



U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy



# **SYNTHESIS AND ANALYSIS OF MEDICARE'S HOSPICE BENEFIT:**

## **EXECUTIVE SUMMARY AND RECOMMENDATIONS**

March 2000

## **Office of the Assistant Secretary for Planning and Evaluation**

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

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In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-97-0010 between HHS's ASPE/DALTCP and the Urban Institute. For additional information about this subject, you can visit the DALTCP home page at [http://aspe.hhs.gov/\\_/office\\_specific/daltcp.cfm](http://aspe.hhs.gov/_/office_specific/daltcp.cfm) or contact the ASPE Project Officer, Jennie Harvell, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: [Jennie.Harvell@hhs.gov](mailto:Jennie.Harvell@hhs.gov).

# **SYNTHESIS AND ANALYSIS OF MEDICARE'S HOSPICE BENEFIT: Executive Summary and Recommendations**

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March 2000

Prepared for  
Office of Disability, Aging and Long-Term Care Policy  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services  
Contract #HHS-100-97-0010

Other Project Officers working with this contract included John Drabek of DALTCP and Carol Blackford from the Health Care Financing Administration. The authors thank the following people for helpful comments on earlier drafts of these reports: Joanne Lynn, M.D. George Washington University; Carol Blackford/Lynn Riley/Beverly Cullen, HCFA; Tom Komanieck, OIG; and Henry Krakauer, M.D. ASPE; and Pauline Chouinard, MEDSTAT for careful report management.

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

# TABLE OF CONTENTS

<b>STUDY PURPOSE</b> .....	1
<b>STUDY SCOPE</b> .....	2
<b>FINDINGS OF THE SPECIFIC REPORTS</b> .....	4
Report 2. Important Questions for Hospice in the Next Century .....	4
Report 3. Medicare’s Hospice Benefit: Use and Expenditures-1996 Cohort .....	6
Reports 4 and 5. Use of Medicare’s Hospice Benefit by Nursing Facility Resident and Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents.....	7
Report 6. Hospice Benefits and Utilization in the Large Employer Market.....	9
<b>RECOMMENDATIONS</b> .....	11

## STUDY PURPOSE

This study was conducted under the auspices of the Office of Disability, Aging and Long-Term Care Policy (DALTCP), Office of the Assistant Secretary for Planning and Evaluation (ASPE), in the Department of Health and Human Services (DHHS). The goal is to inform policy makers about the role of Medicare's hospice benefit in general, and its contribution to end-of-life care for institutionalized beneficiaries in particular. The study provides an overview of Medicare's hospice program which pays for almost four-fifths of all hospice in the United States, a discussion of Medicaid's hospice benefit, including issues specific to the dually-eligible, and a description of alternative benefit design options as offered under employer-sponsored benefit packages. Also included are claims analyses of hospice use by three populations: (1) all Medicare hospice enrollees, (2) a subset of Medicare hospice users in nursing facilities in five states, and (3) a younger subset of hospice users in employer-based or other private insurance plans.

# STUDY SCOPE

The study comprises five reports and the Executive Summary:

Important Questions for Hospice in the Next Century provides the framework for all the other reports. It includes overviews of:

- The Medicare hospice benefit -- its history, current structure, and influence on care of the dying;
- Hospice benefits provided by other insurers, such as state Medicaid programs and private employers, including coverage overlaps and differences among the various insurers' benefits;
- The literature on hospice use and quality of care in the community and in nursing facilities;
- Policy and program issues regarding benefit and care coordination for hospice enrollees in nursing facilities, as raised by a group of key informants that included providers, federal and state surveyors, and state Medicaid officials.

Medicare's Hospice Benefit: Use and Expenditures: 1996 Cohort focuses on Medicare's hospice users and payment patterns. Based on an analysis of Medicare claims for beneficiaries who first enrolled in hospice in 1996 and including use and payments data through 1997, it describes:

- Changes in the types of Medicare beneficiaries who enroll in hospice today compared with the early 1990s;
- Enrollment patterns of Medicare hospice patients and the types of hospice services they use;
- Medicare expenditures of these patients in the six months prior to hospice enrollment.

Use of Medicare's Hospice Benefit by Nursing Facility Residents studies nursing facility residents in five states (New York, Kansas, Maine, Mississippi, and South Dakota) who enroll in hospice. This report analyzes differences in three groups of hospice users based upon time of enrollment in hospice: patients who enroll and complete hospice prior to a nursing home admission, patients who enroll in hospice and continue in it while in a nursing home, and patients who enter a nursing home and then enroll in hospice.

Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents compares the utilization and quality of care for two samples of nursing home patients who die: those who enrolled in hospice while in the nursing home and those who did not.

Hospice Benefits and Utilization in the Large Employer Market addresses the use of hospice and presents information on alternative hospice benefit models used by private employer groups. The data are based on plan booklets and insurance claims from 52 large employers and in-depth discussions with nine plans.

# FINDINGS OF THE SPECIFIC REPORTS

## Report 2. Important Questions for Hospice in the Next Century<sup>1</sup>

The Medicare hospice benefit is the most recently established Medicare benefit. Authorized during the 1980s, it is intended to be both a cost-containment mechanism to limit the program's high costs for beneficiaries in their last year of life and a tool to improve quality of care for the dying.

*Hospice in Nursing Homes.* Through a series of reports beginning in 1997, the Office of the Inspector General (OIG) in DHHS raised questions about the role of the hospice benefit for dually covered Medicare beneficiaries living in nursing facilities. Medicare is the primary payer for a dually-covered enrollee's hospice services. But the state Medicaid program covers room and board when the enrollee lives in a nursing facility. The OIG was concerned that the financial relationships between hospices and nursing facilities may violate anti-kickback statutes (Federal Register, 1999). Of primary interest was whether hospice changed the cost or quality of services provided to dying beneficiaries in nursing facilities, and if so, whether the Medicaid room and board payment rates adequately reflected differences in costs associated with hospice provision in a nursing facility.

This report was initiated in response to the first OIG study which highlighted how little was known about the use of hospice in nursing homes. The report reviews the literature on the Medicare hospice benefit, its cost-effectiveness and use in nursing homes, and summarizes discussions with key informants on issues in providing hospice services in nursing homes and caring for the terminally ill in this setting. There was little information in the literature concerning the use hospice in nursing homes.

*The Benefit.* Hospices receive a capitated per diem payment from Medicare for almost all services provided to the patient, and in exchange, manage the total care and costs of treating the patient's terminal illness. Excluded from the Medicare payment are room and board costs (which are provided by Medicaid for recipients who live in nursing facilities) and any costs for attending physicians who are not hospice staff or for services not related to the terminal illness. The hospice benefit is unique among Medicare benefits, because it covers all outpatient prescription drugs (including non-IV-based drugs) typically used to treat pain and other symptoms of the terminal illness. Medicare's hospice benefit also covers counseling and bereavement services for beneficiaries' and their family members.<sup>2</sup> While eligibility is based on having a prognosis of 6 months or less to live, benefit coverage is unlimited provided the patient is recertified every 60 days.

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<sup>1</sup> The Executive Summary is the first of the six reports in the study.

<sup>2</sup> Although health maintenance organizations (HMOs) may cover some outpatient drugs for Medicare beneficiaries, those benefits vary by plan and generally are more limited than the pain medications covered under Medicare's hospice benefit. Medicare covers only IV-based outpatient drugs in the fee-for-service sector.

Medicare pays for 77 percent of all hospice expenditures. The rest is paid for by private insurance (12 percent), Medicaid (4 percent), and other sources (7 percent). In 1997, Medicare covered 374,723 hospice enrollees at a cost of \$2.02 billion (MedPAC, 1998). The length of time beneficiaries are in hospice, which varies by provider type, averages 50 days. Most hospice enrollees live at home or in a private residence, but some live in nursing facilities.

*Cost-Effectiveness.* Even though hospice is a relatively new Medicare benefit, it has been studied extensively. The National Hospice Study (NHS) found that the benefit produced net Medicare savings, due primarily to hospice patients having reduced inpatient hospital costs, particularly in the last months of life (Kidder, 1992). A more recent study updating the NHS arrived at similar conclusions (Lewin, 1995). A 1993 study of high-cost hospice users -- and the adequacy of Medicare's payment rates for their care -- showed that the higher expenses were due to longer enrollment periods, not higher daily costs (HCFA, 1993). As a result, the Secretary of DHHS concluded that the hospice per diem payment rates, because they adjusted for volume, were adequate to cover even the higher cost hospice population. A 1995 study of the effects of coverage showed that, for most cases, length of use did not increase substantially when the 210 day limit was removed in 1988 (Banaszak-Holl and Mor, 1995). The patients most likely to use the longer enrollment period were patients with illnesses other than cancer, because they tended to have longer episodes of hospice care. In addition to these national program studies, hospice use is also profiled regularly by the National Center for Health Statistics (NCHS, 1998). The NCHS surveys show that almost 80 percent of all hospice users are 65 or older, further highlighting the importance of Medicare in providing hospice.

