

Who Pays for Hospice?

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Hospice is a way of caring for a patient whose disease cannot be cured. Providing palliative rather than curative care, hospice uses a team-oriented approach to medical care, pain management, and emotional and spiritual support customized to the dying patient's needs and wishes. Medicare provides coverage for this comprehensive end-of-life care delivered at home or in a hospice facility.

The Medicare Hospice Benefit

The Medicare Hospice Benefit (MHB), established in 1982 and implemented in 1983, was the first use of a prospective payment system by Medicare and is the most comprehensive end-of-life care benefit available. Under the Balanced Budget Act of 1997, the MHB provides hospice care for two 90-day periods, followed by an unlimited number of 60-day periods. The benefit periods may be used consecutively or at necessary intervals. Regardless of whether they are used consecutively or at different times, the patient must be

certified by 2 physicians as terminally ill at the beginning of each period.

A Medicare-certified hospice program assumes responsibility for reasonable and necessary medical and support services for the management of a terminal illness under a plan-of-care established by the beneficiary's attending physician and the hospice team. Medicare-covered hospice services are listed in Table 1.

MHB Expenditures

National health care expenditures are projected at \$2,163.9 billion

for 2006.¹ Specific data on national expenditures for hospice are sparse, but detailed data are available on Medicare hospice expenditures and utilization. These data show that the MHB represents a small proportion of the total Medicare spending. In 2005, hospice care received an estimated 2.5% of Medicare benefit payments (Table 2). Projections for 2006 suggest that hospice care will continue to be a small proportion of total Medicare spending.

MHB Reimbursement

In addition to Medicare and Medicaid, additional sources of hospice revenue are derived from commercial insurers, managed care, and the Federal government (Veterans Affairs, Active Duty Military) plans. Some hospice programs provide care to patients with little or no insurance using community donations and grants to add to the revenue base.

Medicare payments for hospice services are made on a prospective basis and are adjusted by a geographic area wage index. Current rates, effective October 1, 2005 are shown below:²

- **Routine home care rate: \$126.49/day.** This covers care provided to patients who are at home (defined as the patient's own home or wherever the patient considers home, such as a nursing home).
- **Continuous home care rate: \$738.26/day, or \$30.76 per hour.** This covers care (half of which must be skilled nursing

Table 1.

Medicare-covered Hospice Services Provided as Necessary for Palliative Care

- Nursing care
- Physician care
- Medical social worker services
- Medical appliances and supplies (including drugs and biologicals)
- Inpatient care (including both respite care and short-term inpatient care for procedures necessary for pain control and acute and chronic symptom management)
- Home care aide and homemaker services
- Counseling (including dietary, pastoral, and other)
- Physical and occupational therapies
- Speech-language pathology services
- Family bereavement services (for up to 13 months following a beneficiary's death)

care) at home during a period of crisis of at least 8 hours within a 24-hour period, and only as long as necessary to maintain the terminally ill patient at home.

- **General inpatient care rate: \$562.69/day.** This pays for inpatient care for pain control or acute or chronic symptom management that cannot be provided in a setting other than a Medicare-certified hospital, a skilled nursing facility, or an inpatient unit of a hospice.
- **Inpatient respite care rate: \$130.85/day.** This pays for care by the patient's Medicare-certified hospice program in an approved inpatient facility to pro-

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vide a respite for family members or others caring for the hospice patient.

Hospice and Managed Care
Health care in the United States

is increasingly being financed through managed care organizations (MCOs). A report by the Medicare Payment Advisory Commission (MedPAC) showed that 34% of people enrolled in a Medicare+Choice plan chose hospice, compared with only 25% of those enrolled in the traditional Medicare program at the time of their death.³

When a Medicare-eligible patient who belongs to an MCO decides to elect hospice care, he or she must meet the Medicare-specified eligibility requirements and must receive care through a Medicare-approved hospice. The patient does not need a referral or have to disenroll from the MCO. Because MCOs generally specify a capitated payment for the care of patients, Medicare pays the hospice for its services and the MCO for physician services and services not related to the patient's terminal illness. Thus, the increasingly competitive health care environment has created a number of incentives for hospices to enter managed care provider networks.

Hospice Utilization

Numerous studies have shown that hospice is a more cost-effective care option compared to hospitals and skilled nursing facilities. Table 3 compares the average costs for a Medicare patient to stay 1 day in each of these facilities during the period from 1998 to 2005. Hospice charges are consistently and substantially lower than those for hospitals and skilled nursing facilities.

