

raphy was released in February 2009. The opinions expressed in this article are those of the authors and do not necessarily represent the positions of the CMS or the U.S. government.

This article (10.1056/NEJMp0904408) was published on May 27, 2009, at NEJM.org.

Dr. Dhruva is a resident, and Dr. Redberg a professor of medicine, at the University of California, San Francisco, School of Medicine, San Francisco. Dr. Phurrough is a medical officer at the Agency for Health-

care Research and Quality, Rockville, MD. Dr. Salive is the director of the Division of Medical and Surgical Services at the CMS, Baltimore.

- Centers for Medicare and Medicaid Services. Decision memo for screening computed tomography colonography (CTC) for colorectal cancer (CAG-00396N). (Accessed June 4, 2009, at <https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=220>.)
- Dhruva SS, Redberg RF. Variations between clinical trial participants and Medicare beneficiaries in evidence used for Medicare national coverage decisions. *Arch Intern*

Med 2008;168:136-40. [Erratum, *Arch Intern Med* 2008;168:774.]

- Granger K. CMS made wrong decision in prohibiting Medicare reimbursement of virtual colonoscopies. (Accessed June 4, 2009, at <http://www.viatronix.com/pdfs/Granger.pdf>.)
- Redberg RF, Walsh J. Pay now, benefits may follow — the case of cardiac computed tomographic angiography. *N Engl J Med* 2008;359:2309-11.
- Pear R. Recession drains social security and Medicare. *New York Times*. May 12, 2009:A1.

Copyright © 2009 Massachusetts Medical Society.

A New Era of For-Profit Hospice Care — The Medicare Benefit

John K. Iglehart

To ensure that a reluctant medical community would embrace Medicare at its inception in 1965, Congress declared that any willing provider could participate. Since that time, the vast majority of physicians and hospitals have come to rely on Medicare as a major source of revenue. But as additional Medicare benefits have been created, they have increasingly been provided by for-profit companies that find doing business with government, though sometimes frustrating, a worthwhile commercial venture. Perhaps the most untraditional Medicare service offered by such organizations is hospice care.

The hospice benefit was created in 1982 to offer terminally ill patients an alternative to conventional care, but “there was also a strong expectation that hospice services would result in lower costs to the Medicare program than conventional medical interventions at the end of life,” according to the Medicare Payment Advisory Commission (MedPAC), which advises Congress.¹ Hospice services, whose palliative nature contrasts with the medically intense acute care generally provided by Medicare, address patients’

changing preferences regarding end-of-life care — while challenging the professional impulse of some physicians to deploy all appropriate means for prolonging life.

Although most legislators support the provision of hospice services, Congress has not exercised much oversight of the benefit in recent years. The Office of Inspector General in the Department of Health and Human Services (DHHS) has produced a number of studies of the hospice benefit and has three more on its agenda, including one that will review physician billing. MedPAC, for its part, has recommended substantial changes designed to improve the accuracy of Medicare payments to hospices, increase hospice organizations’ accountability, and ensure greater involvement by physicians in end-of-life care.¹ A recent study showed that physicians often end all contact with patients once they refer them for hospice care.²

The hospice benefit is available to Medicare beneficiaries who, according to two physicians (one of whom is the hospice medical director), have a life expectancy of 6 months or less if their dis-

ease runs its normal course and who agree to forgo Medicare coverage for curative treatment of their terminal illness. The benefit provides an array of medical and support services, some of which are not covered by traditional Medicare, including social-work services, bereavement counseling for family members, and pastoral services. Beneficiaries’ cost sharing is minimal.

Initially, most patients who elected the benefit had received a diagnosis of terminal cancer. But physicians and families gradually recognized that hospice services could benefit patients with other terminal illnesses, and enrollment grew: in 2006, about 40% of Medicare beneficiaries who died had opted for hospice. About two thirds of them had had noncancer diagnoses — such as Alzheimer’s disease, Parkinson’s disease, congestive heart failure, or less-specific debilities — that led to longer hospice stays (see table). By 2007, about 1 million Medicare beneficiaries were enrolled in hospices — more than double the enrollment of a decade earlier. Medicare’s hospice spending soared from \$2.9 billion to about \$10 billion between 2000

Mean Length of Hospice Stays in 2006, According to Disease Category.

Disease Category	Mean No. of Days of Stay*	Percent of Cases with Length of Stay >180 Days
Alzheimer's disease or other cerebrodegenerative disease	88	31.1
Nervous system diseases except Alzheimer's disease	86	28.2
Dementia	78	26.2
Organic psychosis	77	25.4
Chronic airway obstruction, not otherwise specified	73	23.9
Nonspecific symptoms or signs	72	21.3
Debility, not otherwise specified	70	20.8
Heart failure	66	20.3
Circulatory disease except heart failure	57	18.7
Other cancer	47	8.9
Lung cancer	45	7.7
Other disease	43	12.6
Respiratory disease	41	12.0
Digestive disease	38	8.7
Genitourinary disease	25	4.7
All	59	16.8

* Mean lengths of stay were calculated on the basis of claims for which the length of stay could be determined. Data are from MedPAC.¹

and 2007 and is projected to more than double over the next decade.

