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**Service Category Definition - Ryan White Part A Grant  
2012-2013**

HRSA Service Category Title: <b>RWGA only</b>	<b>Hospice Services</b>
Local Service Category Title:	<b>Hospice Care</b>
Budget Type: <b>RWGA only</b>	<b>Unit Cost</b>
Budget Requirements or Restrictions: <b>RWGA only</b>	Not applicable.
HRSA Service Category Definition: <b>RWGA only</b>	<i>Hospice services</i> include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.
Local Service Category Definition:	Services, including services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist, provided to a client or a client's family as part of a coordinated program consistent with the standards and rules adopted under this chapter. These services include palliative care for terminally ill clients and support services for clients and their families.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals diagnosed with AIDS residing in the Houston Eligible Metropolitan Area (EMA).
Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.
Service Unit Definition(s): <b>RWGA only</b>	A unit of service is defined as one day of hospice services including admission and discharge dates that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA Services</i> .
Client Eligibility:	Individuals with an AIDS diagnosis and physician certification that the client (patient) is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.
Agency Requirements:	Provider must be licensed by the Texas Department of State Health Services as a hospital, special hospital, special care facility or Home and

**Service Category Definition - Ryan White Part A Grant  
2012-2013**

	Community Support Services Agency. <b>Agency must have the capability to bill Medicaid/Medicare for eligible clients. served at Medicaid eligible facilities.</b>
Staff Requirements:	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.
Special Requirements: <b>RWGA only</b>	<p>These services must be:</p> <ul style="list-style-type: none"> <li>a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement;</li> <li>b) Provided by a medically-directed interdisciplinary team;</li> <li>c) Provided in a home, nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.</li> </ul>

Service Category Definition - Ryan White Part A Grant  
2012-2013

***FY 2013 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Assurance Committee</b>		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup #2</b>		Date: <b>04/23/12</b>
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**Service Category Definition - DSHS State Services Grant**  
**September 1, 2012 - August 31, 2013**

Local Service Category:	<b>Hospice Services</b>
Amount Available:	<b>To be determined</b>
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals with AIDS residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by a physician as having a life expectancy of 6 months or less.
Agency Requirements:	Provider must be licensed by the Texas Department of State Health Services as a hospital, special hospital, special care facility or Home and Community Support Services Agency with Hospice Designation. Agency must have the capability to bill for Medicaid eligible clients served.
Staff Requirements:	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client.  Must comply with the Joint Part A/B Standards of Care.

***FY 2013 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

DSHS STATE SERVICES  
 1213 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE  
 HOSPICE SERVICES

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.1	<p><u>Scope of Service</u>                      Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client’s family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.</p> <p>Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.</p>	<ul style="list-style-type: none"> <li>• Program’s Policies and Procedures indicate compliance with expected Scope of Services.</li> <li>• Documentation of provision of services compliant with Scope of Services present in client files.</li> </ul>
9.2	<p><u>Client Eligibility</u>                      In addition to general eligibility criteria, , individuals must meet the following criteria in order to be eligible for services:</p> <ul style="list-style-type: none"> <li>• Referred by a licensed physician</li> <li>• Deemed by his or her physician to be terminally ill as defined as having six (6) months or less to live</li> <li>• Must be reassessed by a physician every six (6) months</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> </ul>
9.3	<p><u>Clients Referral and Tracking</u>                      Agency receives referrals from a broad range of HIV/AIDS service providers and makes appropriate referrals out when necessary.</p>	<ul style="list-style-type: none"> <li>• Documentation of referrals received.</li> <li>• Documentation of referrals out</li> <li>• Staff reports indicate compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.4	<u>Ongoing Staff Training</u> <ul style="list-style-type: none"> <li>• Eight (8) hours of training in HIV/AIDS and clinically-related issues is required annually for licensed staff (in addition to training required in General Standards).</li> <li>• One (1) hour of training in HIV/AIDS is required annually for all other staff (in addition to training required in General Standards).</li> </ul>	<ul style="list-style-type: none"> <li>• Materials for staff training and continuing education are on file</li> <li>• Documentation of training in personnel file</li> </ul>
9.5	<u>Staff Experience</u> A minimum of one year documented hospice and/or HIV/AIDS work experience is preferred.	<ul style="list-style-type: none"> <li>• Documentation of work experience in personnel file</li> </ul>
9.6	<u>Staff Requirements</u> Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	<ul style="list-style-type: none"> <li>• Review of personnel file indicates compliance</li> <li>• Staff interviews indicate compliance</li> </ul>
9.7	<u>Volunteer Assistance</u> Volunteers cannot be used to substitute for required personnel. They may however provide companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: <ul style="list-style-type: none"> <li>• Be provided with clearly defined roles and written job descriptions</li> <li>• Conform to policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation of all training in volunteer files</li> <li>• Signed compliance by volunteer</li> </ul>
9.8	<u>Volunteer Training</u> Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV/AIDS. For volunteers who are licensed practitioners, training addresses documentation practices.	<ul style="list-style-type: none"> <li>• Review of training curriculum indicates compliance</li> <li>• Documentation of all training in volunteer files</li> </ul>
9.9	<u>Staff Supervision</u> Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years experience in hospice care of persons with HIV. All licensed personnel shall received supervision consistent with the State of Texas license requirements.	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance.</li> <li>• Review of agency's Policies &amp; Procedures Manual indicates compliance</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.10	<p><u>Facility Licensure</u> Agency has and maintains a valid Texas Special Care Facility license and an AIDS Hospice designation.</p>	<ul style="list-style-type: none"> <li>• Documentation of license and/or certification is available at the site where services are provided to clients</li> </ul>
9.11	<p><u>Multidisciplinary Team Care</u> Agency must use a multidisciplinary team approach to ensure that patient and the family receive needed emotional, spiritual, physical and social support. The multidisciplinary team may include physician, nurse, social worker, nutritionist, chaplain, patient, physical therapist, occupational therapist, care giver and others as needed. Team members must establish a system of communication to share information on a regular basis and must work together and with the patient and the family to develop goals for patient care.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s Policies &amp; Procedures Manual indicates compliance</li> <li>• Documentation in client’s records</li> </ul>
9.12	<p><u>Comprehensive Health Assessment</u> A comprehensive health assessment, including medical history, a psychosocial assessment and physical examination, is completed for each patient within 48 hours of admission and once every six months thereafter. Symptoms assessment (utilizing standardize tools), risk assessment for falls and pressure ulcers must be part of initial assessment and should be ongoing. Medical history should include the following components:</p> <ul style="list-style-type: none"> <li>• History of HIV infection and other co morbidities</li> <li>• Current symptoms</li> <li>• Systems review</li> <li>• Past history of other medical, surgical or psychiatric problems</li> <li>• Medication history</li> <li>• Family history</li> <li>• Social history</li> <li>• A review of current goals of care</li> </ul> <p>Clinical examination should include all body systems, neurologic and mental state examination, evaluation of radiologic and laboratory test and needed specialist assessment.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>

