

CHAPTER

6

**Hospice care in Medicare:
Recent trends and
a review of the issues**

Hospice care in Medicare: Recent trends and a review of the issues

The Medicare hospice benefit is designed to provide palliative care to beneficiaries with terminal illnesses who are approaching the end stages of their lives. Its use has grown considerably in the last several years with matched increases in Medicare spending. The hospice payment system—based on fixed daily rates—has not changed since the benefit was established in 1983. As MedPAC has recommended previously, an examination of the services hospices currently provide is needed to assure that payments accurately account for efficient provider costs. With improved data on the services hospices provide, this evaluation could examine payment refinements related to case mix, length of hospice enrollment, care settings, geographic variation, as well as hospice eligibility. Also, to encourage hospice quality improvement, Medicare needs to establish and collect quality measures for public reporting. Finally, a restructuring of Medicare’s payment arrangement to Medicare Advantage plans could encourage plans to continue their care coordination activities after patients elect hospice care.

In this chapter

- What is the Medicare hospice benefit and how has its use changed over time?
- Hospice payment policy and issues

End-of-life care is an important issue for the Medicare program because most Americans are Medicare beneficiaries when they die. Many clinicians, policymakers, and consumers have called for greater focus on the quality of care delivered to dying patients and their families (IOM 1997).

Medicare offers a benefit—the hospice benefit—that is specifically targeted to Medicare beneficiaries with a terminal illness. Medicare’s hospice benefit covers a broad set of palliative services for beneficiaries whose physicians have determined that, if their illness runs a normal course, they are expected to die within six months. To elect the hospice benefit, beneficiaries must forgo curative treatment for their terminal condition.

Although in earlier years, observers were concerned about low use of this benefit, in the last five years, use of Medicare’s hospice benefit has increased rapidly, signaling the improved awareness and appreciation of the benefit by physicians, hospitals, patients, and their families. In the last couple of years, CMS has also promoted the availability of the benefit to providers and beneficiaries. Medicare spending on hospice has grown from \$1.9 billion in 1995 to an estimated \$5.9 billion in 2003.

The Commission has recommended that the Secretary of the Department of Health and Human Services (HHS) collect and disseminate information on the quality of hospice care and refine the payment system to ensure that payments reflect the costs of efficient providers while ensuring quality of care (MedPAC 2002, 1999). This chapter reviews these recommendations, examines ways to refine payments, and considers ways for hospices to account for the services and the quality of care they provide to this vulnerable population.

What is the Medicare hospice benefit and how has its use changed over time?

Medicare’s hospice benefit offers a broad array of palliative care services, including counseling and other psychological services, to beneficiaries with a terminal illness. Started in 1983, use of the hospice benefit has grown rapidly over the last several years with an expansion in the types of patients enrolling in hospice care. The supply of hospice provider organizations has also increased. Medicare spending on the hospice benefit has more than doubled since 2000.

Hospice services and providers

The Medicare hospice benefit covers the following services for palliative care:

- skilled nursing care
- medical social services
- physician services
- patient counseling (dietary, spiritual, and other)
- short-term inpatient care
- medical appliances and supplies
- drugs and biologicals for pain control and symptom management
- home health aide services
- homemaker services
- therapy (physical, occupational, and speech)
- inpatient respite care (providing a limited period of relief for informal caregivers by placing the patient in an inpatient setting like a nursing home)
- family bereavement counseling
- any other item or service listed in a patient’s care plan as necessary for the palliation and management of the terminal illness

The Medicare hospice benefit has always covered prescription drugs for palliative purposes. Even though recent legislation added coverage for prescription drugs to Medicare (starting in 2006), hospices will still be required to cover drugs for palliative care. Thus, beneficiaries in hospice care will continue to be covered for symptom management of their terminal illness through the hospice benefit. Drugs for conditions unrelated to their terminal illness could be covered through the optional Medicare drug benefit.

Hospice services are furnished most often in the patient’s home—the place where most beneficiaries report that they would prefer to die (Ratner et al. 2001). Hospice services may also be provided in nursing facilities and other inpatient settings. Providers deliver hospice care based on the patient’s care plan. Hospices may decide not to admit patients if they believe they do not have the resources to care for them.¹

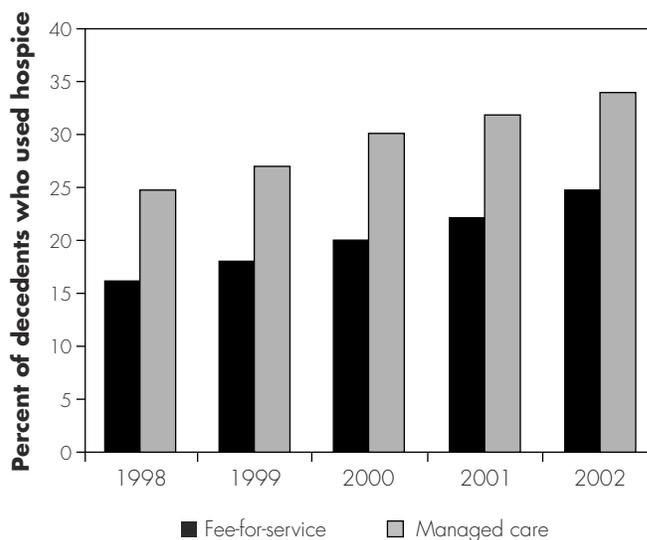
Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day.²

Hospice services can continue as long as patients are certified as eligible. Both the hospice medical director and the patient's attending physician (if he or she has one) must complete the initial certification of terminal illness. The initial benefit period is 90 days, which may be followed by another 90-day benefit period. Subsequently, a beneficiary may qualify for an unlimited number of 60-day benefit periods. The medical director of the hospice must recertify that the patient is terminally ill at the beginning of each benefit period. Beneficiaries may change their hospice provider once in each benefit period. At any time, beneficiaries may discontinue their hospice care, in which case they revert back to their full Medicare coverage.