In addition, hospice is proven to be a compassionate and dignified means of delivering health care

Table 2.
Medicare Benefit Payments, FY2005 and FY2006

	2005 (Estimated)		2006 (Projected)	
	Amount (\$ millions)	Percent of Total	Amount (\$ millions)	Percent of Total
Total Medicare benefit payments*	330,639	100.0	386,568	100.0
Part A				
Hospital care	121,563	36.8	120,984	31.1
Skilled nursing facility	18,128	5.5	17,607	4.5
Home health	5,963	1.8	6,009	1.5
Hospice	8,318	2.5	9,246	2.4
Managed care	27,001	8.2	31,999	8.2
Total	180,973	54.7	185,845	47.7
Part B				
Physician	57,281	17.3	58,739	15.1
Durable medical equipment	7,841	2.4	7,570	1.9
Carrier lab	3,515	1.1	3,654	0.9
Other carrier	15,183	4.6	15,863	4.1
Hospital	19,604	5.9	20,553	5.3
Home health	6,560	2.0	6,596	1.7
Intermediary lab	2,924	0.9	2,994	0.8
Other intermediary	11,767	3.6	13,014	3.3
Managed care	23,868	7.2	28,282	7.3
Total	148,543	44.9	157,264	40.4

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, FY2007 President's Budget (February 2006).

*Part A total does not include peer review organization payments. Figures may not add to totals due to rounding.

services to terminally ill patients. The focus is on care, not cure, and helping to make the most out of remaining life by providing comfort and relief from pain is emphasized. Yet few terminal Medicare beneficiaries access the MHB. Patients do not understand the hospice option, and many have the misconception that hospice care is reserved only for the last days of life. Physicians do not think of the benefit until very late in the course of the patient's disease, and there is misunderstanding of the disease states and conditions appropriate for hospice care.

Hospice in the Future

The number of patients accessing the MHB has increased in recent years, with the largest growth seen in residents of nursing home facilities. Still, only a fraction of those eligible for the MHB take advantage of it. As more patients and families learn about the benefits of hospice care, and as the cost of health care continues to increase, the use of hospice as an alternative to other clinical settings will most likely increase.

Take-Away Message

- Hospice provides improved clinical and financial outcomes for patients needing end-of-life care as certified by 2 physicians.
- These programs are paid on a capitated basis, so they are able to provide care through an entire interdisciplinary team.
- Despite its advantages, hospice is still underutilized.

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- By exposing patients to hospice sooner, a more timely and beneficial admission into this program may be realized.
- Because of the significant needs in managing patients during the end of life, hospice can offer practices an opportunity to bring in a team of providers to help in the care of these especially needy patients.

For additional information and resources on hospice care, contact the organizations below:

- American Hospice Foundation (www.americanhospice.org/)
- City of Hope Pain/Palliative Care Resource Center 9 (<http://prc.coh.org>)
- Growth House, Inc. (www.growthhouse.org)
- Hospice and Palliative Nurses Association (www.hpna.org)
- Hospice Association of America (www.hospice-america.org/)
- Hospice Foundation of America (www.hospicefoundation.org/)
- Medicare Rights Center (www.medicarerights.org/)
- National Association for Home Care and Hospice (www.nahc.org/)
- National Family Caregivers As-

sociation (www.nfcares.org/)

- National Hospice and Palliative Care Organization (www.nhpco.org/templates/1/homepage.cfm)

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References

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2. Dept of Health and Human Services. Part IV. Centers for Medicare & Medicaid Services. 42 CFR part 418. Medicare program; hospice wage index for fiscal year 2006; final rule. *Fed Regist*. 2005;70:45130-45247. Available at: <http://www.cms.hhs.gov/QuarterlyProviderUpdates/Downloads/cms1286f.pdf>. Accessed June 12, 2006.
3. Medicare Payment Advisory Commission. *Report to the Congress: New Approaches in Medicine*. Washington, DC: Medicare Payment Advisory Commission. June 2004. Available at: http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1&sid=2&subid=0. Accessed June 11, 2006.

Table 3.

Comparison of Hospital, Skilled Nursing Facility, and Hospice Medicare Charges, 1998-2005

	1998	1999	2000	2001	2002	2003	2004	2005
Hospital inpatient charges per day	\$2,177	\$2,583	\$2,762	\$3,069	\$3,574	\$4,117	\$4,559	\$4,787
Skilled nursing facility	482	424	413	422	475	487	493	521
Hospice charges per covered day of care	113	113	118	120	125	126	129	131

Sources: The hospital and SNF Medicare charge data are from the Annual Statistical Supplement, 2005, and the Social Security Bulletin, Social Security Administration. Hospital and skilled nursing facility data for 2005 are updated using the Bureau of Labor Statistics' (BLS) Hospital Producer Price Index (PPI) and the BLS Nursing Care Facility PPI, respectively. The hospice charge data for 1998 are from the Health Care Financing Review (HCFR), Statistical Supplement, Health Care Financing Administration, 2000. Hospice data for 1999 are from the HCFR, Statistical Supplement.