#	STANDARD	MEASURE
<b>9.0 Service-Specific Requirements</b>		
9.13	<p><u>Plan of Care</u>            Following history and clinical examination, the provider should develop a problem list that reflects clinical priorities and patient’s priorities.            A written Plan of Care is completed for each patient within 48 hours of admission and once every six months thereafter or more frequently as clinically indicated. Hospice care should be based on the USPHS guidelines for supportive and palliative care for people living with HIV/AIDS            ( <a href="http://hab.hrsa.gov/tools/palliative/contents.html">http://hab.hrsa.gov/tools/palliative/contents.html</a>) and professional guidelines</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.15	<p><u>Medication Administration Record</u>            Agency documents each patient’s scheduled medications. Documentation includes patient’s name, date, time, medication name, dose, route, reason, result, and signature and title of staff.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.16	<p><u>PRN Medication Record</u>            Agency documents each patient’s PRN medications. Documentation includes patient’s name, date, time, medication name, dose, route, reason, result, and signature and title of staff.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.17	<p><u>Physician Orders</u>            Patient’s physician orders are documented.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>
9.18	<p><u>Bereavement and Counseling Services</u>            The need for bereavement and counseling services for family members must be assessed and a referral made if requested.</p>	<ul style="list-style-type: none"> <li>• Documentation in patient record</li> </ul>

**DSHS STATE SERVICES**  
**1112 HOUSTON HSDA OUTCOME MEASURES**  
**HOSPICE SERVICES**

Purpose: The purpose of the DSHS State Services Outcome Measures is to provide a measurement of the effectiveness of services in terms of health, quality of life, cost-effectiveness, and knowledge, attitudes, and practices (KAP), where applicable.

Outcome Measure	Indicator	Data Collection Method
<b>1.0 Knowledge, Attitudes, and Practices</b>		
1.1. Increased client understanding of the terminal process	85% of clients will report an increased or maintained understanding of the terminal process over time	<ul style="list-style-type: none"> <li>• Self-Administered Client/Caregiver Survey</li> </ul>
1.2 Increased family understanding of HIV/AIDS and the terminal process	85% of family members will report an increased or maintained understanding of HIV/AIDS and the terminal process over time	<ul style="list-style-type: none"> <li>• Self-Administered Caregiver/Family Survey</li> </ul>
<b>2.0 Health</b>		
2.1 Improved management of pain	85% of clients will increase or maintain pain management over time	<ul style="list-style-type: none"> <li>• Provider Assessment/Client Record Abstraction</li> </ul>
2.2 Improved management of symptoms that present with disease progression	85% of clients will increase or maintain symptom control over time	<ul style="list-style-type: none"> <li>• Provider Assessment/Client Record Abstraction</li> </ul>
<b>3.0 Quality of Life</b>		
3.1 Decreased levels of depression/anxiety	85% of clients will report decreased or maintained levels of depression/anxiety over time	<ul style="list-style-type: none"> <li>• Self-Administered Client/Caregiver Survey</li> </ul>
3.2 Maintenance of preferred levels of participation in life/social interaction	85% of clients will report a maintenance or improvement in their preferred levels of participation in life/social interaction	<ul style="list-style-type: none"> <li>• Self-Administered Client/Caregiver Survey</li> </ul>

Outcome Measure	Indicator	Data Collection Method
<b>4.0 Cost-Effectiveness</b>		
4.1 Cost savings due to decreased number of days of HIV/AIDS-related hospitalization	Difference between the total cost of Part A hospice care per client compared with the cost of continued hospitalization (based on HCHD costs).	<ul style="list-style-type: none"> <li>• Client Record Review</li> </ul>



HOSPICE SERVICES  
2011 CHART REVIEW

## PREFACE

### DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HSDA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

### QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

### Scope of Funding

TRG contracts one Subgrantee to provide hospice services in the Houston HSDA.

## INTRODUCTION

### Description of Service

Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Programs.

### Tool Development

The TRG Hospice Review tool is based upon the established local and DSHS standards of care.

### Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

### File Sample Selection Process

File sample was selected from a provider population of 54 who accessed case management services between 1/1/2011 – 12/31/2011. The records of 20 clients were reviewed, representing 37% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

### Report Structure

A categorical reporting structure was used. The report is as follows:

- Consents
- Admission Orders
- Standing Orders
- Medication Administration
- Care Plan
- Multidisciplinary Team Meetings
- Homelessness
- Substance Abuse assessment
- Psychiatric Assessment
- Pain Assessment and treatment
- Support Systems

## FINDINGS

## CONSENTS

Consent for Service

Percentage of clients that have a signed and completed consent for service document in the record

	Yes	No	N/A
Number of HIV- positive clients served who have a documented consent for service in the record.	20	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20
Rate	100.0%	-	-

Consents – Exchange/Release of Information

Percentage of clients that have a signed exchange/release of information document in the record

	Yes	No	N/A
Number of HIV- positive clients served who have a documented Consent for exchange/release of information in the record.	20	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20
Rate	100.0%	-	-

Consents Proof of Receipt by Client of Client Confidentiality Policy

Percentage of charts reviewed that have evidence that the client received the agency confidentiality policy

	Yes	No	N/A
Number of HIV- positive clients served who have a documented Proof of Receipt by Client of Confidentiality Policy in the record.	20	0	0
Number of HIV- positive clients who were served during the measurement year.	20	20	20
Rate	100.0%	-	-

## ADMISSION ORDERS

Percentage of HIV-positive client records that have admission orders

	Yes	No	N/A
Number of client records that showed evidence of an admission order document.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	100%	0.0%	-

**SYMPTOM MANAGEMENT ORDERS**

Percentage of HIV-positive client records that have symptom management orders

	Yes	No	N/A
Number of client records that showed evidence of symptom management orders.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>100%</b>	0.0%	-

**MEDICATION ADMINISTRATION**

Percentage of HIV-positive client records that have medication administration record

	Yes	No	N/A
Number of client records that showed evidence of medication administration.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>100%</b>	0.0%	-

**CARE PLAN**

Percentage of HIV-positive client records that have a completed initial plan of care

	Yes	No	N/A
Number of client records that showed evidence of completed initial plan of care.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>100%</b>	0.0%	-

**WEEKLY IDT MEETING**

Percentage of HIV-positive client records that showed weekly updates to the Interdisciplinary Team (IDT) care plan

	Yes	No	N/A
Number of client records that showed evidence of weekly updates to the IDT.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>100%</b>	0.0%	-

**HOMELESSNESS**

Percentage of HIV-positive client records that show the client was homeless on admission

	Yes	No	N/A
Number of client records that showed evidence of documentation that the client was homeless on admission.	5	15	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>25%</b>	75.0%	-

**SUBSTANCE ABUSE**

Percentage of HIV-positive client records that showed the client had active substance abuse on admission.

	Yes	No	N/A
Number of client records that showed evidence of active substance abuse on admission.	4	16	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>20%</b>	80.0%	-

**PSYCHIATRIC ILLNESS**

Percentage of HIV-positive client records that showed the client had active psychiatric illness on admission (excluding depression).