For hospice coverage, beneficiaries have the choice of any certified hospice provider that agrees to admit them. Several types of agencies provide hospice care to Medicare beneficiaries (Table 6-1). Half of all hospice agencies are freestanding. The remaining half are owned

FIGURE 6-1

Hospice use has grown and remains higher for decedents in managed care



Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

by other types of providers, namely, home health agencies, hospitals, and skilled nursing facilities.³ Most hospice agencies are not-for-profit organizations, but for-profits have grown to over a third of the industry.

TABLE 6-1

Trends in the mix of hospice type and ownership have continued

| | 2001 | 2002 | 2003 |
|--------------------------|------|------|------|
| Hospice type | | | |
| Freestanding | 42% | 46% | 50% |
| Home health agency based | 33 | 29 | 27 |
| Hospital based | 24 | 24 | 23 |
| SNF based | 1 | 1 | 1 |
| Ownership | | | |
| Not for profit | 59 | 58 | 56 |
| For profit | 31 | 33 | 36 |
| Government | 8 | 8 | 8 |
| Other | 2 | 1 | 1 |

Note: SNF (skilled nursing facility). Some columns do not total 100 percent due to rounding.

Source: MedPAC analysis of unpublished data from CMS.

Hospice use trends

CMS data show continued acceleration in use of the hospice benefit and associated spending increases. From 1998 to 2002, the percentage of beneficiaries using hospice before they died grew from 16 percent to 25 percent in fee-for-service and from 25 percent to 34 percent in managed care (Figure 6-1). While 60 percent of beneficiaries who died of cancer used hospice, growth has been substantial among patients with noncancer diagnoses and among patients in nursing homes (MedPAC 2002).

In addition to these growth trends, a provision in the recently passed Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is likely to increase hospice use even further. This provision allows hospice physicians to bill Medicare for hospice consultation sessions, which may be used to evaluate a beneficiary's eligibility and need for hospice services. This session may also be used to discuss hospice care options and referrals.

Length of enrollment

In most cases, a beneficiary's length of enrollment is determined by the number of days a beneficiary lives after electing the hospice benefit. Between 2001 and 2002 the average length of enrollment for a beneficiary in hospice care increased from 50 days to 55 days (Table 6-2) but the median remained 16 days. This suggests that a consistent subset of the hospice population has short lengths of stay, while longer lengths of stay for the remaining beneficiaries drove up the average. In fact, from 1998 to 2002, more than 25 percent of beneficiaries dying in hospice stayed less than a week. The number of days at the 90th percentile, however, has grown. Thus, long stays are getting longer. The increased prevalence of nursing home residents in hospice care may be a factor in this long-stay trend.

Demographic differences

Growth in the use of hospice has occurred among beneficiaries in each age, race, and sex group. Examining hospice use among age groups, we see that growth among the oldest decedents has been fastest (Figure 6-2).

Between 1998 and 2002, the share of beneficiaries age 95 or older who died while in hospice care rose from 12 percent to 23 percent.

This trend is consistent with findings that hospice use has increased considerably among beneficiaries in nursing facilities and beneficiaries with noncancer diagnoses. From 1992 to 2000, use of hospice by beneficiaries in nursing facilities grew from 11 percent to 36 percent (Hogan 2002). Over this same period, the percentage of new hospice patients with noncancer diagnoses rose from 24 percent to 49 percent (MedPAC 2002).

TABLE 6-2

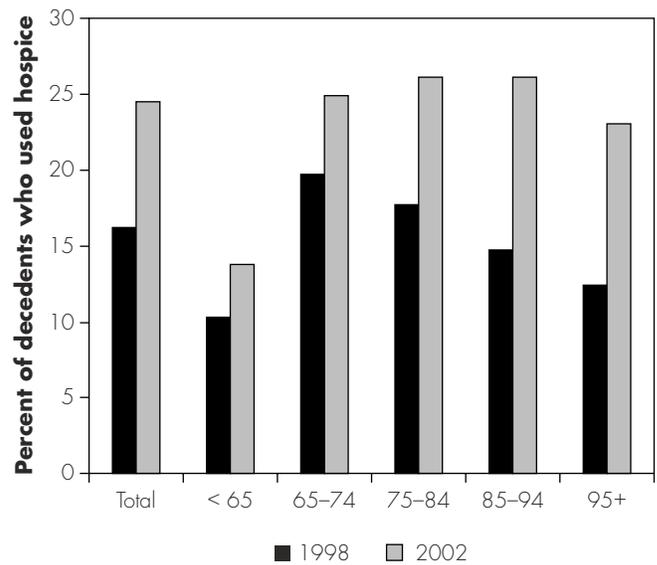
Long stays in hospice are getting longer but short stays persist

| | Length of stay (in days) | | | |
|------|--------------------------|-----------------------------|--------|-----------------------------|
| | Mean | 25 th Percentile | Median | 90 th Percentile |
| 1998 | 52 | 6 | 18 | 123 |
| 1999 | 51 | 6 | 17 | 129 |
| 2000 | 51 | 6 | 16 | 130 |
| 2001 | 50 | 6 | 16 | 133 |
| 2002 | 55 | 5 | 16 | 147 |

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

FIGURE 6-2

Growth in hospice use is greatest among older decedents



Note: Excludes beneficiaries in managed care.

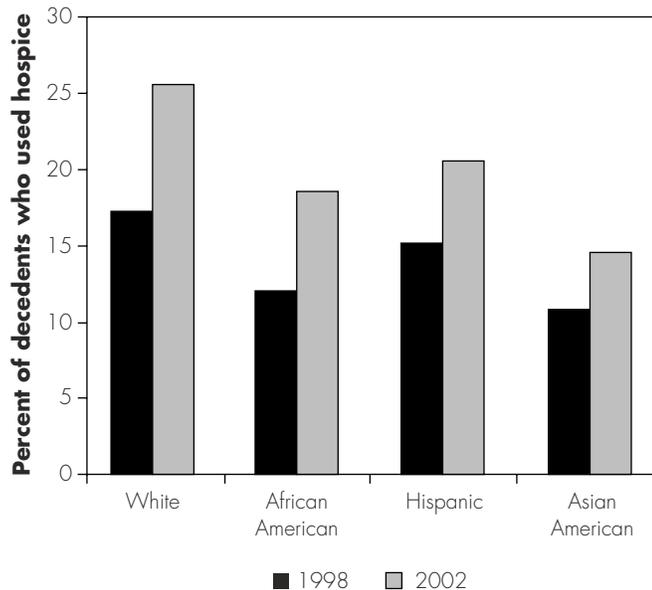
Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

Hospice use also has increased for beneficiaries of each race, but white beneficiaries tend to use the hospice benefit more than beneficiaries of other races (Figure 6-3). This finding is consistent with earlier research. Some have attributed lower use of hospice among minorities to factors such as differences in culture and heritage affecting views of death, differences in religion, socialization, and education, as well as disparities in access to care for health services in general (Crawley et al. 2000, Mahoney 2000).

