texas (1,168 complaints), California (747 complaints), and Missouri (430 complaints). Of course, that Florida, Texas, and California receive more complaints than other states is somewhat unsurprising, given their sizeable hospice populations. The number of deficiencies identified as a result of complaint-driven surveys provides a more meaningful view of complaints across states.

Florida conducted 416 complaint-driven surveys between 2004 and 2014. For each of these surveys, Florida identified 0.7 deficiencies, compared to a national average of 1.4 deficiencies per complaint-driven survey. By this measure, Florida hospice providers appear to have generated complaints at much lower rates than non-CON states like Texas (1 deficiency per complaint-driven survey), Georgia (2 deficiencies per complaint-driven survey), California (2 deficiencies per complaint-driven survey), and even other hospice CON states like New York (1.4 deficiencies per complaint-driven survey), South Carolina (2.8 deficiencies per complaint-driven survey), Alabama (2.8 deficiencies per complaint-driven survey).

In this time period, only 18 states, including Florida, could lay claim to having identified less than one deficiency per complaint-driven survey (of which seven leveraged CON policies for hospice). On average, hospice CON states identified 1.14 deficiencies per complaint-driven survey, slightly fewer than non-CON states, which found 1.54 deficiencies per complaint-driven survey. These differences are starker across the medians of the different groups, with hospice CON states at 0.9 deficiencies per complaint-driven survey, and other states at 1.29. These differences cannot be wholly explained by the fact that CON states generally have fewer providers to survey, as even non-CON states with relatively few providers discover higher levels of deficiencies as a result of complaint-driven surveys. Consider non-CON states such as Arkansas, which had only 4 providers in the ten-year period, and identified 1.8 deficiencies per complaint-driven survey, and South Dakota, with 14 providers, identified 7.3 deficiencies per complaint-driven survey.

Florida's ratio of complaint-to-certification deficiencies is 0.52, slightly lower than the national average of 0.55 complaint-to-certification deficiencies. California (non-CON, 0.53 complaint-to-certification deficiencies) and Tennessee (CON, 0.53) are almost in line with Florida by this metric, while Georgia

(non-CON, 0.64) and Alabama (CON, 0.63) indicate slightly more complaint-driven systems. On average, hospice CON states perform slightly better by this measure, with 0.42 deficiencies stemming from complaints per certification deficiency, compared to 0.6 in non-CON states.

Some states that outperformed Florida by this metric include hospice CON states such as North Carolina (0.25) and New York (0.26), as well as non-CON states like Massachusetts (0.14) and Mississippi (0.45). Nonetheless, each of these states found a greater number of absolute deficiencies, suggesting that their survey mechanisms are not entirely preferable to Florida's. Maine, Kentucky, Rhode Island, and Utah are the only states to surpass Florida in both complaint-to-certification deficiency ratios *and* average number of deficiencies. Of these states, only Utah exceeds Florida in number of providers (92 to Florida's 47), and altogether these states cared for about 70 percent fewer hospice patients than Florida. The evidence suggests that Florida's hospice surveillance system is on par with states that have generally well-performing hospice programs.

Rather than concerns about lack of oversight, hospice beneficiaries and their families in Florida are more likely to face dilemmas when formal complaints and/or informal, perceived inadequacies are a recurring problem. Between 2004 and 2014, 12 providers underwent no complaint-driven surveys, while 22 providers underwent two or fewer surveys of this kind. In the same ten-year span, 26 providers were reported as having fewer than five deficiencies identified by way of complaint-driven surveys. These statistics lend credibility to provider performance in Florida.

Hospice Cost

Given the relatively high numbers and levels of care provided in Florida, it would be unsurprising that the state outspends many others in per beneficiary costs. Florida does not, however, deviate too far from national patterns in this respect. When standardized to remove geographic differences in payment rates for individual services, Florida spends an average of $13,519 per beneficiary, placing it 8th in spending,[54] behind non-CON states including Alabama ($14,835 per beneficiary), South Carolina ($14,523 per beneficiary), Georgia ($14,072 per beneficiary), and Texas ($14,066 per beneficiary). In general, hospice CON states outspend their non-CON peers, an average of $11,200 per beneficiary to $10,842, or about three percent more per enrollee.