As the profile of hospice patients has changed, so have the number and character of the organizations that serve them. Between 2000 and 2007, the number of Medicare-participating hospices grew from about 2300 to more than 3200, largely owing to the entry of for-profit hospices. In its 2009 report, MedPAC attributed the growth in supply in part to increasing demand but added that “a large part may also have been due to financial incentives in Medicare’s hospice payment system, under which long stays are more profitable than short stays.”¹

Medicare pays hospice providers a daily rate for each day a patient is under care, regardless of whether a provider has visited the patient on that day. Routine

home care, for which Medicare paid \$135 per day in 2008, accounts for about 90% of reimbursed days; the remaining 10% of days are reimbursed for continuous home care (\$236 for every 8 hours of care in 2008), inpatient respite care to provide relief for family caregivers (\$140 per day in 2008), and general inpatient care to treat symptoms that aren’t manageable outside the hospital (\$601 per day in 2008).

Although a patient’s diagnosis is a strong predictor of the length of stay, MedPAC concluded that because the payment system does not require a daily visit, some hospices admit patients who need little care but generate payments similar to those for patients who require more care. “As a result,” the commission notes, “a strong correlation exists between length of hospice stay and profitability. . . . The concern is that some

new hospice providers, which are predominantly for-profit, may be pursuing a business model based on maximizing length of stay, and thus profitability.”¹

Between 2000 and 2006, the average stay of a hospice patient increased from 62 to 82 days. But at the 90th percentile of the distribution, the stays increased from 144 days in 2000 to 212 days by 2005, a jump of almost 50%. MedPAC recommends that Medicare adjust its per diem payments to reflect the changing resource intensity through the course of a patient’s stay; hospices would receive a higher per diem payment for the first 30 days and progressively lower per diem payments for subsequent 30-day periods, with an increase at the end of a stay to reflect the higher costs incurred. Under this system, as modeled by MedPAC, aggregate Medicare payments to hospices with the longest stays would be reduced by 6.6 to 10.8%, whereas hospices with the smallest share of long stays would see gains of 16.6 to 24.1%.

MedPAC based this recommendation in part on an analysis it conducted of the intensity of hospice stays using data from a large, proprietary national hospice chain¹ — an outside database it relied on because, until recently, the Centers for Medicare and Medicaid Services (CMS) had little information on the type or quality of the hospice care it purchases. Since last July, the CMS is requiring hospices to report the number of visits by physicians, nurse practitioners, nurses, home health aides, and social workers.

The increasing proportion of lengths of stay exceeding 180 days and the variability in length of stay among hospices also convinced MedPAC that Medicare should change the manner in

which patients are recertified for eligibility. After being deemed eligible by two physicians, one of whom is the hospice medical director, beneficiaries elect hospice care for defined periods, the first of which is 90 days. After a second 90-day period, patients can be recertified for an unlimited number of 60-day periods if their life expectancy remains 6 months or less. But after initial approval, recertification falls solely within the purview of the hospice's medical director, not the patient's physician. In an effort to improve adherence to the coverage criteria in determining eligibility, MedPAC has recommended requiring documented physician oversight as well as additional medical review of long stays at hospices with a disproportionate number of such stays — to “identify providers with inappropriate admissions or recertification practices.”

MedPAC also recommended

that the Office of Inspector General investigate the prevalence of financial relationships between hospices and long-term care facilities “that may represent a conflict of interest and influence admissions to hospice” and examine the enrollment practices of hospices with patterns of unusually long or short stays. Finally, MedPAC recommended that the DHHS collect more data on hospice care, since “much more information will be needed to modernize the hospice-payment system in light of changes in hospice use during the past decade.”

In general, the National Hospice and Palliative Care Organization, which advocates on behalf of most organizations that care for Medicare beneficiaries, supports MedPAC's recommendations, noting that “a payment system that closely matches . . . actual cost curves of patient care, such as a ‘first and last periods of care’ system, done on a

budget neutral basis has merit.”³ If Congress considers MedPAC's hospice recommendations, however, it will probably do so this year, in the context of intensified efforts to slow Medicare spending — rather than in the budget-neutral fashion recommended by both the commission and providers of hospice services.

No potential conflict of interest relevant to this article was reported.

Mr. Iglehart is a national correspondent for the *Journal*.

1. Report to the Congress: Medicare payment policy. Washington, DC: Medicare Payment Advisory Commission, March 2009.
2. Back AL, Young JP, McCown E, et al. Abandonment at the end of life from patient, caregiver, nurse, and physician perspectives: loss of continuity and lack of closure. *Arch Intern Med* 2009;169:474-9.
3. National end-of-life organizations release consensus statement on hospice, the Medicare hospice benefit, and key issues for the future. Alexandria, VA: National Hospice and Palliative Care Organization, 2009. (Accessed June 4, 2009, at <http://www.nhpc.org/i4a/pages/index.cfm?pageid=5803>.)

Copyright © 2009 Massachusetts Medical Society.