Beneficiaries with end-stage renal disease (ESRD) also have low enrollment in the hospice benefit, despite their high mortality rates (Hogan 2002). For hospice patients with ESRD, ESRD may or may not be their terminal diagnosis. If ESRD is their terminal diagnosis, then dialysis needed on a palliative basis is considered a covered hospice service and would be paid for through the per diem hospice rate. If, however, ESRD is not their terminal diagnosis, then Medicare would continue to cover their dialysis outside the hospice benefit, and their hospices would not be liable. The high cost of ESRD care (with and without dialysis) and confusion among agencies

FIGURE 6-3

Hospice use has increased among all races



Note: Excludes beneficiaries in managed care. Figure does not show "other" or unidentified race.

Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

regarding its coverage in and out of the hospice benefit likely contribute to low enrollment of this population in hospice care.

Use of hospice by managed care enrollees

Consistently, beneficiaries in managed care plans use hospice more often than those in the fee-for-service program during their last year of life (Figure 6-1, p. 141). Previous research has also found greater use of hospice among Medicare decedents in managed care, even after controlling for age, sex, race, Medicaid status, and ESRD status (Riley and Herboldsheimer 2001). Higher use of the hospice benefit by managed care enrollees may reflect a variety of factors, including patient preference for care and financial incentives for managed care plans to refer patients to hospice (see discussion later in this chapter).

One might expect that the higher use of hospice by beneficiaries in managed care plans reflects earlier referrals to hospice, but beneficiaries in managed care plans have, on average, shorter lengths of enrollment. In 2002, the mean length of enrollment for managed care

enrollees in hospice was 50 days compared with 55 for fee-for-service hospice users. Both populations had similar median lengths of stay.

Hospice agency trends

The number of Medicare-certified hospice agencies increased by 8 percent between 2001 and 2003. Not-for-profit programs remain the largest share of the industry (56 percent), but for-profit facilities have seen the most rapid growth, shown in Tables 6-1 (p. 141) and 6-3. In particular, for-profit hospices grew in number by 25 percent, significantly more than facilities with other types of ownership. The number of freestanding agencies grew 29 percent—considerably more than their provider-based counterparts, which all experienced single-digit change between 2001 and 2003. According to CMS, similar trends have emerged in the first several months of 2004. The strong growth in the number of for-profit hospices may suggest that the financial environment for providing hospice care may be attractive for some providers.

Hospice volume within agencies has grown as well. Hospice volume is measured roughly by the total number of days an agency's patients were enrolled in the hospice

TABLE 6-3

The number of freestanding and for-profit facilities has increased the most

| | Number of hospice facilities | | | Percent change 2001-2003 |
|--------------------------|------------------------------|--------------|--------------|--------------------------|
| | 2001 | 2002 | 2003 | |
| All hospices | 2,266 | 2,323 | 2,454 | 8% |
| Hospice type | | | | |
| Freestanding | 949 | 1,067 | 1,222 | 29 |
| Home health agency based | 744 | 677 | 653 | -12 |
| Hospital based | 553 | 560 | 562 | 2 |
| SNF based | 20 | 19 | 16 | -20 |
| Ownership | | | | |
| Not for profit | 1,340 | 1,339 | 1,384 | 3 |
| For profit | 706 | 762 | 883 | 25 |
| Government | 187 | 188 | 189 | 1 |
| Other | 35 | 34 | 34 | -3 |

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of unpublished data from CMS.

benefit. Thus, hospice volume may grow in size through increases in patient census as well as increases in patients' lengths of stay. Between 2001 and 2003, the number of high-volume hospice agencies increased, while the number of low-volume hospice agencies declined.⁴ Analysis from cost reports reveals that most high-volume agencies are freestanding, while most low-volume agencies are hospital based.

Medicare spending trends on hospice and end-of-life care

Consistent with increases in the number of users and the average length of hospice enrollment, Medicare spending for hospice care has increased. CMS's Office of the Actuary projected spending to grow from \$3.5 billion in 2001 to \$5.9 billion in 2003, a 30 percent annual increase (Figure 6-4). In relative terms, total Medicare spending for hospice services is now close to that for dialysis services (including drugs) for beneficiaries with ESRD.

It is well known that spending is disproportionately high at the end of life—when people are often the sickest. Medicare spending in the last year of a beneficiary's life is about six times higher, on average, than annual spending for beneficiaries who do not die—a ratio that has been consistent over the last two decades (Hogan 2002). Chapter 2 also examines this distinction with regard to

disease management analyses, finding that Medicare spending for beneficiaries is usually higher in the last year of life.

Soon after the hospice benefit began in 1983, results from the National Hospice Study suggested that hospice would save money for the Medicare program (Mor and Kidder 1985). Indeed, the structure of the hospice benefit—restrictive eligibility, waiver of curative care, and caps—was originally intended to reassure policymakers that it would not add substantially to Medicare's cost (Moon and Boccuti 2002).

Recent analysis finds that in the last year of life, beneficiaries who had hospice care incurred Medicare spending that was 4 percent higher, on average, than beneficiaries who did not elect hospice care, but this comparison varied by diagnosis (Campbell et al. 2004). Other recent work reports similar findings (Moon and Boccuti 2002, Hogan 2002), but the Campbell study further addresses selection differences (including the propensity to use hospice) and matches decedents who used hospice to those who did not. Among decedents with cancer, the study finds that Medicare spends 10 percent less on those who elect hospice care in the last year of life compared to those who do not. Among those with all other diagnoses, hospice use correlates with higher Medicare spending, particularly for those with dementia. Although a number of differences characterize the typical patterns of service use for cancer and noncancer decedents, the key distinction is that hospice decedents without cancer tend to use more intense hospital inpatient services before they enter hospice, and have more expensive hospice stays.