There are critics who believe that Certificate of Need has largely failed in its original goal of reducing healthcare spending. In April 2017, joint testimony from Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) asserted that market pressures are sufficient moderators of health care investment without additional state intervention. The testimony rejected the idea that CON laws have generally succeeded in controlling costs or improving care quality. The FTC and DOJ maintained that CON application processes add to the cost of investment for both incumbents and potential entrants, and that CON laws shield incumbents from competitive

54 Based on the most available nation-wide data (from 2014). See Medicare Provider Utilization and Payment Data: Hospice Providers. U.S. Center for Medicaid and Medicare Services. September 2017. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html.

incentives to invest.[55] These federal agencies have jointly issued similar statements in 2016, 2015, 2010, and 2007, before various state legislators, as different states have entertained bills repealing CON oversight.

Those who would rush to judgment and recommend that Florida, like many other states, repeal CON for hospice should consider the likely consequences. First, the demand for health care professionals trained to care for older adults continues to outpace the supply of geriatric specialists. Although older Floridians account for a disproportionate share of professional health care services, the number of geriatric specialists remains low. The expected proliferation of elder care providers after the removal of CON will increase the demand for these professional services, which already exceeds supply. The increased demand will cause upward wage pressure in many areas, resulting in increased overall costs or reduced quality of care, even with minimum staffing level requirements under existing regulations.

Second, the incidence of fraud is likely to increase. Florida already leads the nation in many types of Medicaid and Medicare fraud. When Florida deregulated home healthcare in 2000, fraud increased significantly, and it was the taxpayers who ultimately bore the costs of this fraud. While government programs and regulation seeks to identify fraud, the requirement to demonstrate projected need through the CON process helps to reduce fraud. This additional deterrent is especially important in elder care – including nursing homes and hospice services – because of the massive opportunity for lucrative fraudulent claims to Medicare and Medicaid.

Third, the increased competition that will likely result from the repeal of CON is not likely to reduce the costs of hospice care because most hospice services are funded by government programs (e.g., Medicare and Medicaid) that reimburse providers at a fixed per diem rate. As a result, the market for Medicaid patients is not competitive. Essentially, all healthcare markets are less subjected to free market pressures than other businesses because patients are not direct-payers, and because of the limited availability of information regarding outcomes. Hospitals and other medical care providers generally have a more diverse payer base with private insurance payers as well as government payers, but hospices are almost totally reliant on government funding sources (Medicaid and Medicare). In 2015, the vast majority of hospice income came from Medicare (85 percent). Medicaid paid 6 percent of hospice reimbursement, 4 percent came from third parties, 4 percent was uncompensated, and less than 1% came from private pay or other sources.[56]

Finally, repealing CON for hospice providers is likely to limit access for rural patients. One of the purposes of CON is to ensure access for all patients. Repealing CON requirements would likely cause a significant increase in providers serving urban areas with high concentrations of eligible potential patients and healthcare professionals, but would likely result in decrease of coverage areas by both new and existing providers. This would leave rural patients without access to care. Similar concerns relate to poor areas of large cities. Hospice facilities are less likely to locate there.

55 Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62. April 2017. www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf.

56 Florida Department of Elder Affairs, "2016 Report: Hospice Demographics and Outcome Measures," November 2016.

Best Practices of Other States

Florida is one of 12 states that regulate hospice through Certificate of Need. Although Florida's CON process has been successful, it is important to look at "best practices" of other CON states to identify ways that Florida hospice regulators can better control hospice costs, improve the quality of hospice care, and direct investments into medically-underserved areas.

The North Carolina Division of Health Service Regulation implements a 14-step process for determining need using a five-year death rate and a two-year trailing average. Need is established if: (1) an additional 90 patients are projected to be eligible for hospice care; and (2) the number of licensed hospice home care offices per 100,000 population in the county is three or less. In North Carolina, each of the 100 counties in the state is a separate hospice planning area. North Carolina separately calculates need for inpatient beds by utilizing a two-year average trailing growth rate of admissions applying it to a five-year projection of hospice enrollment. That state targets an 85 percent occupancy of inpatient hospice beds and identifies a projected deficit of six or more hospice beds in one county as grounds for additional, single-county hospice inpatient units.[57] The application of these methodologies resulted in 78 hospice providers in North Carolina in 2014, nearly double the number of providers in Florida that year.