	Yes	No	N/A
Number of client records that showed evidence of active psychiatric illness (excluding depression).	5	15	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>25.0%</b>	75.0%	-

**PAIN ASSESSMENT**

Percentage of HIV-positive client records that showed assessment for pain at each shift

	Yes	No	N/A
Number of client records that showed evidence of a pain assessment at each shift.	20	0	-
Number of HIV-infected clients in hospice services that were reviewed.	20	20	-
Rate	<b>100.0%</b>	80.0%	-

**FAMILY SUPPORT**

Percentage of HIV-positive client records that showed support services were given to the family.

	Yes	No	N/A
Number of client records that showed evidence of support services being offered to the family.	9	0	11
Number of HIV-infected clients in hospice services that were reviewed.	20	20	20
Rate	<b>45.0%</b>	0.0%	55.0%

Conclusion

2011 shows Hospice Care remains at a very high standard. Nine out of the nine data elements were scored at 100%. Twenty-five percent (25%) of records reviewed indicated that the client was homeless. Twenty percent (20%) of records reviewed showed evidence that the client had active substance abuse. Twenty-five percent (25%) of records reviewed showed evidence of active psychiatric illness.



## Researchers conclude nonprofit hospices disproportionately care for costly patients

February 1st, 2011 in Medicine & Health / Health

**For-profit hospice agencies had a higher percentage of patients with diagnoses associated with less skilled care and longer lengths of stay (LOS) in hospice, than their nonprofit counterparts, a difference that may leave "nonprofit hospice agencies disproportionately caring for the most costly patients," Beth Israel Deaconess Medical Center researchers report.**

The findings appear in the Feb.2 issue of the *Journal of the American Medical Association* (JAMA).

"There was a big increase in the number of for-profit hospice agencies from 2000 to 2007, and previous work has shown that those agencies tended to have significantly higher [profit margins](#) than their nonprofit counterparts," said lead author, Melissa W. Wachterman, MD, MPH, a palliative care physician and research fellow in BIDMC's Division of General Medicine and Primary Care. "The Medicare per diem payment rate is the same, regardless of patient diagnosis, location in which care is received (for example, private home versus nursing home), or length of stay, and we wanted to know whether for-profit and nonprofit hospices were responding differently to potential [financial incentives](#) inherent in the Medicare Hospice Benefit."

Researchers examined a nationally representative sample of patients discharged from hospice, primarily due to death (85 percent) in 2007. In all, data from 4,705 patients, representing an estimated 1.03 million patients discharged from hospice nationwide, were analyzed, looking at diagnosis, location of care, length of stay, and number of visits per day by different hospice care providers.

The data showed that nonprofit hospice agencies had a higher proportion of the types of patients who required more visits from skilled care providers than for-profit agencies. For example, nonprofit agencies had a higher proportion of cancer patients, while for-profit agencies had a higher proportion of dementia patients. Cancer patients required more visits per day from skilled personnel such as nurses and social workers than patients with dementia. Wachterman explains that patient selection of this nature has important policy implications because caring for [dementia](#) patients rather than cancer patients "could be financially advantageous for hospices under the current capitated reimbursement system."

However, it is important to note that "clinicians caring for patients considering hospice can be reassured that for-profit hospices provide as many nursing visits to patients with a given diagnosis as nonprofit hospices," adds senior author Ellen McCarthy, PhD, MPH, an epidemiologist at BIDMC and a professor of medicine at Harvard Medical School.

The study also looked at length of stay and found that the median LOS for patients in for-profit hospice agencies was four days longer when compared with nonprofit hospice agencies. Because there are considerable fixed costs at the time of enrollment in hospice and again at the time of death, longer stays are "thought to be more profitable," the study noted.

The significant differences between for-profit and nonprofit hospice agencies mean that hospices serving the neediest patients "may face difficult financial obstacles to providing appropriate care in this fixed per-diem payment system," explains Wachterman.

These findings may "have potentially important implications both for clinicians taking care of [patients](#) at the end of life and for policymakers in the area of Medicare hospice payment." The study may help inform current debate around payment reform in the Medicare Hospice Benefit.

The Medicare Payment Advisory Committee (MedPAC) has recommended a U-shaped reimbursement plan that considers the intensity of care required at the beginning and end of a hospice stay. The plan also recommends that a higher per diem rate be paid for the first 30 days of enrollment and a standard payout be made at the time of death.

**More information:** JAMA. 2011;305[5]:472-479.

Provided by Beth Israel Deaconess Medical Center

"Researchers conclude nonprofit hospices disproportionately care for costly patients." February 1st, 2011. <http://www.physorg.com/news/2011-02-nonprofit-hospices-disproportionately-costly-patients.html>

# Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care, and Length of Stay

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**D**URING THE PAST 10 YEARS, the for-profit hospice sector has increased substantially.<sup>1</sup> From 2000 to 2007, the number of for-profit hospices more than doubled from 725 to 1660, while the number of nonprofit hospices remained essentially the same—1193 in 2000 and 1205 in 2007.<sup>2</sup> Overall, for-profit hospices have significantly higher profit margins than nonprofit hospices, varying from 12% to 16% between 2001 and 2004, compared with -2.9% and -4.4% for nonprofit hospices.<sup>2</sup> This rapid increase in the for-profit hospice sector and the differential profit margins have raised questions about potential financial incentives in hospice reimbursement.

Medicare payment policy is a key determinant of hospice reimbursement. Medicare beneficiaries compose 84% of patients in hospice,<sup>3</sup> and about 40% of Medicare decedents use hospice annually.<sup>2</sup> Medicare reimburses hospices a per diem rate (\$142.91/d in 2010) for routine care, which can be provided at home or in a nursing home.<sup>3</sup> This capitated rate is fixed regardless of the care needs of individual patients or the services that they receive and may create a financial incentive to select patients requiring less resource-intensive services. Moreover, longer hospice stays are thought to be more profitable than

**Context** Medicare's per diem payment structure may create financial incentives to select patients who require less resource-intensive care and have longer hospice stays. For-profit and nonprofit hospices may respond differently to financial incentives.

**Objective** To compare patient diagnosis and location of care between for-profit and nonprofit hospices and examine whether number of visits per day and length of stay vary by diagnosis and profit status.

**Design, Setting, and Patients** Cross-sectional study using data from the 2007 National Home and Hospice Care Survey. Nationally representative sample of 4705 patients discharged from hospice.

**Main Outcome Measures** Diagnosis and location of care (home, nursing home, hospital, residential hospice, or other) by hospice profit status. Hospice length of stay and number of visits per day by various hospice personnel.