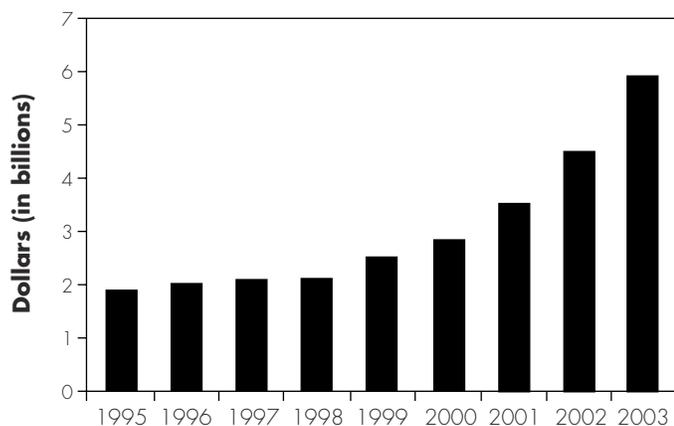
These findings do not call into question the important value of the benefit to Medicare beneficiaries, but they may disappoint those who hope that hospice saves Medicare money, on average. The rise in hospice use suggests a growing demand for the benefit, which underscores the need for Medicare to ensure that hospice payments reflect the efficient provision of quality patient care for all types of patients.

Hospice payment policy and issues

The method Medicare uses to pay hospices is fairly basic and has not been altered since the benefit began in 1983. Hospices can provide many different services within a patient's care plan, but we have limited data on what

FIGURE 6-4

Recently, Medicare spending for hospice services has increased sharply



Source: CMS Office of the Actuary.

services are actually provided, what level of services different patients need, and how the different settings of care may affect providers' costs.

This section reviews improvements that researchers and the Commission have previously recommended regarding payment and data needs for hospice services, and discusses the continued special treatment of hospice within the Medicare Advantage program. This section also reviews the most recent evidence on Medicare program expenditures associated with hospice use, suggesting that hospice use is associated with savings for some types of patients but increases in the aggregate (Campbell et al. 2004).

How does Medicare pay for hospice care?

Medicare makes daily (per diem) payments to hospice agencies for each day a beneficiary is enrolled in the hospice benefit. The payment structure is based on four levels of care, with the vast majority of care provided in just one category—routine home care. The daily payments are constant, regardless of patient case mix or the services provided. For enrolled beneficiaries, hospice agencies may receive daily routine home care payments even for days when no services are provided.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the early 1980s. Although payments have been updated annually based on the hospital market basket index, the set of services included in the payment has not been examined or recalibrated to reflect possible changes in patterns of hospice care and associated costs.

Hospice payment categories

The four hospice payment levels, listed below, vary according to expected input cost differences:

- **Routine home care.** Patients receive hospice services at home or in a nursing facility but do not receive continuous care, as defined below. This category accounts for 95 percent of patient days in hospice care (NHPCO 2004). Medicare's national daily payment for this level of care is \$118 in fiscal year 2004.
- **Continuous home care.** Patients receive continuous nursing care at home, and sometimes receive home health aide or homemaker services. Continuous home care is paid on an hourly basis. It is furnished only

during periods of crisis and only as required to allow patients to stay home. Continuous home care accounts for 1 percent of patient days in hospice care (NHPCO 2004). Medicare's national daily payment for 24 hours of care at this level is \$689 in fiscal year 2004.

- **General inpatient care.** Patients receive care in an inpatient facility—a hospital, skilled nursing facility, or unit in a hospice facility that meets many standards of an inpatient facility—to control pain or manage acute symptoms that cannot be managed in another setting. General inpatient care accounts for 4 percent of patient days in hospice care (NHPCO 2004). Medicare's national daily payment for this level of care is \$525 in fiscal year 2004. From this amount, the hospice is responsible for paying the inpatient facility.
- **Inpatient respite care.** Patients receive short-term care at a facility (including any of the inpatient settings for general inpatient care listed above) to relieve family caregivers who need a short period of relief. Payment is limited to no more than five consecutive days per benefit period, but there is no lifetime limit on availability of respite care. Inpatient respite care accounts for less than 1 percent of patient days in hospice care (NHPCO 2004). Medicare's national daily payment for this level of care is \$122 in fiscal year 2004. From this amount, the hospice is responsible for paying the facility.

When a Medicare beneficiary elects hospice, and is certified as eligible, the hospice provider can begin to bill Medicare for services. Medicare pays for only one type of service per day; if the patient is not receiving continuous home care, general inpatient care, or inpatient respite care, the hospice provider bills for routine home care for each day of the hospice election.

Hospice caps

Hospice has two fixed annual caps. One cap is an absolute dollar amount; the other limits the number of days of inpatient care. The caps are not applied on a patient-by-patient basis; rather, the caps are based on agency-level aggregate averages. The caps are calculated from November 1 through October 31 of a given year, rather than on the traditional October to September fiscal year. The two caps are described in more detail below:

- An agency's total Medicare payments may not exceed an annual cap, which is calculated based on the total number of beneficiaries served in the year. For the

2003 cap year, the quotient of total payments over total number of beneficiaries cannot exceed \$18,661.

- An agency's inpatient care days (either general or respite and regardless of setting) may not exceed 20 percent of its total patient care days in the cap year.

Although most agencies do not reach the caps, those that average long lengths of stay are more likely to exceed the total payment cap than are agencies that average shorter lengths of stay. A review of industry investor reports indicates that some agencies do, indeed, reach the total payment cap due to long average lengths of stay, and thus have billed Medicare for more than \$18,661 per enrolled beneficiary, on average, in the 2003 cap year. The total payment cap is not adjusted for geographic differences in wage levels, although the hospice payment rates are. Thus, a hospice in a high-wage area, theoretically, could reach the cap more quickly than one in a lower-wage area.

Update mechanism

Hospice payments and the cap amount are updated every year in two ways: Per diem payments are increased each year based on the hospital market basket index, and the hospice caps are increased by the medical expenditure category of the consumer price index for all urban consumers. In some previous years, Medicare statutes have called for updates to the per diem payments of less than the full market basket increase. But since 2003, automatic updates have been the full market basket increase.