*Key Informant Discussions.* Discussions were held with nursing facility and hospice providers, and with survey and certification specialists, to help distinguish between the responsibilities of hospice providers and those of nursing homes in caring for terminally ill patients in nursing facilities. Discussants raised three issues in particular.

The first was the need for more training of nursing home staff in caring for the terminally ill. Since hospices and nursing facilities have divergent goals, they naturally emphasize different treatment norms. The hospice focus on palliative care, for example, may result in levels of pain medication considered inappropriate in a nursing facility. All agreed, however, that caring for dying patients is a central mission of nursing facilities, and that facility staff (including nursing and aide staff) could benefit from greater training in caring specifically for these patients. All agreed also that hospice staff provided an important educational function in the nursing facility, which had beneficial spillover effects in improving the care of terminally ill residents in that facility who were not enrolled in hospice. There was also a strong consensus that the need for more training on the special needs of the terminally ill should be given to all non-hospice professionals, including physicians and survey and certification personnel.

The second important issue raised was the need for better specification of the responsibilities of hospice versus nursing home staff. Concerns were raised that, despite having treatment plans developed by both the nursing facility and the hospice staff in the residents' record, nursing facilities could still be cited for negative effects when a resident's health declines. Some states, such as Colorado and Wisconsin, have model nursing facility and hospice contract requirements which require the responsible provider to be identified and their responsibilities specified in the care plan. Other states have issued "comfort care measures" to be used by nursing facilities in caring for dying residents when hospice care is unavailable. All informants agreed that such measures would minimize problems of conflicting treatment orientations and related legal issues.

The third major issue raised was the need to simplify room and board payment policies for dual-eligible beneficiaries enrolled in hospice and residing in nursing facilities. Currently, hospices are paid by state Medicaid programs, and in turn, must pay nursing facilities for Medicaid-covered room and board payments for their enrollees. Although the room and board service is not provided by the hospice, the state nursing facility payment is reduced by 5 percent when a recipient enrolls in hospice. The hospice then negotiates a room and board rate with the nursing facility. This has been very controversial because of the perceived potential for kickbacks. The OIG has issued rules clarifying that hospices are at risk of being investigated if they pay nursing facilities an amount greater than the state room and board rate (Federal Register, 1999). All participants concurred that both the administrative and conflict-of-interest burden on hospices would be reduced by having state Medicaid programs pay nursing homes directly for hospice enrollees' room and board.

### **Report 3. Medicare's Hospice Benefit: Use and Expenditures-1996 Cohort**

This report uses 1996 and 1997 Part A claims to examine Medicare payments and service use for the 317,198 beneficiaries who first enrolled in hospice in 1996. About 5 percent of the elderly die each year, and of them, about 18 percent enroll in Medicare hospice. Medicare's hospice population continues to be dominated by beneficiaries with a primary diagnosis of cancer, but the proportion having other primary diagnoses, such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stroke, and Alzheimer's Disease, has been rising throughout the 1990s. For all but about 3 percent of beneficiaries in hospice care, their time in hospice is ended by death.

The types of hospice services used, length of enrollment in hospice, number of benefit periods, and per case payments vary by primary diagnosis, with average payments and use skewed by the small proportion of users with very long or expensive stays. The mean payment per case (\$6,433), for example, is almost 2.5 times greater than the median payment per case (\$2,809), and the mean hospice stay averages 65 days (compared with a median of only 24). Enrollees with the longest lengths of stay and highest payments per case are those with a primary diagnosis of Alzheimer's Disease (with a mean time in hospice of 104 days and a mean payment of \$9,824 per

case). Stroke patients stayed the shortest time in hospice (averaging 10 days and \$5,539 per case).

Use of Medicare Part A services in the six months prior to hospice enrollment also varies by primary diagnosis. Over 71 percent of all 1996 cases used hospital outpatient services at least once. Only 61.2 percent had an inpatient stay prior to entering hospice, down slightly from 68.6 percent in 1990. Non-cancer and non-Alzheimer's cases, such as those with a primary diagnosis of CHF, COPD, and stroke were most likely to have been hospitalized in the six months preceding enrollment in hospice.