**Results** For-profit hospices (1087 discharges from 145 agencies), compared with nonprofit hospices (3618 discharges from 524 agencies), had a lower proportion of patients with cancer (34.1%; 95% CI, 29.9%-38.6%, vs 48.4%; 95% CI, 45.0%-51.8%) and a higher proportion of patients with dementia (17.2%; 95% CI, 14.1%-20.8%, vs 8.4%; 95% CI, 6.6%-10.6%) and other noncancer diagnoses (48.7%; 95% CI, 43.2%-54.1%, vs 43.2%; 95% CI, 40.0%-46.5%; adjusted  $P < .001$ ). After adjustment for demographic, clinical, and agency characteristics, there was no significant difference in location of care by profit status. For-profit hospices compared with nonprofit hospices had a significantly longer length of stay (median, 20 days; interquartile range [IQR], 6-88, vs 16 days; IQR, 5-52 days; adjusted  $P = .01$ ) and were more likely to have patients with stays longer than 365 days (6.9%; 95% CI, 5.0%-9.4%, vs 2.8%; 95% CI, 2.0%-4.0%) and less likely to have patients with stays of less than 7 days (28.1%; 95% CI, 23.9%-32.7%, vs 34.3%; 95% CI, 31.3%-37.3%;  $P = .005$ ). Compared with cancer patients, those with dementia or other diagnoses had fewer visits per day from nurses (0.50 visits; IQR, 0.32-0.87, vs 0.37 visits; IQR, 0.20-0.78, and 0.41 visits; IQR, 0.26-0.79, respectively; adjusted  $P = .002$ ) and social workers (0.15 visits; IQR, 0.07-0.31, vs 0.11 visits; IQR, 0.04-0.27, and 0.14 visits; IQR, 0.07-0.31, respectively; adjusted  $P < .001$ ).

**Conclusion** Compared with nonprofit hospice agencies, for-profit hospice agencies had a higher percentage of patients with diagnoses associated with lower-skilled needs and longer lengths of stay.

*JAMA.* 2011;305(5):472-479

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shorter stays,<sup>2,4</sup> and emerging evidence suggests that hospice costs tend to be U-shaped with considerable fixed costs at the time of enrollment and again near death.<sup>5-8</sup> Thus, hospices can reduce their average daily costs by attracting patients with longer lengths of

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stay (LOS).<sup>7,9</sup> Some data suggest that for-profit hospices are less likely to admit patients with shorter expected LOS,<sup>10</sup> while other data suggest no difference in mean LOS between for-profit and nonprofit hospices.<sup>11</sup> The Balanced Budget Act of 1997 relaxed the previous 210-day cap on Medicare hospice coverage, allowing for an unlimited number of 60-day periods, provided patients are recertified (ie, deemed to have 6 months or less to live if their disease runs its normal course).<sup>2</sup> This policy change allowed for longer reimbursable stays in hospice and may have contributed to the rise of for-profit hospices.

In this context, we compared patient diagnosis and location of care between for-profit and nonprofit hospices and examined whether LOS and the number of visits per day by hospice personnel vary by diagnoses and by profit status.

## METHODS

We examined a nationally representative sample of patients discharged from hospice, primarily due to death (84%), using the 2007 National Home and Hospice Care Survey (NHHCS).<sup>12</sup> The 2007 NHHCS used a stratified 2-stage sampling design. A representative sample of US home health and hospice care agencies was selected after being stratified by agency type and metropolitan statistical area. From more than 15 000 agencies, 1545 agencies were randomly sampled from the strata with probability proportional to size. Overall, 1461 selected agencies were eligible (95%), and 1036 agreed to participate (unweighted, 71%; weighted, 59%).<sup>13</sup>

A computer algorithm randomly selected up to 10 current patients per home health agency, up to 10 hospice discharges per hospice agency, or a combination of up to 10 current home health patients and hospice discharges for a mixed agency. Hospice discharges during the 3-month period before the agency interview were eligible. Our study focused solely on the sample of 4733 patients discharged

from hospice. We excluded 28 discharges with any missing data on our main factors of interest (LOS, diagnosis, and location of care). Our final sample consisted of 4705 hospice discharges.

Data were collected through in-person interviews with the hospice staff member who knew each sampled patient best; questions were answered in consultation with the patient's medical record or other records. No patients or family members were interviewed. This study was deemed exempt by the Beth Israel Deaconess Medical Center institutional review board because we used publicly available deidentified data.

Hospice profit status was obtained from the agencies' administrators. The agency was considered for-profit if it was owned by an individual, partnership, or corporation and nonprofit if owned by a nonprofit organization, religious group, or government agency.

### Patient Characteristics

We classified patients' primary admission diagnoses into the following 3 groups using codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification*: cancer (140-239), dementia (290.0, 290.42, 294.8, 294.9, 331.0, 331.11, 331.4, 331.82, and 331.9), and other (all remaining codes, such as congestive heart failure). We categorized location of care as home, nursing home, hospital, residential hospice, or other. Length of stay was measured from date of hospice enrollment until discharge or death, whichever came first. We also assessed LOS in categories of less than 7 days, 7 to 30 days, 31 to 180 days, 181 to 364 days, and 365 days or longer. We measured number of visits per day by each of the following hospice personnel: nurses, social workers, and home health aides. We computed each measure by dividing the total number of visits by the patient's LOS.

We used the following demographic characteristics as covariates: age at hospice entry (<50 y, 50-64 y, 65-74 y, 75-84 y, 85-89 y, ≥90 y), sex,

race/ethnicity (non-Hispanic white, non-Hispanic black, Hispanic, other), marital status (married/partnered, not married), primary payment source (Medicare, Medicaid, private, other), and presence of a primary caregiver (yes/no). The NHHCS collected race/ethnicity data using predetermined categories through interviews with the hospice staff members who knew the participants.

The available clinical characteristics other than diagnosis included the number of activities of daily living needing assistance (eating, bathing, dressing, toileting, transferring: categorized as 0, 1-3, 4, or all 5) and mobility impairment (required no assistance, required assistance with walking, and did not walk). Data were only available for 2 agency characteristics other than profit status: whether the hospice agency was part of a chain (yes/no) and metropolitan statistical area, defined by the US Census as metropolitan (at least 1 urban area with a population ≥50 000), micropolitan (an area with a population of 10 000-49 999), or "neither," eg, rural (did not meet criteria for metropolitan or micropolitan).

### Statistical Analyses

All analyses were performed using SAS-callable SUDAAN version 10 (RTI International, Research Triangle Park, North Carolina) to account for the complex sampling design. Data were weighted to reflect national estimates of hospice discharges. We report weighted percentages with corresponding 95% confidence intervals (CIs). Statistical tests were 2-sided.

We used Pearson  $\chi^2$  tests and *t* tests to examine the association between profit status and patient and agency characteristics, hospice LOS, and number of visits per day. We used log transformation for our outcomes of LOS and number of visits per day to approximate normal distributions and fit unadjusted linear regression models to examine the association between profit status and each outcome. For patients with no visits of a particular

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type, we imputed a visit rate of 0.5 divided by the patient's LOS to avoid taking the logarithm of zero. We then repeated these analyses stratifying by diagnosis to assess differences by profit status within each diagnosis group. We further assessed whether

number of visits per day varied by categories of LOS.