Payment policy issues for hospice care

The hospice payment system generates little information on the services delivered and the types of patients who receive services. In its May 2002 report to the Congress, MedPAC called for the Secretary of HHS to evaluate hospice payments to ensure that they are consistent with the costs of providing appropriate care (MedPAC 2002). The Commission also recommended that the Secretary research differences in the care and resource needs of hospice patients and determine whether a case-mix adjusted payment system for hospice care is feasible, including studying ways to establish a high-cost outlier policy. Other researchers have recommended some additional modifications to hospice payment policy.

Possible changes to hospice payment policy cited by MedPAC and others (Huskamp et al. 2001, Lynn and Adamson 2003, Virnig et al. 2004) include adjustments for:

- patient case mix
- outliers
- length of hospice enrollment
- setting (home or nursing home)
- geographic area (urban or rural)
- eligibility requirements
- quality of care

Case-mix and outlier adjustments

Adopting case-mix adjustments could help Medicare pay more accurately for hospice services. Although hospice providers report their costs in cost reports and submit claims, these data are not enough to calculate patient-level case-mix adjustments or to identify outliers. Additional data are needed. To develop the case-mix adjustment system for home health agencies, for example, CMS had contractors conduct a detailed analysis of home health claims, visits, cost reports, and data from the Outcome and Assessment Information Set (OASIS), which provides functional status measures. For hospice, case-mix adjustment could be based on a similar instrument or, more crudely, on diagnosis.

Data on hospice costs could also be used to determine the need for outlier payments. If there is a need to compensate hospices for extraordinary covered expenses, then cost analyses, which account for case mix, could help establish the parameters for outlier payments.

Hospices report that their costs for drugs are rising (as is the case for other providers that purchase drugs), but little is known about the types, mix, intensity, or acquisition costs for drugs hospice patients use. Some hospices may be using formularies to help manage their drug costs, but no data are available to understand how these work.

Recent research found that some hospices deny admission to patients with high expected service costs (Lorenz et al. 2004). Specifically, 63 out of 100 California hospices surveyed said that they denied admission to individuals for one or more reasons. These reasons included that the patient lacked a caregiver at home, or was receiving total parenteral nutrition, tube feedings, radiotherapy, chemotherapy, or transfusions. Representatives of

hospices corroborated these findings with MedPAC staff, stating that agencies that do not feel they have enough resources to care for costly patients can, and sometimes do, deny their enrollment. Case-mix adjustments are designed to help correct this problem by directing higher or lower payments to agencies based on expected patient care costs. Without case-mix adjustment, the financial incentives of a fixed daily payment system encourage providers to admit the patients with the lowest daily costs.

Length of hospice enrollment adjustments

The number of days a patient receives hospice care is an important issue. The longer the hospice enrollment, the greater the opportunity for dying beneficiaries to receive a comprehensive program of palliative care, including multiple counseling visits. As noted earlier, at least 25 percent of hospice beneficiaries are in hospice for less than a week (Table 6-2 on p. 142). Long hospice stays generally incur lower average daily costs for the agency than short hospice stays, because the first and last days usually require more intensive services. In a previous report, MedPAC noted that if costs for short hospice stays are considerably higher than Medicare's payments, then higher per diem payments for the first and last days of a short hospice stay might be needed (MedPAC 2002).

A preliminary review of 2002 cost report data shows that patients at for-profit agencies have longer lengths of stay, on average. Hospice enrollment periods for patients receiving care from for-profit hospices averaged 73 days—over 50 percent higher than those in not-for-profit facilities (48 days).

Representatives of the hospice industry and investor reports state that cancer patients often have shorter lengths of stay in hospices than those with other terminal diagnoses, such as chronic heart failure and chronic obstructive pulmonary disease. If noncancer patients average longer lengths of stay, then Medicare makes a higher number of per diem hospice payments for them than for cancer patients, on average. Because noncancer patients are the fastest growing population of hospice patients, the financial impact of this distinction is becoming more significant (MedPAC 2002).

With some adjustments, the per diem payment system is better suited for hospice care than a per case payment system; per diem payments do not penalize agencies when patients remain in hospices for more than the average

number of days, as would per case payments. However, the variance in average daily costs by length of stay may not be reflected in the current per diem payments.

Payment adjustments by patient residence

Patient costs may differ depending on whether patients reside at home or in a nursing home, or in an urban or rural area. When a hospice beneficiary eligible for Medicaid lives in a nursing home, Medicaid pays the hospice at least 95 percent of the Medicaid nursing home rate in the state. The hospice, in turn, contracts with the nursing home and pays for the patients' room, board, and other nursing home services unrelated to the patients' terminal condition. Drugs for palliative treatment of the terminal condition are covered under the hospice benefit, but other drugs unrelated to the terminal condition may be covered by the Medicaid payment.

Costs for providing hospice care in nursing facilities may be lower than in patients' homes. Investor reports note that hospice workers providing services in a nursing home are able to visit multiple patients at the nursing home, thereby reducing time and transportation costs. Studies conducted by the Department of Health and Human Services' Office of Inspector General (OIG) highlighted a number of issues regarding Medicare beneficiaries receiving hospice benefits while residing in nursing homes (OIG 1997). The OIG found that these Medicare beneficiaries received hospice-specific services less often than those outside nursing homes, and that the covered services for general nursing home care and hospice care may overlap. To address these issues, the OIG recommended that the Secretary of HHS seek legislation to modify Medicaid or Medicare payments for hospice patients in nursing facilities. CMS and hospice associations have since issued guidance on the appropriate care for hospice patients in nursing homes.

Hospices in rural and urban areas may also have different cost structures. Although the rate of hospice use has increased faster in rural areas than in urban areas, the rate of use in rural areas remains lower (MedPAC 2002). Many factors may contribute to this discrepancy, including differences in hospice supply, hospice demand, and hospice input costs. Medicare hospice payments are usually lower for rural hospices than urban hospices to adjust for wage differences, as in other Medicare sectors.⁵ Payments are not, however, adjusted for other cost factors that may relate to urban and rural differences. For

example, rural hospice providers likely face high transportation costs due to greater distance between patients' homes (MedPAC 2002). Hospices in some urban areas may also face high transportation costs related, instead, to traffic and security needs. Other research has noted that rural hospices have less ability to employ economies of scale because they are typically smaller than urban hospices (Virnig et al. 2004).