Length of use and type of hospice services used also vary by state, reflecting differences in general practice patterns and service availability as well as differences in patient needs. Louisiana, for example, which has the highest Medicare home health payments in the nation, has continuous home care hospice use levels almost 200 percent of the national average but inpatient hospice use levels only 75 percent of the national average.

Finally, insurance coverage affects hospice payments and use. After controlling for age, sex, race, and primary diagnosis, both hospice enrollees in an HMO prior to or during hospice enrollment and dually eligible enrollees had significantly higher hospice payments and length of time in hospice (compared with their non-HMO and higher income counterparts, respectively).

## **Reports 4 and 5. Use of Medicare's Hospice Benefit by Nursing Facility Residents and Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents**

Merging nursing home resident assessment data (the Minimum Data Set, or MDS) with Medicare enrollment and claims data for the states of Kansas, Maine, Mississippi, New York and South Dakota made it possible to directly examine the scope of hospice in nursing homes, the characteristics of hospice recipients vs. other dying nursing home residents, and the expenditures and benefits associated with providing hospice in nursing homes. Based upon the merged files and the data contained in Chapter 2 of this report we estimate that, overall, 24 percent of the Medicare hospice beneficiaries in the 5 study states reside in nursing homes. However, this estimate varies considerably across states from 11 percent in Mississippi to 48 percent in Kansas. Further study is needed to determine whether this range reflects national proportions.

*Hospice Utilization.* The length of stay experience of hospice patients in nursing homes is largely similar to that of their counterparts in the community. Their average time in hospice is short, with over 50 percent under hospice care for less than 30 days, 25 percent for a week or for less, and 7 percent for two days or less. Of those initiating hospice while in a nursing facility, 14 percent are discharged from hospice alive. This makes the length of stay distribution quite skewed, as it is among community residents. (Nursing facility patients discharged from hospice have lengths of stay averaging 176

days, compared with 61 days for nursing home patients who die in hospice.) Only 11 percent of all nursing home patients under hospice have any hospice inpatient days and less than 3 percent use continuous care -- both well below rates for hospice patients overall. Thus, hospice expenditures for the nursing home population are almost exclusively a function of length of stay; most patients have very short stays and incur correspondingly low hospice payments.

*Benefits and Expenditures.* What can be said about the benefits and expenditures of hospice in the nursing home environment? For this study we examined total Medicare expenditures prior to death, adjusting for 1 of 4 diagnosis groups and state of nursing home residence. The gross expenditures associated with hospice in the nursing home are clearly the added Medicare hospice expenditures (mean expenditures of \$7,848 and median of \$3,093 per person). The benefits are reductions in Medicare expenditures in the last 30 days from reduced hospitalizations and improvements in quality of care, both examined in the report Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents of this study. In the absence of a randomized trial, no definitive cost-benefit conclusions can be drawn. But an adjusted comparative analysis of beneficiaries who died in nursing facilities with and without hospice provides suggestive evidence. When patients are matched on selected qualities (diagnosis group, state of residence, and time from last MDS to death)--and other differences are controlled for by multivariate analysis--results indicate hospice enrollment to be associated with statistically significant reductions in acute care hospitalization and a statistically significant increased likelihood that analgesic management of daily pain will occur.<sup>3</sup>

- A. *Hospitalization.* Relative to nursing home residents who die without hospice, nursing home patients who died under hospice are significantly less likely to have been hospitalized in the last 30 days of life (12.5 percent vs. 41.3 percent) as well as in the last 90 days (24.5 percent vs. 53 percent) and the last 6 months of life (39.8 percent vs. 61.6 percent). This reduction in hospitalizations in the last 30 days of life translates into acute inpatient savings of \$2,908, an amount sufficient to offset the increased expenditures associated with daily hospice care (\$2,282) in the last 30 days of life. Even a non-hospice patient's probability of hospitalization decreases as the volume of hospice in the nursing facility increases, suggesting that there may be other hospice-related savings contributing to overall reductions in Medicare expenditures.

As with hospice provided in other settings, Medicare expenditures increase and expenditure savings decrease with increased hospice lengths of stay. Although hospice patients with stays under 30 days have lower total expenditures in the last 30 days and the last 6 months of life, opportunity may remain for further savings from reduced hospital data.