In South Carolina, a Certificate of Need is only required for an inpatient hospice facility; it is not required for the establishment of home-based and outpatient hospice programs. Inpatient hospice facilities must be owned or operated either directly or through contractual agreement with a licensed hospice program.[58] This approach yielded 94 hospice providers in South Carolina in 2014.

Tennessee frames determinations of need around a penetration rate. This is determined by dividing the mean annual number of unduplicated hospice patients served in a county in the previous two years by the mean annual number of death in a county for the preceding two years. Need is established in a service area when: (1) the hospice penetration rate is less than 80 percent of the statewide hospice penetration rate; and (2) every county in the service area has demonstrated a positive need for additional hospice service recipients. Tennessee also requires that provider applicants disclose a summary of surveys/inspections of agencies' establishments in other states and disclose any Department of Justice investigations and/or settlements.[59] This resulted in the provision of 57 hospice providers in Tennessee in 2014.

57 2017 State Medical Facilities Plan, North Carolina Division of Health Service Regulation. January 2017, www2.ncdhhs.gov/dhsr/ncsmfp/2018/proposed2018smfp.pdf.

58 2017–2018 South Carolina Health Plan, South Carolina Health Planning Committee Department of Health & Environmental Control. June 2017.

59 Hospice Services: Certificate of Need Standards and Criteria. Tennessee State Health Plan: 2014 Update. June 2014.

Conclusions and Recommendations

Hospice is instrumental for its capacity to alleviate both suffering and cost burdens at the time when health care is most intensive and expensive: in one's final days. This is particularly important for states like Florida, with its rapidly growing elderly population. Characteristic of states whose hospice programs are regulated through a CON program, Florida has a large number of patients, a small number of providers, and a large patient-to-provider ratio. While much of the country has experienced explosive growth in the number of hospice providers, CON oversight has resulted in a more modest growth of hospice providers in Florida.

While historically, CON oversight was intended to rein in exorbitant spending, its function has evolved. In Florida, the review and approval process is largely leveraged to ensure the provision of health care, including hospice, in service areas that are more rural and/or less affluent. The mechanism for this assurance is the AHCA approval process: each new hospice must receive approval for establishment, and is required to provide care to the entirety of the service area in which it operates. The CON process recognizes that free market principles do not work as well in hospice (where risk assumption, reimbursement, per diem, etc., are set by the government) as in other sectors of the economy. Thus, the CON regulation supports high utilization rates among existing hospices, and helps to reduce the likelihood of oversaturation of hospice providers, which results in a decrease in quality of care, "cherry picking" of patients, and reduced access, and increased costs to the overall healthcare system (especially Medicare).

In addition to economies of scale, Florida hospices support high utilization rates among providers. High utilization helps offset some of the risk hospices incur by way of the per diem reimbursement structure, and some of the cost associated with providing in-home services in more fragmented or rural regions.

Limited competition and mandated service areas support large hospice organizations in the state, as measured by a patient-to-provider ratio, compared to the national average. Florida providers also greatly exceed the national average in number and level of hospice care services provided. Despite this, the CON process for hospice works. Utilization rates are high, and there are no service areas where the demand for hospice exceeds the supply.

Florida TaxWatch recommends that the CON process be retained in statute, and that hospice regulators continue to identify ways that Florida hospice providers can better control hospice costs, improve the quality of hospice care, and direct investments into medically-underserved areas.

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As an independent, nonpartisan, nonprofit taxpayer research institute and government watchdog, it is the mission of Florida TaxWatch to provide the citizens of Florida and public officials with high quality, independent research and analysis of issues related to state and local government taxation, expenditures, policies, and programs. Florida TaxWatch works to improve the productivity and accountability of Florida government. Its research recommends productivity enhancements and explains the statewide impact of fiscal and economic policies and practices on citizens and businesses.

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