Recent Medicare legislation established a small demonstration project to examine hospice care for rural patients in inpatient facilities of 20 or fewer beds. Eligible beneficiaries for these facilities will be limited to those who lack an appropriate caregiver at home and who are unable to receive home-based hospice care. The cap on the number of inpatient days is waived under this demonstration.

Eligibility requirement adjustments

The requirement that beneficiaries have a six-month terminal prognosis, if the disease runs its expected course, may arbitrarily exclude beneficiaries who could appropriately benefit from hospice care. This constraint may be particularly problematic for patients with chronic and eventually fatal illnesses. Because prognoses for noncancer diagnoses can be difficult to determine, physicians may err on the side of being too conservative or too optimistic about their patients' life spans (Austin and Fleisher 2003). Thus, the timing of hospice referrals can be challenging under the prognosis requirement. Perhaps in recognition of this difficulty, Aetna and Kaiser Permanente—two large insurers—have recently initiated palliative care options for patients with prognoses of 12 months or less to live (McLaughlin 2004).

Medicare addresses some of the difficulties with determining a prognosis by allowing physicians to recertify patients for hospice care, even if their patients lived longer than expected (provided that their terminal illness still carries a reasonable prognosis of six months or less to live). Researchers have noted that many patients could benefit if hospice eligibility were determined by acuity level or diagnosis, rather than by time constraints (Lynn 2001). We are not aware, however, of any research that has attempted to quantify how changes in eligibility for hospice care would affect beneficiary access or Medicare spending.

Quality of care issues

MedPAC has recommended that Medicare implement financial incentives for providers to furnish high quality care (MedPAC 2004). This recommendation could eventually extend to hospice providers as well, once quality data are routinely collected. MedPAC also recommended in 1999 that the Secretary of HHS make end-of-life care a national quality-of-care improvement priority for Medicare (MedPAC 1999). Although some Quality Improvement Organizations (QIOs) have developed special projects to improve end-of-life care (in nursing homes, for example), this initiative is not a national QIO priority. Furthermore, QIOs' recent scopes of work do not include working with hospices to improve the care they provide. CMS has not initiated a process to review hospice quality measures to establish a core set of quality measures for public reporting.

Medicare does not require hospice agencies to conduct ongoing quality improvement, as it does other providers, such as hospitals. Conditions of participation for hospice providers do not require quality assessment or quality improvement programs, which generally create an expectation for continued improvement and often specify areas to be improved.⁶ However, most hospices do conduct quality assessment, because it is a typical requirement for accreditation sought outside of Medicare. Therefore, if Medicare were to add a quality assessment requirement in its conditions of participation, accredited agencies likely would not face a significant burden.

A critical foundation for quality incentives and quality improvement is that providers submit data on common measures of quality. In 1999, MedPAC recommended that the Secretary of HHS sponsor projects to develop and test measures of the quality of end-of-life care for Medicare beneficiaries. We cataloged a number of such initiatives. One example is the Toolkit of Instruments to Measure End-of-Life Care—a project funded by the Robert Wood Johnson Foundation—that reviews a variety of quality measurement tools in each of 10 different aspects of end-of-life care (CGHCR 2004).

Many members of the hospice industry have worked to develop a voluntary measurement process. For example, the National Hospice and Palliative Care Organization (NHPCO) has sponsored research to identify measurement tools along three domains of care: self-determined life closure, safe and comfortable dying, and effective

grieving. The organization also has developed a survey instrument to assess family satisfaction with hospice care. Member hospices voluntarily collect information on bereaved families' perceptions, reports of care, and satisfaction with the deceased person's hospice experience. These hospices can also provide their results to prospective patients and their families.

Additional measures not captured on NHPCO's survey may be useful, as well. One is the management of pain, for which there are many instruments, including OASIS for home health. A second is the percentage of beneficiaries dying at home—a setting for death that most people prefer.

Developing quality measures for public reporting should be a priority for the Medicare hospice program. One approach CMS could take is to contract with a research firm to develop a quality measure set, which was the approach used for home health care. Another alternative is to task the QIOs with developing and testing measures. This approach was used to develop the hospital quality measures that are now being reported through a voluntary public-private initiative. Neither effort would require the development of an exhaustive set of measures to capture all the domains of quality hospice, nor more broadly, end-of-life care; these could be brought into the measure set over time. Some measures developed as part of this work could also apply to other parts of the program, reflecting the fact that most Medicare beneficiaries die without enrolling in hospice. To reinforce the process of measure development, CMS could also revise the hospice conditions of participation to require a process for quality improvement.

Data needed to refine the hospice payment method

To assess payment adequacy and quality issues described above, more data are needed. Data on the types of services different patients use could be collected nationally by requiring hospice providers to report the information on claims forms or in cost reports. Alternatively, the data could be collected from a sample subset of providers. Some combination may be appropriate so that basic data on service use is provided by all hospices, while more detailed documentation on patient cost and service delivery could be collected from a sample. Any data collection effort should balance the need for information with the burden placed on providers and CMS.

How does Medicare pay for hospice beneficiaries in Medicare Advantage?

Medicare Advantage plans are not required to offer the Medicare hospice benefit, but their enrollees may elect hospice care outside their plan under the same eligibility rules as beneficiaries in fee-for-service Medicare. Beneficiaries who elect hospice care do not need to disenroll from their Medicare Advantage plan, but they may do so if they wish.⁷

When Medicare Advantage enrollees elect hospice care, Medicare reduces its monthly capitated payments for those beneficiaries because plans are no longer financially liable for all Medicare-covered services used by beneficiaries in hospice care. That is, for hospice patients who are enrolled in Medicare Advantage plans, fee-for-service Medicare pays for the hospice care as well as care unrelated to the terminal condition. Plans continue to be liable, however, for non-Medicare benefits that they offer to their enrollees (such as vision or dental care). Medicare's reduced capitated payment is meant to cover this liability.