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<sup>3</sup> Data on expenditure patterns come from Medicare claims and include only skilled nursing, home health, hospital, and hospice claims. Data on quality of care come from facility MDS records. To allow for observation of a hospice effect, only MDS assessments completed after a hospice patient's admission could be used. This results in a sample of primarily long stay hospice patients, since short stay patients were less likely to have had a relevant MDS

- B. *Quality of Care.* The MDS data contain considerable clinical information pertaining to pain, symptom management and, in the states studied, even the type and frequency of pain medicines provided. Comparative analyses of this data clearly reveal superior pain assessments for terminal hospice patients compared to terminal nursing home patients who did not receive hospice. First, the pain of those under hospice care was more likely to be detected. Second, among those patients assessed as being in daily pain, those under hospice care were also more likely to be treated with pain medications and less likely to receive medications via intramuscular or intravenous routes. Also, lower percentages of hospice patients, compared to non-hospice patients, had physical restraints, received parenteral/intravenous feeding, or had feeding tubes in place.

## **Report 6. Hospice Benefits and Utilization in the Large Employer Market**

This report comprises three components: analysis of hospice benefits offered by large employers through examination of their Summary Plan Description (SPD) booklets; discussions with selected large employers about their hospice benefits; and quantitative analysis of hospice use and expenditures of commercially insured patients.

*Benefits.* Hospice is a benefit commonly offered by the 52 large employers in the study sample and appears in a wide variety of configurations. The vast majority (88 percent) of the health plans offered a hospice benefit, and conditioned eligibility on precertification of terminal illness by a physician. But only half the plans requiring precertification of terminal illness used the Medicare definition of six months or less to live. Most plans did not impose cost sharing on the hospice benefit. Lifetime maximum day and dollar limits were infrequently and inconsistently imposed. The share of plans explicitly distinguishing coverage of hospice services across settings of care (inpatient hospital, hospice facility, and at home) also varied considerably.

While plan specifications appear relatively rigid on paper, detailed telephone discussions with eight of the plans revealed considerable flexibility and discretion exercised by employers and plans in the administration and implementation of the hospice benefit. It became clear that the hospice provisions laid out in the plans were often perceived as guidelines that were typically not stringently applied in individual cases.

Three general approaches to the design and administration of the hospice benefit were revealed in these discussions: the Medicare-like Model, the Comprehensive Model, and the Unbundled Model.

*The Medicare-like Model.* Two of the plans interviewed structure their hospice benefit based upon the Medicare program's hospice benefit. These plans impose benefit periods and eligibility requirements similar to those in Medicare and require the same waiver of curative treatments when hospice care commences.

*The Comprehensive Model.* Half the plans interviewed take a different approach, the Comprehensive Model, which deviates significantly from the Medicare-like Model. Notably, suspension of curative treatments is not required while a patient undergoes hospice treatment under this model.

*The Unbundled Model.* Two of the plans interviewed use the Unbundled Model, which provides service coverage for care unique to hospice but has lower lifetime limits than in the other models. All non-hospice care in this model is provided through other plan provisions (prescription drugs through the outpatient prescription drug plan, home health through the medical plan, etc.). And case managers are responsible for coordinating the entire spectrum of care for the terminally ill individual.

*Use Patterns.* Hospice services are used infrequently by the younger, employed population that constitutes the vast majority of the commercially insured. Less than one person in 1,000 covered lives used hospice services in 1995, for example. Hospice episodes of care are brief, with a mean length of 21 days and a median length of one day (over half last only one day).<sup>4</sup> Commercially insured hospice service users are a relatively diverse group, ranging in age from 0 to 88 years with a wide variety of terminal conditions (including rare congenital diseases as well as common cancers). Mean payments per hospice episode are relatively low, \$2,951 for hospice services and \$3,114 for non-hospice medical services.

Two major findings emerging from this study are worth reemphasizing. First, many commercial plans deviate from the Medicare hospice model, both in age of population served and in administration of benefits. Second, most commercial plans seem to administer their hospice benefits with a fair modicum of flexibility, accommodating the needs and desires of patients and families. It is also clear, however, that commercial plans can afford this flexibility given the low demand for hospice in their covered populations.

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<sup>4</sup> These estimates are rough because plans that actually had a hospice benefit did not always specify one. In such cases, existence of the benefit only became clear when a hospice provider submitted a bill

## RECOMMENDATIONS

This final section collects together the major recommendations of the study. Some of these come from discussions with key informants among the provider, certification, and policy communities. Others emerge from the data analyses undertaken specifically for the study.