We used logistic regression to determine whether diagnosis and location of care were independent correlates of having been in a for-profit vs non-profit hospice after adjusting for demo-

graphic, clinical, and agency covariates. We used linear regression to examine the association between profit status and log(LOS) adjusted for all covariates, including diagnosis and location of care. We used linear regression models to examine differences in num-

**Table 1.** Characteristics of Hospice-Discharged Patients and Hospice Agencies by Hospice Profit Status<sup>a</sup>

	All Patients (N = 4705)		Patients From For-Profit Hospices (n = 1087) <sup>b</sup>		Patients From Nonprofit Hospices (n = 3618) <sup>b</sup>		P Value
	No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	
Age, y							
<50	175	3.5 (2.7-4.5)	39	4.1 (2.5-6.6)	136	3.2 (2.4-4.4)	.20
50-64	638	13.6 (12.1-15.3)	147	12.1 (9.6-15.2)	491	14.3 (12.5-16.3)	
65-74	785	14.8 (13.0-16.7)	168	12.8 (9.7-16.9)	617	15.6 (13.6-17.8)	
75-84	1459	29.6 (27.3-32.0)	323	29.9 (25.6-34.6)	1136	29.4 (26.8-32.2)	
85-89	828	19.5 (17.7-21.6)	185	18.5 (15.3-22.2)	643	20.0 (17.8-22.4)	
≥90	820	19.0 (17.0-21.2)	225	22.6 (18.8-26.9)	595	17.5 (15.1-20.0)	
Female sex	2600	54.9 (52.1-57.6)	627	57.4 (52.7-62.0)	1973	53.8 (50.4-57.1)	.22
Race/ethnicity <sup>c</sup>							
Non-Hispanic white	4080	86.4 (83.8-88.7)	845	79.6 (73.5-84.6)	3235	89.4 (86.9-91.5)	.02
Non-Hispanic black	310	7.7 (6.0-9.9)	135	10.6 (7.0-15.8)	175	6.4 (4.7-8.7)	
Hispanic	147	4.2 (3.0-5.9)	55	7.5 (4.5-12.3)	92	2.7 (1.8-4.1)	
Other	79	1.7 (1.2-2.6)	25	2.2 (1.1-4.5)	54	1.5 (0.9-2.4)	
Marital status <sup>c</sup>							
Married/partnered	2045	45.3 (42.2-48.5)	419	40.1 (33.3-47.4)	1626	47.7 (44.4-51.0)	.06
Not married	2497	54.7 (51.5-57.8)	638	59.9 (52.6-66.7)	1859	52.3 (49.1-55.6)	
Primary payment source <sup>c</sup>							
Medicare	3816	82.6 (80.6-84.4)	875	82.0 (78.6-84.9)	2941	82.8 (80.3-85.1)	.36
Medicaid	190	4.0 (3.1-5.2)	52	5.7 (1.2-3.7)	138	3.4 (2.5-4.5)	
Private insurance	354	9.3 (7.9-11.0)	57	8.2 (6.0-11.2)	297	9.8 (8.0-11.9)	
Other	222	4.1 (3.1-5.4)	50	4.2 (2.5-7.0)	172	4.0 (2.9-5.5)	
Has a primary caregiver <sup>c</sup>							
Yes	4328	91.5 (89.3-93.2)	1027	93.8 (89.6-96.4)	3301	90.4 (87.8-92.5)	.10
No	365	8.5 (6.8-10.7)	59	6.2 (3.6-10.4)	306	9.6 (7.5-12.3)	
No. of ADLs needing assistance <sup>c</sup>							
0	441	9.4 (7.6-11.7)	83	6.7 (3.7-12.0)	358	10.6 (8.5-13.2)	.11
1-3	614	13.1 (11.1-15.4)	137	12.6 (9.0-17.5)	477	13.3 (11.0-15.9)	
4	1003	19.6 (17.1-22.4)	223	17.3 (13.1-22.6)	780	20.6 (17.6-23.9)	
5	2097	57.9 (54.2-61.5)	543	63.3 (55.9-70.2)	1554	55.5 (51.3-59.6)	
Mobility							
No assistance needed	721	15.1 (12.8-17.6)	134	11.6 (8.1-16.3)	587	16.7 (13.9-19.8)	.14
Needs assistance	1970	50.0 (45.7-54.4)	517	51.4 (42.2-60.4)	1453	49.4 (44.6-54.2)	
Not mobile	1431	34.9 (30.6-39.4)	332	37.0 (28.7-46.2)	1099	34.0 (29.1-39.2)	
Agency characteristics							
MSA							
Metropolitan	1722	87.3 (85.5-88.9)	479	91.0 (86.9-94.0)	1243	85.6 (83.1-87.8)	.11
Micropolitan	1749	9.1 (7.8-10.6)	352	6.6 (4.2-10.1)	1397	10.2 (8.4-12.3)	
Neither	1234	3.6 (2.9-4.5)	256	2.4 (1.2-4.7)	978	4.2 (3.3-5.3)	
Chain status							
Yes	894	26.8 (20.9-33.7)	587	74.0 (61.1-83.7)	307	5.9 (3.5-9.8)	<.001
No	3811	73.2 (66.4-79.1)	500	26.0 (16.3-38.9)	3311	94.2 (90.2-96.6)	

Abbreviations: ADLs, activities of daily living; CI, confidence interval; MSA, metropolitan statistical area.

<sup>a</sup>No. indicates sample size, and percentages are weighted to reflect national estimates. Columns may not add to 100% because of rounding.

<sup>b</sup>Discharges were from 145 for-profit agencies and 524 nonprofit agencies.

<sup>c</sup>Data were unknown or missing for race/ethnicity (n=89), marital status (n=163), primary payment source (n=123), caregiver status (n=12), No. of ADLs needing assistance (n=550), and mobility needs (n=583).

**Table 2.** Diagnosis and Location of Care of Patients by Hospice Profit Status<sup>a</sup>

Diagnosis <sup>c</sup>	All Patients (N = 4705)		Patients From For-Profit Hospices (n = 1087)		Patients From Nonprofit Hospices (n = 3618)		Adjusted OR of For-Profit Status (95% CI) <sup>b</sup>
	No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	No.	Weighted % (95% CI)	
Cancer	2092	44.0 (41.2-46.9)	364	34.1 (29.9-38.6)	1728	48.4 (45.0-51.8)	1 [Reference]
Dementia	462	11.1 (9.4-13.1)	150	17.2 (14.1-20.8)	312	8.4 (6.6-10.6)	2.32 (1.44-3.72)
Other	2151	44.9 (42.1-47.7)	573	48.7 (43.2-54.1)	1578	43.2 (40.0-46.5)	1.62 (1.17-2.24)
Location of care <sup>d</sup>							
Home	2834	55.4 (52.1-58.7)	655	51.5 (44.6-58.3)	2179	57.1 (53.5-60.7)	1 [Reference]
Hospital	393	10.3 (7.8-13.4)	69	8.4 (5.3-12.9)	324	11.1 (8.0-15.3)	0.72 (0.30-1.75)
Nursing home	1201	26.5 (23.7-29.6)	319	34.2 (27.9-41.0)	882	23.1 (20.4-26.1)	1.32 (0.88-1.96)
Hospice residence	240	6.7 (5.2-8.6)	40	5.6 (3.2-9.5)	200	7.2 (5.5-9.5)	0.73 (0.34-1.58)
Other	37	1.1 (0.5-2.3)	4	0.4 (0.1-1.4)	33	1.4 (0.7-3.1)	0.27 (0.05-1.58)

Abbreviations: CI, confidence interval; OR, odds ratio.