The following example illustrates this payment arrangement: Medicare pays \$700 per member per month to a given plan. The plan spends \$650 to cover all Medicare-covered services and uses the remaining \$50 to cover vision and dental care (non-Medicare-covered services) at no additional cost to enrollees. If an enrollee elects hospice, and chooses to stay in the managed care plan, Medicare will reduce its payment to the plan for that beneficiary to \$50 per month so the plan can continue to cover the patient's vision and dental care. For Medicare-covered services unrelated to the terminal condition, plans (or individual providers and suppliers) may bill Medicare on a fee-for-service basis. As with all Medicare beneficiaries, hospice agencies bill Medicare directly for providing hospice care.

Payment policy issues for hospice beneficiaries in Medicare Advantage

The current payment arrangement for hospice beneficiaries enrolled in Medicare Advantage plans works against the goal of fully integrated health care delivery through private plans. Generally, under Medicare Advantage, the Medicare program pays a capitated amount to care for the full array of Medicare services. Because the program does not pay separately for each type of service (e.g., hospital, physician), plans have incentives to coordinate all care, and to choose the most effective

setting to improve quality and lower costs. By contrast, beneficiaries electing hospice are moved out of the managed care payment system for all Medicare-covered services, which discourages plans from continuing efforts to coordinate their care.

The policy raises two further concerns. It explicitly pays plans to offer non-Medicare-covered services to hospice enrollees, which it does not do for any other set of beneficiaries. The policy is also administratively complex; the capitation payments made to plans for the non-Medicare services must be figured separately for each plan depending on its adjusted community rate proposal.

The payment arrangement for hospice beneficiaries enrolled in Medicare Advantage plans establishes a financial incentive for plans to direct patients to hospice care; it allows plans to eliminate their financial liability for Medicare-covered services to their sickest (and usually most expensive) enrollees—those with terminal illnesses. Data presented earlier in this chapter show higher use of the hospice benefit by decedents in Medicare Advantage plans, consistent with these incentives. Some research indicates that the higher use is appropriate, particularly among beneficiaries with cancer (McCarthy et al. 2003).

It is unclear why the Congress opted to exclude the hospice benefit from the earlier risk-contracting program, then from the Medicare+Choice program—now referred to as the Medicare Advantage program. Efforts to ensure beneficiary access to hospice care may have been a consideration. Also, hospice may have been treated

differently from other Medicare benefits because of the uncertainty of the cost of hospice care in 1983, the same year that the risk-contracting program was started. At that time, few hospice providers existed and data on their costs were largely unavailable (Riley and Herboldsheimer 2001).

Although removing managed care plans' financial liability for hospice care may increase use of these important services, it may discourage plans from developing chronic disease management programs that provide palliative care. In the past, some managed care plans may have been reluctant to develop innovative end-of-life and chronic care management programs for fear of attracting terminally ill enrollees who would raise plans' costs (Raphael et al. 2001). Recent research has suggested that, although risk-adjustment addresses some of these concerns, the current risk-adjustment measures could be improved to compensate plans more accurately when delivering care to people with terminal illnesses (Buntin et al. 2004).

Ideally, if Medicare Advantage plans were liable for hospice beneficiaries' full spectrum of care, they would be more likely to coordinate care across settings and potentially employ chronic care disease management protocols for appropriate beneficiaries. Indeed, some commercial plans have such innovations in place for the broad populations they enroll, as described in the text box opposite. ■

A broader perspective: End-of-life care

Many clinicians, policymakers, and consumers have called for improvements in care delivered to dying patients and their families (IOM 1997). MedPAC has made similar recommendations with respect to the Medicare program (MedPAC 1999). End-of-life care analysis often draws the distinction between palliative and curative care, but the division between the two is not always clear-cut. Palliative care at the end of life focuses on controlling symptoms of disease such as pain; it also concentrates on allowing patients to maintain function. Services to address emotional, spiritual, and social concerns with death and dying are also features of palliative care. Curative care, by contrast, focuses on curing disease. Elements of each type of care are often present in the course of a patient's illness, sometimes simultaneously. Because physicians are often unable to make absolute prognoses, palliative care may be desirable in conjunction with curative treatment.

Concerned that patients and their physicians face difficult choices between palliative and curative care, Aetna and Kaiser Permanente—two large insurers—have recently started programs which allow patients with terminal illnesses to receive a combination of both (McLaughlin 2004). Another example is the Palliative Care Option developed by Regence BlueShield, which has looser eligibility requirements than the Medicare hospice benefit. Started as a program for children, the plan is intended to have a broader appeal than the Medicare hospice benefit, potentially decreasing costs for emergency room visits and hospital care and improving patient and provider satisfaction with managed care.

Many researchers have called for Medicare to encourage the provision of palliative care that is not tied so tightly to prognosis (Lynn et al. 1998). They point out that as patients become ill and transition toward death, the need for curative care gradually declines and the share of services devoted to palliative care gradually rises; there is no fixed point in time when all care should shift from curative to palliative.

Organizations have been experimenting with different approaches to end-of-life care. For example, a national initiative supported by the Robert Wood Johnson Foundation has explored a variety of hospital-hospice partnerships in palliative care (CAPC 2001). Some of these ventures focus on increasing the use of Medicare's hospice benefit through a variety of approaches ranging from professional education to developing specialized units. Others have developed new nonhospice palliative care services. Another initiative supported by other foundations provides funds to support the training of physicians in the principles of palliative care (PDA 2003). Still another initiative has funded community-oriented palliative care (UHFNY 2004)

People concerned about better care for the dying have raised concerns about whether the services covered in Medicare outside the hospice benefit support quality end-of-life care, particularly considering that most beneficiaries are not in hospice when they die (Moon and Boccuti 2002). Some have called for broader Medicare coverage outside the hospice benefit, including coverage of outpatient drugs, transportation, and nonskilled home care (Raphael et al. 2001). Covering more types of palliative care services for beneficiaries who are very ill but who have not yet been given a six-month prognosis could improve their quality of life; however, such additional benefits would likely raise Medicare spending.