*Training.* Although many hospice services are similar in type to those offered under other Medicare benefits, enrolling in hospice provides more personal care services, covers additional services and prescription drugs, and delivers care that is specialized for the dying. By definition, however, these benefits are in lieu of non-hospice Medicare-covered services.

The tensions inherent in this situation become particularly salient in the nursing home environment. Many nursing home residents are terminally ill and nursing homes are required to provide appropriate care. Yet, as the providers we spoke with pointed out, nursing home staff are less trained in caring for the special needs of the terminally ill than are hospice staff. The providers also pointed out that when a nursing facility resident elects hospice, there are often beneficial spillover effects as hospice staff work with facility staff to train them in hospice procedures.

Informants recommended that all health care professionals and paraprofessionals, including nursing home staff, be educated about the needs and appropriate care of the terminally ill patient. Periodic training is particularly needed for paraprofessional nursing home staff, who often have high turnover rates. Greater training is also needed regarding the respective responsibilities of the two types of provider when a hospice patient lives in a nursing facility. Both providers and certification officials recommended that clear guidance and regulation on caring for dying nursing home residents, whether or not they are enrolled in hospice, be provided at both federal and state levels. Federal guidelines have recently been issued on some of these areas, but more training is needed in their application. Guidelines are also needed to clarify the need for nursing facilities to provide palliative care and the roles and responsibilities of hospices and nursing facilities when treating a hospice patient. Minimal contract provisions affecting the two types of providers when treating residents enrolled in hospice are needed as well.

*Care Outcome Measurement.* Many nursing home residents are terminally ill, but only a minority receive hospice. More work is needed on defining and measuring care outcomes, so that any differences in outcomes between the two groups of dying residents can be interpreted in light of differences in the treatments they receive.

*Payment Policies.* This study of the Medicare hospice benefit began as a result of concern raised by the OIG that hospice payments to nursing facilities or room and board services may be triggering anti-kickback provisions. Questions were raised, in particular, about whether having hospices pay the nursing facility for dually eligible

enrollees' room and board services affected referral rates to hospice. This problem could be relieved by simplifying the room and board payment policy for dually-eligible nursing facility residents who elect hospice. Medicare pays the hospice for the specific medical and palliative care the hospice provides. Medicaid pays the hospice for room and board and for standardized levels of nursing care--even though these services are provided by the nursing facility staff independently of the hospice. The hospice then has to reimburse the facility. All informants concurred that both administrative burdens and any concerns about kickback effects could be reduced by having the Medicaid program pay the nursing home directly.

*Eligibility Standards and Access.* Medicare's current hospice benefit requires a physician to certify that a potential beneficiary has a life expectancy of six months or less if the illness runs its normal course. Furthermore, enrollees must waive their rights to other Medicare benefits in the treatment of their terminal illness. Under these rules, only 18 percent of the elderly who died in 1996 were enrolled in Medicare hospice and their hospice periods were relatively short--a mean of 65 and a median of 24 of the allowed 180 days. Only 9 percent used the benefit for over six months. One explanation for these low use levels may be a reluctance on the part of beneficiaries, providers, and family members to discuss the patient's life expectancy explicitly and actively decide to waive other treatments.

Two models of hospice care used in the private sector may provide valuable lessons for increasing access to Medicare hospice services. The Comprehensive Model, for example, does not require hospice enrollees to waive curative treatments while receiving palliative care and often defines terminal illness in other terms than having a six-month prognosis. The Unbundled Model expands these parameters even more widely, simply covering services needed by the terminally ill patient but not otherwise covered. Although a public program such as Medicare obviously has less flexibility in defining eligibility and benefit parameters than the much smaller private sector programs, these models are useful in illustrating that there are many plausible ways to structure a hospice benefit.

*Data Gaps.* One of the most difficult barriers in answering questions about hospice within nursing homes is identifying which hospice beneficiaries are nursing home residents. Nursing facilities throughout the country are now required to submit MDS data which will identify individuals as being hospice users in nursing homes and provide some information on their quality of care. Still, this source may be incomplete for two reasons. First, the rules governing whether a MDS must be completed when residents enroll in hospice are ambiguous. It is unclear whether enrolling in hospice always constitutes a significant change, which in turn, would trigger an assessment. Second, even if a facility interprets the regulation as requiring an assessment, facilities have 14 days to complete them. However, given that almost 25 percent of nursing home residents who begin using hospice subsequent to nursing home admission use 8 or fewer days of hospice services, beneficiaries may die before an assessment is complete. To identify this populations' changing needs, and develop and implement needed plans of care, assessments should be completed within a shorter time frame.

