



## Forum Session Meeting Announcement

**Friday, August 1, 2008**  
9:00–9:30am — Breakfast  
9:30–11:15am — Session

# Medicare's Hospice Benefit: In the Spotlight

### A Discussion Featuring:

**Mark Miller, PhD**  
*Executive Director*  
Medicare Payment Advisory Commission

**Susan Lloyd**  
*President and Chief Executive Officer*  
Delaware Hospice

**Barry Kinzbrunner, MD**  
*Executive Vice President and Chief Medical Officer*  
VITAS Innovative Hospice Care

### With Commentary From:

**Thomas Hoyer**  
*Former Director*  
Chronic Care Policy Group  
Centers for Medicare & Medicaid Services

### Location

**Reserve Officers Association  
of the United States**  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor  
*(Across from the Dirksen Senate  
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# Medicare's Hospice Benefit: In the Spotlight

## OVERVIEW

*Medicare's hospice benefit is in the spotlight because of notable increases in Medicare expenditures on hospice care, the number of beneficiaries served by hospice and the number of days they spend in hospice care, the number of new Medicare-participating hospices (particularly for-profit hospices), and hospices that exceed the annual payment limit, or cap. Policymakers eye these trends warily because they have little information on the number, type, and duration of services delivered to perhaps the most vulnerable Medicare beneficiaries. This session will examine the trends and assess whether they point to the need for change. It will also explore the state of hospice quality measurement, improvement, and reporting, which some say lags behind advances in quality measurement for other health care benefits. Finally, the session will touch on recent efforts by the Centers for Medicare & Medicaid Services to update the conditions under which hospices may participate in Medicare.*

## SESSION

The Medicare hospice benefit has caught the eye of policymakers concerned about hospice payment and quality issues. These issues certainly are not new to other Medicare benefits, but until recently hospice care has been somewhat insulated from the scrutiny often reserved for more expensive and more widely used benefits such as hospital or physician services. Hospice allows Medicare beneficiaries to live the last months of life generally at home, with palliative care rather than more aggressive medical intervention. Beneficiaries may elect hospice if their physician certifies that they have a life expectancy of 6 months or less; if the patient survives beyond that expectation, a physician will periodically re-certify the patient's life expectancy. Once admitted, beneficiaries generally forego curative treatment.

Choosing hospice is becoming more commonplace among beneficiaries: about 40 percent of Medicare beneficiaries who died in 2005 used hospice, up from 27.3 percent in 2000.<sup>1</sup> Since the benefit's inception in 1983, hospice advocates have contended that the benefit is less expensive than hospital-based end-of-life care. Today, end-of-life care that is palliative, home-based, and less expensive than curative care is still the primary goal of hospice care.

## Hospice Benefit Trends

The Medicare hospice benefit has experienced remarkable growth in the number of beneficiaries served and the number of days they spend in

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hospice care, the number of hospices serving Medicare beneficiaries, and Medicare payments in recent years (see table, right).

A portion of the growth in hospice use and expenditures can be attributed to a wider range of patient diagnoses. In the past, hospice care was typically used by cancer patients in the last stage of life. Other primary diagnoses, including heart disease, Alzheimer’s disease, and dementia are now common, and patients with these principal diagnoses tend to need more days of hospice care. In 2005, the most common diagnoses for hospice patients were lung cancer (38.4 percent of patients), circulatory and heart failure (18.9 percent of patients), and Alzheimer’s disease (5.5 percent of patients).<sup>2</sup>

In addition, the number of hospice organizations has grown, and most of that growth is attributable to growth in the number of for-profit hospice organizations. According to the Medicare Payment Advisory Commission (MedPAC), the number of for-profit hospices grew from 755 organizations in 2000 to 1,660 in 2007, whereas the number of nonprofit hospices remained relatively stable, increasing from 1,193 organizations in 2000 to 1,205 in 2007.<sup>3</sup> The rise in the number of for-profit companies in itself does not signal a particular problem, but some find it noteworthy that for-profit companies are finding new business opportunities in the Medicare hospice benefit.

### Payment Incentives

Medicare pays hospices a pre-determined daily rate for each patient. The base payment rate is adjusted to account for differences in wages and other costs, and for inflation. The majority of patient days (about 95 percent) are paid based on the patient receiving routine care at home. However, the daily payment rate changes if the patient needs continuous care, or is admitted to an inpatient hospice or hospital. Some analysts are concerned that Medicare pays hospices a daily rate regardless of whether services are actually delivered on a particular day. And, despite daily payments from Medicare, very little information is now publicly available on the number, duration, and types of services provided. Therefore, some argue that more accountability is in order.

As noted above, one of the tenets of hospice care is that it should cost no more than curative care. In order to help ensure that hospice payments do not exceed the cost of curative care, the law requires a limit, or cap, on total annual payments to each hospice. The cap is based on the number of beneficiaries the hospice serves; it is not a cap on payments for any particular beneficiary. Analysts point to issues with the cap, including the fact that the underlying method for calculating it has not been updated since the inception of the benefit, and that it is not adjusted for geographic

### Medicare Hospice Benefit Growth, 1993–2006

	1993	2006
<b>Beneficiaries Served</b>	215,088	942,375
<b>Average Days of Hospice Care</b>	59 days	70 days
<b>Number of Hospices</b>	1,445	3,071
<b>Benefit Expenditures</b>	\$1.3 billion	\$9.2 billion