<sup>a</sup>No. indicates sample size and percentages are weighted to reflect national estimates.

<sup>b</sup>Adjusted ORs and 95% CIs were derived from a single model that adjusted for age, sex, race/ethnicity, primary payment source, having a primary caregiver, No. of ADLs needing assistance, mobility needs, and metropolitan statistical area.

<sup>c</sup> $P < .001$  for unadjusted comparison by profit status.  $P < .001$  for adjusted comparison by profit status.

<sup>d</sup> $P = .01$  for unadjusted comparison by profit status.

ber of visits per day by profit status and diagnosis after adjustment. To determine whether the association between diagnosis and number of visits per day varied by profit status, we used the Wald  $\chi^2$  test to further assess the interaction between profit status and diagnosis group. We performed similar multivariable analyses to examine differences in number of visits per day by profit status and LOS categories.

All statistical testing was 2-sided. Our 3 main factors of interest (profit status, diagnosis, and location of care) were defined a priori, and our study was considered hypothesis generating rather than definitive testing. However, we did calculate a Bonferroni-corrected critical value of  $P < .017$ , given our 3 factors of interest.

## RESULTS

Our sample included 4705 patients discharged from hospice in 2007, of which 1087 patients (30.7%) were discharged from 145 for-profit agencies and 3618 patients (69.3%) were discharged from 524 nonprofit agencies. Our sample was representative of an estimated 1.03 million patients discharged from hospice in 2007. TABLE 1 presents characteristics by agency profit status. Patients from for-profit and nonprofit hospices were similar except that those from for-

profit hospices compared with nonprofit hospices were more likely to be non-Hispanic black (10.6%; 95% CI, 7.0%-15.8%, vs 6.4%; 95% CI, 4.7%-8.7%, respectively) or Hispanic (7.5%; 95% CI, 4.5%-12.3%, vs 2.7%; 95% CI, 1.8%-4.1%;  $P = .02$ ). For-profit agencies compared with nonprofit agencies were also more likely to be part of a chain (74.0%; 95% CI, 61.1%-83.7%, vs 5.9%; 95% CI, 3.5%-9.8%, respectively;  $P < .001$ ).

TABLE 2 demonstrates that diagnosis and location of care both varied by profit status. Compared with nonprofit hospices, for-profit hospices had a lower proportion of patients with cancer (48.4%; 95% CI, 45.0%-51.8%, vs 34.1%; 95% CI, 29.9%-38.6%, respectively) and higher proportions of patients with dementia (8.4%; 95% CI, 6.6%-10.6%, vs 17.2%; 95% CI, 14.1%-20.8%) and other diagnoses (43.2%; 95% CI, 40.0%-46.5%, vs 48.7%; 95% CI, 43.2%-54.1%). These differences remained significant after adjustment ( $P < .001$ ). Compared with nonprofit hospices, for-profit hospices also had a higher proportion of patients residing in nursing homes (23.1%; 95% CI, 20.4%-26.1%, vs 34.2%; 95% CI, 27.9%-41.0%, respectively) and a lower proportion residing at home (57.1%; 95% CI, 53.5%-60.7%, vs 51.5%; 95% CI, 44.6%-58.3%). However, there was no

independent association of location of care with profit status after adjustment for all covariates, most notably diagnosis.

Reasons for discharge among for-profit hospices and nonprofit hospices were, respectively, death (77.7% vs 87.3%), condition stabilized or improved (6.7% vs 4.3%), obtained more aggressive therapy (7.7% vs 3.2%), moved to a different geographic region (2.3% vs 1.6%), and other reasons (5.2% vs 3.5%). Also, for-profit hospices had a higher proportion of discharges based on readmissions than nonprofit hospices (9.3% vs 5.5%, respectively).

TABLE 3 presents the median LOS in hospice with corresponding 25th and 75th percentiles by profit status of all patients and stratified by diagnosis. Median LOS was 4 days longer in for-profit hospices as compared with nonprofit hospices (20 days; interquartile range, [IQR], 6-88, vs 16 days; IQR, 5-52;  $P = .002$ ). The unadjusted LOS was 41.0% longer (95% CI, 13.5%-75.1%) in for-profit hospices vs nonprofit hospices. After full adjustment, LOS remained significantly longer in for-profit hospices compared with nonprofit hospices (26.2%; 95% CI, 4.9%-51.9%;  $P = .01$ ). A model adjusting for only diagnosis and location of care was nearly identical, suggesting

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**Table 3.** Hospice Length of Stay by Profit Status

	All Patients (N = 4705)	Patients From For-Profit Hospices (n = 1087)	Patients From Nonprofit Hospices (n = 3618)	Unadjusted P Value
<b>Patients by Category</b>				
LOS categories, No. of patients (%) [95% CI] <sup>a</sup>				
<7 d	1375 (32.4) [29.9-34.9]	245 (28.1) [23.9-32.7]	1130 (34.3) [31.3-37.3]	.005 <sup>b</sup>
7-30 d	1442 (30.5) [28.4-32.7]	311 (27.9) [24.4-31.8]	1131 (31.6) [29.2-34.2]	
31-180 d	1340 (26.7) [24.3-29.2]	342 (30.4) [26.3-34.8]	998 (25.0) [22.2-28.1]	
181-364 d	323 (6.4) [5.1-8.0]	99 (6.7) [4.3-10.3]	224 (6.2) [4.8-8.1]	
≥365 d	225 (4.1) [3.2-5.2]	90 (6.9) [5.0-9.4]	135 (2.8) [2.0-4.0]	
<b>LOS per Patient</b>				
LOS, median (IQR), d				
Overall	17 (5-62)	20 (6-88)	16 (5-52)	.002 <sup>c</sup>
Stratified by diagnosis <sup>d</sup>				
Cancer	16 (6-40)	15 (6-44)	16 (6-39)	
Dementia	35 (7-161)	43 (10-161)	26 (6-135)	
Other	17 (4-85)	23 (6-100)	14 (4-70)	

Abbreviations: CI, confidence interval; IQR, interquartile range; LOS, length of stay.