Recent legislation addresses some of the perceived barriers for Medicare to provide end-of-life care outside the hospice benefit. Coverage of outpatient drugs is one important area; the chronic care initiative is another (see Chapter 2). The chronic care initiative may be one way to address concerns that hospice care is not well accessed by beneficiaries with chronic illnesses that have less predictable prognoses, and by beneficiaries who do not necessarily wish to forgo all curative care. ■

Endnotes

- 1 Hospices may not apply separate admission criteria based only on payer status (e.g., Medicare versus private insurance).
- 2 Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which is \$876 in 2004.
- 3 The term “freestanding” means that the agency is not owned by another type of provider; it does not refer to an actual freestanding building. Freestanding agencies commonly provide hospice services to patients residing at home or in a nursing facility.
- 4 Information on hospice volume is from CMS data reported in the *Federal Register* (vol. 66, no. 188, p. 49475; vol. 67, no. 169, p. 56113; vol. 68, no.189, p. 56507).
- 5 Wage adjustments are based on the location of the patient, not the hospice agency.
- 6 Hospices are, however, required to have a quality assurance program in place. Such programs usually review processes of care, but do not focus on outcome measures or improvements.
- 7 If beneficiaries decide to remain in their plan, they must continue to pay their premiums, if applicable.

References

- Austin, B. J., and L. Fleisher. 2003. *Financing end-of-life care: Challenges for an aging population*. Washington, DC: AcademyHealth.
- Buntin, M., A. Garber, M. McClellan, et al. 2004. The Costs of Decedents in the Medicare Program: Implications for Payments to Medicare+Choice Plans. *Health Services Research* 39, no. 1 (February): 111–130.
- Campbell, D., J. Lynn, T. Louis, et al. 2004. Medicare program expenditures associated with hospice use. *Annals of Internal Medicine* 140, no. 4 (February 17): 269–278.
- Center to Advance Palliative Care. 2001. *Hospital-hospice partnerships in palliative care*. New York: CAPC.
- Center for Gerontology and Health Care Research, Brown Medical School. 2004. *Toolkit of instruments to measure end-of-life care*. Providence, RI: CGHCR. <http://www.chcr.brown.edu/PCOC/indextools.htm>.
- Crawley, L., R. Payne, J. Bolden, et al. 2000. Palliative and end-of-life care in the African American community. *Journal of the American Medical Association* 284, no. 19 (November 15): 2518–2521.
- Hogan, C., Direct Research, LLC. 2002. *Medicare beneficiaries' use of hospice services: Updated to 2000*. Washington, DC: MedPAC.
- Hogan, C., J. Lynn, J. Gabel, et al. 2001. *Medicare beneficiaries' costs and use of care in the last year of life: Final report to the Medicare Payment Advisory Commission*. Washington, DC: MedPAC.
- Huskamp, H., M. Buntin, V. Wang, et al. 2001. Providing care at the end of life: Do Medicare rules impede good care? *Health Affairs* 20, no. 3: 204–211.
- Institute of Medicine. 1997. *Approaching death: Improving care at the end of life*. Washington, DC: National Academy Press.
- Lorenz, K., S. Asch, K. Rosenfeld, et al. 2004. Hospice admission practices: Where does hospice fit in the continuum of care? *Journal of the American Geriatrics Society* 52: 725–730.
- Lynn, J. and D. Adamson. 2003. *Living well at the end of life: Adapting health care to serious chronic illness in old age*. Santa Monica, CA: RAND. <http://www.rand.org/publications/WP/WP137/WP137.pdf>
- Lynn, J. 2001. *Healthcare issues at the end of life: Selected articles reprinted from Journal of the American Medical Association and the Joint Commission on Quality Improvement*. Santa Monica, CA: RAND.
- Lynn J., A. Wilkenson, F. Cohn, et al. 1998. Capitated risk-bearing managed care systems could improve end-of-life care. *Journal of the American Geriatrics Society* 46: 322–330.
- Mahoney, J. 2002. Beneficiaries' access to the Medicare hospice benefit. Unpublished report to the Medicare Payment Advisory Commission.
- McCarthy, E., R. Burns, Q. Ngo-Metzger, et al. 2003. Hospice use among Medicare managed care and fee-for-service patients dying with cancer. *Journal of the American Medical Association* 289, no. 17 (May 7): 2238–2245.
- McLaughlin, K. 2004. Expanding the reach of hospice care. *The Wall Street Journal*. May 2.
- Medicare Payment Advisory Commission. 2004. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2002. *Report to the Congress: Medicare beneficiaries' access to hospice*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 1999. *Report to the Congress: Selected Medicare issues*. Washington, DC: MedPAC.
- Moon, M., and C. Boccuti. 2002. *Medicare and end-of-life care*. Washington, DC: Last Acts Financing Committee.
- Mor, V., and D. Kidder. 1985. Cost savings in hospice: Final results of the National Hospice Study. *Journal of Health Services Research* 20: 407–422.
- National Hospice and Palliative Care Organization. 2004. *NHPCO Facts and Figures*. Alexandria, VA: NHCPO.
- Office of Inspector General, Department of Health and Human Services. 1997. *Hospice patients in nursing homes*. Washington, DC: OIG.
- Project on Death in America. 2003. Foundations join together to support care of the dying: Over \$1 million dollars awarded to improve post-graduate medical training. Press release, PDA, New York. January 6.

Raphael, C., J. Ahrens, and N. Fowler. 2001. Financing end-of-life care in the USA. *Journal of the Royal Society of Medicine* 94 (September): 458–461.

Ratner, E., L. Norlander, and K. McSteen. 2001. Death at home following a targeted advance-care planning process at home: The kitchen table discussion. *Journal of the American Geriatrics Society* 49 no. 6 (June): 778–781.

Riley, G., and C. Herboldsheimer. 2001. Including hospice in Medicare capitation payments: Would it save money? *Health Care Financing Review* 23, no.1 (Fall): 137–147.

United Hospital Fund of New York. 2004. *Research & Programs: Background on the Community-Oriented Palliative Care Initiative*. New York: UHFNY.
<http://www.uhfny.org/homepage3219>.

Virnig, B., I. Moscovice, S. Durham, et al. 2004. Do rural elders have limited access to Medicare hospice services? *Journal of the American Geriatrics Society* 52: 731–735.