Better information is also needed for understanding the impact of receiving hospice services by nursing home residents. This study suggests that nursing home residents who are hospice patients receive better pain and symptom management than their counterparts who do not enroll in hospice. But this finding is based on data for only five states, which do not include some of the states with the largest numbers of hospice beneficiaries in the nation. MDS data now available will permit national studies of the effect of hospice in nursing homes.

In addition, information is needed on whether beneficiaries residing in nursing facilities receive the same types and levels of hospice treatment as those in the community. Key informants indicated that hospice beneficiaries in nursing homes received less hospice service than hospice users in the community. However, differences in the type and level of hospice care provided in nursing homes and community settings should be more systematically studied. Differences in service use could be examined more efficiently by modifying the hospice claim to identify service location (nursing facility, other group home, individual residence). This would allow analysis of differences in use between the two populations without requiring the use of multiple datasets.

Understanding whether institutionalized enrollees affect provider cost is another important area requiring better data. Modifying the new cost reports to include a measure of the share of patients seen in nursing facilities would provide gross estimates of whether provider costs vary by differences in the proportion of institutionalized patients treated. While this would be useful for understanding whether a payment differential for institutionalized populations may be warranted, it still would not answer why provider costs differ. To fully understand whether these hospice patients receive different levels of care, and are treated by different types of professionals, with varying lengths of visits would require a primary data collection effort.

# SYNTHESIS AND ANALYSIS OF MEDICARE HOSPICE BENEFITS

## Reports Available

The goal of ASPE's Medicare Hospice Benefit study was to provide general information on the role of the Medicare hospice benefit and more specific information about how end of life care is provided to institutionalized beneficiaries. Six reports were reproduced from this study:

**Synthesis and Analysis of Medicare's Hospice Benefit: Executive Summary and Recommendations** (report 1) briefly summarizes the methods used for each report and the findings and recommendations that emerged from each of the following reports under this study.

HTML

<http://aspe.hhs.gov/daltcp/reports/samhbes.htm>

PDF

<http://aspe.hhs.gov/daltcp/reports/samhbes.pdf>

**Important Questions for Hospice in the Next Century** (report 2) synthesizes the literature related to the Medicare hospice benefit and summarizes discussions with key informants on the use of hospice in nursing homes.

Executive Summary

<http://aspe.hhs.gov/daltcp/reports/impquees.htm>

HTML

<http://aspe.hhs.gov/daltcp/reports/impques.htm>

PDF

<http://aspe.hhs.gov/daltcp/reports/impques.pdf>

**Medicare's Hospice Benefit: Use and Expenditures, 1996 Cohort** (report 3) analyzes Medicare utilization and payments for hospice users in 1996.

HTML

<http://aspe.hhs.gov/daltcp/reports/96useexp.htm>

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<http://aspe.hhs.gov/daltcp/reports/96useexp.pdf>

**Use of Medicare's Hospice Benefit by Nursing Facility Residents** (report 4) examines differences in hospice utilization and expenditures as a function of when nursing facility residents started using hospice services (i.e., before or during a nursing home stay).

HTML

<http://aspe.hhs.gov/daltcp/reports/nufares.htm>

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<http://aspe.hhs.gov/daltcp/reports/nufares.pdf>

**Outcomes and Utilization for Hospice and Non-Hospice Nursing Facility Decedents** (report 5) compares pain management and types of services provided to dying nursing home residents receiving hospice compared to other dying residents who did not receive hospice.

HTML

<http://aspe.hhs.gov/daltcp/reports/2000/oututil.htm>

PDF

<http://aspe.hhs.gov/daltcp/reports/2000/oututil.pdf>

**Hospice Benefits and Utilization in the Large Employer Market** (report 6) reports on how hospice services are provided by 52 large employers and used by their employees, and identifies alternative approaches to designing and administering hospice benefits.

Executive Summary <http://aspe.hhs.gov/daltcp/reports/empmktes.htm>

HTML <http://aspe.hhs.gov/daltcp/reports/empmkt.htm>

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Washington, D.C. 20201  
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