<sup>a</sup>No. indicates sample size and percentages are weighted to reflect national estimates.<sup>b</sup>Comparing LOS categories between profit and nonprofit hospices using a  $\chi^2$  test.<sup>c</sup>Outcome was log transformed; unadjusted model based on 1-unit increase in log(LOS).<sup>d</sup>P values are based on a single model that also adjusts for age, location of care, sex, race/ethnicity, type of insurance, primary caregiver, No. of ADLs needing assistance, mobility needs, and metropolitan statistical area. In analyses of LOS,  $P = .01$  comparing profit status and  $P < .001$  comparing diagnoses.**Table 4.** Visits per Day by Hospice Personnel by Profit Status, Overall and Stratified by Diagnosis

	Median (IQR)			Unadjusted P Value
	All Patients (N = 4705)	Patients From For-Profit Hospices (n = 1087)	Patients From Nonprofit Hospices (n = 3618)	
<b>Overall<sup>a</sup></b>				
Nursing visits	0.45 (0.28-0.83)	0.45 (0.27-0.82)	0.45 (0.28-0.83)	.75
Social worker visits	0.14 (0.07-0.31)	0.12 (0.06-0.25)	0.15 (0.07-0.34)	.006
Home health aide visits	0.26 (0.09-0.49)	0.33 (0.15-0.50)	0.25 (0.07-0.45)	.004
<b>Stratified by Diagnosis<sup>b</sup></b>				
Nursing visits <sup>c</sup>				
Cancer	0.50 (0.32-0.87)	0.58 (0.34-0.94)	0.50 (0.31-0.83)	
Dementia	0.37 (0.20-0.78)	0.38 (0.19-0.65)	0.36 (0.23-0.89)	
Other	0.41 (0.26-0.79)	0.41 (0.26-0.79)	0.41 (0.25-0.78)	
Social work visits <sup>d</sup>				
Cancer	0.15 (0.07-0.31)	0.15 (0.07-0.31)	0.15 (0.09-0.30)	
Dementia	0.11 (0.04-0.27)	0.07 (0.04-0.21)	0.12 (0.05-0.37)	
Other	0.14 (0.07-0.31)	0.11 (0.06-0.24)	0.15 (0.07-0.37)	
Home health aide visits <sup>e</sup>				
Cancer	0.22 (0.05-0.44)	0.26 (0.05-0.55)	0.19 (0.05-0.42)	
Dementia	0.35 (0.16-0.50)	0.39 (0.24-0.57)	0.30 (0.08-0.44)	
Other	0.28 (0.12-0.50)	0.37 (0.21-0.50)	0.26 (0.12-0.49)	

Abbreviation: IQR, interquartile range.

<sup>a</sup>Outcome was log transformed; unadjusted model based on 1-unit increase in log(visits/d).<sup>b</sup>Outcome was log transformed; model based on 1-unit increase in log(visits/d). P values are based on a single model that also adjusted for age, sex, race/ethnicity, location of care, primary payment source, having a primary caregiver, No. of ADLs needing assistance, mobility needs, and metropolitan statistical area.<sup>c</sup>For analyses of nursing visits,  $P = .78$  comparing profit status and  $P = .002$  comparing diagnoses.<sup>d</sup>For analyses of social work visits,  $P = .03$  comparing profit status and  $P < .001$  comparing diagnoses.<sup>e</sup>For analyses of home health aide visits,  $P = .02$  comparing profit status and  $P = .80$  comparing diagnoses.

that these 2 factors account for most of the variation in LOS.

Compared with nonprofit hospices, median LOS in for-profit hospices was similar for patients with cancer (16 days; IQR, 6-39, vs 15 days; IQR, 6-44,

respectively) and longer for patients with dementia (26 days; IQR, 6-135, vs 43 days; IQR, 10-161) and other non-cancer diagnoses (14 days; IQR, 4-70, vs 23 days; IQR, 6-100). In adjusted analyses, patients with dementia had

longer median LOS than patients with cancer and other diagnoses (35 days; IQR, 7-161, vs 16 days; IQR, 6-40, and 17 days; IQR, 4-85, respectively;  $P < .001$ ). Compared with patients in nonprofit hospices, patients in for-profit hospices were more likely to have stays longer than 365 days (2.8%; 95% CI, 2.0%-4.0%, vs 6.9%; 95% CI, 5.0%-9.4%) and were less likely to have stays less than 7 days (34.3%; 95% CI, 31.3%-37.3%, vs 28.1%; 95% CI, 23.9%-32.7%;  $P = .005$ ).

TABLE 4 presents the median number of visits per day by nurses, social workers, and home health aides overall and stratified by diagnosis. Overall, for-profit and nonprofit hospices provided similar numbers of nursing visits per day (0.45 visits; IQR, 0.27-0.82, vs 0.45 visits; IQR, 0.28-0.83, respectively). However, for-profit hospice agencies compared with nonprofit agencies provided fewer social work visits per day (0.12 visits; IQR, 0.06-0.25, vs 0.15 visits; IQR, 0.07-0.34; unadjusted  $P = .006$ ; adjusted  $P = .03$ ) and more home health aide visits per day (0.33 visits; IQR, 0.15-0.50, vs 0.25 visits; IQR, 0.07-0.45; unadjusted  $P = .004$ ; adjusted  $P = .02$ ). Compared with cancer patients, those with dementia or other diagnoses had fewer visits per day from nurses (0.50

visits; IQR, 0.32-0.87, vs 0.37 visits; IQR, 0.20-0.78, and 0.41 visits; IQR, 0.26-0.79, respectively; adjusted  $P = .002$ ) and social workers (0.15 visits; IQR, 0.07-0.31, vs 0.11 visits; IQR, 0.04-0.27, and 0.14 visits; IQR, 0.07-0.31, respectively; adjusted  $P < .001$ ). No significant interaction was observed between diagnosis and hospice profit status for any of the types of visits examined. TABLE 5 presents the median number of visits per day by each personnel type, stratified by LOS categories. Although patients with stays less than 7 days had more visits per day by nurses and social workers than patients with longer stays, this did not differ by profit status.

## COMMENT

The recent increase in the for-profit hospice sector raises critical questions about potential financial incentives in hospice reimbursement. Using nationally representative data, we found notable differences in the types of patients enrolled in for-profit hospices compared with nonprofit hospices. For-profit hospices had a disproportionate number of patients with noncancer diagnoses, dementia in particular. For-profit hospices also had a greater proportion of patients with prolonged LOS ( $\geq 365$  days).

We also found that patients with noncancer diagnoses and those with prolonged LOS received fewer visits per day from skilled personnel (ie, nurses and social workers). Despite these differences in case mix, we found that patients received similar rates of nursing visits regardless of hospice profit status. On the other hand, patients in for-profit hospices received fewer social work visits and more home health aide visits per day than those in nonprofit hospices as would be expected given the observed case-mix differences. Our findings have potentially important implications both for clinicians taking care of patients at the end of life and for policy makers in the area of Medicare hospice payment.