*Note: Data are for Medicare fee-for-service beneficiaries only.*

*Source: Centers for Medicare & Medicaid Services, “Health Care Financing Review, 2007 Medicare and Medicaid Statistical Supplement,” table 8.1b; available at [www.cms.hhs.gov/MedicareMedicaidStatSuppl/downloads/2007Table8.1b.pdf](http://www.cms.hhs.gov/MedicareMedicaidStatSuppl/downloads/2007Table8.1b.pdf).*

differences in costs. In addition, many policymakers are concerned that the number of hospices with spending above the cap has increased in recent years.<sup>4</sup> According to MedPAC analysis, 220 hospices (7.8 percent of the total) exceeded the cap in 2005, up from 60 (2.6 percent of the total) in 2002. Almost 90 percent of hospices exceeding the cap in 2005 were for-profit.<sup>5</sup>

Another payment issue that has concerned policymakers is payments for hospice patients residing in nursing homes. Because the nursing home provides for many of the patient's daily needs and is paid separately for those services, it is unclear whether the Medicare payment to the hospice is excessive. As more nursing home patients are admitted to the hospice benefit, policymakers are examining the issues surrounding provision of the benefit in a nursing home setting.

### Quality of Care

It is clear that the trends in the numbers of persons served, days, expenditures, and hospice providers has resulted in more scrutiny of the hospice benefit. Whether hospice beneficiaries are receiving high-quality care is less clear. The Centers for Medicare & Medicaid Services (CMS) does not require hospices to report on a set of quality measures, and such measures would be challenging to develop given the subjective nature of end-of-life care. There are worthwhile quality improvement efforts by hospice and other organizations, but no set of standards yet has gelled into a widely accepted standard for measuring and reporting quality. Survey and certification, long a staple backdrop to quality efforts, seems to have left hospice behind. Medicare only requires an initial survey when a hospice seeks participation in Medicare; additional routine surveys can be 10 years apart. The President's FY 2009 budget request would extend the average length of time between surveys to 11.5 years.<sup>6</sup> Some argue that the lack of consistent quality standards and a scant survey and certification program cannot ensure quality care.

CMS recently published the first major changes to the hospice regulations since 1983.<sup>7</sup> The new rules, which will be effective on December 2, 2008, outline the rights of hospice patients in determining their own care with regard to their treatment plan, pain management, and choice of physician, among other things. There are also updates to how quickly newly admitted hospice patients should be assessed by medical professionals. In addition to this regulatory effort, CMS is also undertaking a significant effort to collect information from hospices about the services they provide. Starting July 1, CMS is requiring hospices to report information on the number of visits provided by hospice workers, including nurses, home health aides, physicians, and social workers. The collection of this basic information—although not the only data needed for any future payment or quality improvements—is a first step in bringing more information to decision making around the Medicare hospice benefit.

## KEY QUESTIONS

- What should be made of the growth in hospice use and expenditures? Why has the use of hospice care changed over time? Are there any trends that should be cause for particular concern, for example, increasing use by beneficiaries, longer lengths of stay, rise in the number of for-profit hospices, or rise in the number of hospices exceeding the annual payment cap?
- What assurances are there that beneficiaries who choose to use hospice services are receiving adequate and desired care? What can be done to help ensure the quality of services delivered by hospice? Is hospice unique in terms of the challenges in measuring quality? Would more frequent hospice surveys improve quality, or are other interventions a better investment?
- What assurances are there that hospice payments are aligned with costs? Given the lack of hospice patient data, quality measures, and recent survey data, do we know that Medicare is paying the right amount for hospice care and that quality services are being delivered to patients?
- Has the hospice benefit met its original goal to deliver palliative, home-based care that is less expensive than curative care? How should Medicare monitor the achievement of the goals of the hospice benefit?

## SPEAKERS

**Mark Miller, PhD**, executive director of the Medicare Payment Advisory Commission (MedPAC), will discuss MedPAC's recently published analyses on the Medicare hospice benefit, including MedPAC's recommendations to Congress. **Susan Lloyd**, president and chief executive officer of the Delaware Hospice (a nonprofit organization), will discuss the management and payment issues facing hospices today. **Barry Kinzbrunner, MD**, executive vice president and chief medical officer of VITAS Innovative Hospice Care (a for-profit organization) will highlight quality of care issues, including the challenges of meaningful quality measurement in hospice. He will also discuss how decisions are made concerning hospice admission and recertifications. **Thomas Hoyer** worked for the Centers for Medicare & Medicaid Services (CMS) and its predecessor organizations from 1972 until his retirement in 2002. He was responsible for implementing the hospice benefit and for producing the regulations that have governed the benefit since 1983. He will provide a historical perspective on the hospice benefit and discuss its future.

## ENDNOTES

1. Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Reforming the Delivery System*, June 2008, p. 203; available at [www.medpac.gov/documents/Jun08\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun08_EntireReport.pdf).
2. MedPAC, *Report to the Congress*, p. 214.
3. MedPAC, *Report to the Congress*, p. 216.
4. The cap is calculated annually, for the period November 1 through October 31. Since the calculation occurs at the end of the period—after Medicare payments have been made—hospices that exceed the cap for the period owe money back to Medicare and the Centers for Medicare & Medicaid Services must recoup the payments.
5. MedPAC, *Report to the Congress*, p. 213.
6. U.S. Department of Health and Human Services, *FY 2009 Justification of Estimates for Appropriations Committees*, available at [www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY09CJ.pdf](http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY09CJ.pdf).
7. The regulations were published in the *Federal Register* on June 5, 2008, and are available at [www.cms.hhs.gov/CFCsAndCoPs/05\\_Hospice.asp](http://www.cms.hhs.gov/CFCsAndCoPs/05_Hospice.asp).



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