The current Medicare Hospice Benefit reimburses hospices at a fixed per

**Table 5.** Median Visits per Day by Hospice Personnel by Profit Status, Stratified by Length of Stay

	Median (IQR) <sup>a</sup>	
	Patients From For-Profit Hospices (n = 1087)	Patients From Nonprofit Hospices (n = 3618)
Nursing visits <sup>b</sup>		
LOS <7 d	1.09 (0.74-1.41)	1.07 (0.71-1.43)
LOS 7-30 d	0.58 (0.36-0.83)	0.49 (0.36-0.73)
LOS 31-180 d	0.32 (0.22-0.43)	0.29 (0.21-0.40)
LOS 181-364 d	0.19 (0.15-0.33)	0.20 (0.15-0.28)
LOS $\geq 365$ d	0.19 (0.15-0.27)	0.19 (0.14-0.28)
Social worker visits <sup>c</sup>		
LOS <7 d	0.37 (0.26-0.63)	0.43 (0.27-0.73)
LOS 7-30 d	0.16 (0.12-0.25)	0.16 (0.16-0.27)
LOS 31-180 d	0.07 (0.04-0.10)	0.07 (0.05-0.11)
LOS 181-364 d	0.04 (0.03-0.07)	0.05 (0.03-0.08)
LOS $\geq 365$ d	0.04 (0.03-0.05)	0.04 (0.03-0.07)
Home health aide visits <sup>d</sup>		
LOS <7 d	0.37 (0.17-0.66)	0.25 (0.14-0.56)
LOS 7-30 d	0.36 (0.16-0.55)	0.21 (0.04-0.43)
LOS 31-180 d	0.33 (0.05-0.45)	0.22 (0.02-0.37)
LOS 181-364 d	0.29 (0.11-0.43)	0.11 (0.00-0.32)
LOS $\geq 365$ d	0.29 (0.07-0.36)	0.30 (0.12-0.40)

Abbreviations: IQR, interquartile range; LOS, length of stay.

<sup>a</sup>Outcome was log transformed; model based on 1-unit increase in log(visits/d).  $P$  values are based on a single model that also adjusted for age, sex, race/ethnicity, diagnosis, location of care, primary payment source, having a primary caregiver, No. of ADLs needing assistance, mobility needs, and metropolitan statistical area.

<sup>b</sup>For analyses of nursing visits,  $P = .56$  comparing profit status and  $P < .001$  comparing LOS.

<sup>c</sup>For analyses of social work visits,  $P = .19$  comparing profit status and  $P < .001$  comparing LOS.

<sup>d</sup>For analyses of home health aide visits,  $P = .006$  comparing profit status and  $P < .001$  comparing LOS.

diem rate that does not consider the patient's diagnosis, location of care, or hospice LOS. Under this system, profit can be maximized by caring for patients with certain diagnoses that require fewer skilled services, patients residing in nursing homes, or patients with longer hospice stays.<sup>2,4,6,10,14</sup> Although other studies have found that patients with noncancer diagnoses were significantly more likely than cancer patients to be in for-profit hospices,<sup>10,11</sup> we further examined the subset of patients with dementia and found that they were even more likely to be enrolled in for-profit hospices. Our findings indicate that approximately two-thirds of patients in for-profit hospices have dementia and other noncancer diagnoses, whereas only about half of patients in nonprofit hospices have these diagnoses.

We also found that these diagnoses were associated with longer stays in hospice, which are known to be more profitable, and that overall patients with these diagnoses had fewer visits per day

by skilled personnel (nurses and social workers), which could be financially advantageous for hospices under a capitated reimbursement system. For-profit hospices were also less likely than nonprofit hospices to have patients enrolled for fewer than 7 days, and these patients had more visits from skilled personnel, which is costly for hospices. Our findings build on previous research that has shown that LOS in hospice and services delivered correlate with patients' terminal diagnoses.<sup>7,15,16</sup>

Previous studies examining the association of profit status or diagnosis with LOS or care intensity have used proprietary data<sup>5,7</sup> or data limited to a single state.<sup>11,17</sup> Lorenz et al<sup>11</sup> used 1997 California data to show that 46% of patients in for-profit hospices had noncancer diagnoses, compared with 28% in nonprofits. We find a similar difference, although of smaller magnitude—which may be partially due to the fact that our 2007 data show a substantial increase in noncancer diagnoses in both

for-profit and nonprofit hospices, compared with their 1997 study.<sup>11</sup> Our study also examined dementia specifically and demonstrated an even stronger association between profit status and dementia. Another study,<sup>18</sup> which used an earlier version of the NHHCS, could only document whether patients had ever received services from a given type of provider because it lacked information on the frequency of visits. Our study, using the most recent NHHCS, expands on prior work by quantifying the number of visits per day delivered by core members of the hospice team and thus provides an improved, albeit imperfect, measure of care intensity. Our study also builds on a study of nursing home patients in a for-profit hospice that found that cancer patients received more visits than noncancer patients.<sup>5</sup>

For-profit hospices had significantly more patients with stays exceeding 365 days and fewer patients with stays less than 7 days. Although hospice is intended for patients with a prognosis of less than 6 months, research demonstrates<sup>19-22</sup> that it is difficult for clinicians to prognosticate, especially for patients with noncancer diagnoses. Therefore, stays that exceed 6 months may have been appropriate at the time of enrollment. While it is unknown whether hospice patients with stays exceeding 1 year were enrolled inappropriately early in the course of their illnesses, these admissions can be particularly lucrative for hospices in a per diem reimbursement system because, as we found, they receive fewer visits per day from skilled hospice personnel.

Our study has several important limitations. First, the NHHCS includes only patients who were discharged from hospice and therefore underestimates LOS because patients with longer LOS have a lower likelihood of having been discharged and are therefore underrepresented in the sample. Nonetheless, we found that for-profit hospices were more likely than nonprofit hospices to have prolonged LOS (ie, >1 year). This undersampling of long LOS means that

our study on the whole probably underestimates the differences in median LOS by profit status.

Second, we lacked data on important agency characteristics beyond metropolitan statistical area and chain status, such as the hospices' geographic location, which may explain the observed differences in racial composition. We also do not know whether hospices were part of a larger system of care, which could facilitate coordination of and transitions in care and thus increase hospice LOS. Third, we lacked data on costs and revenue, and therefore, we do not demonstrate that differences in the diagnostic composition of hospices resulted in lower costs or greater revenue. Fourth, diagnosis is an imperfect measure of disease severity.

Finally, and perhaps most importantly, we are unable to assess the relationship between profit status and quality of care. While our study improves on previous research by assessing the number of visits per day by various hospice personnel, we lacked important information on the length of each visit and care provided. For example, we could not distinguish between a home health aide visit that consisted of a 5-minute "check-in" and a half-day visit providing assistance with activities of daily living. We are also unable to determine whether higher rates of home health aide visits in for-profit hospices reflect additional care or substitution of other types of unmeasured (and potentially more expensive) clinical services. We also could not distinguish between visits delivered by registered nurses and licensed vocational nurses; past research<sup>11,17</sup> suggests that registered nurses, who are more skilled and more expensive, deliver a lower proportion of nursing visits in for-profit hospices vs nonprofit hospices.

Clinicians caring for patients considering hospice can be reassured that for-profit hospices appear to provide as many nursing visits and more home health aide visits (although fewer social work visits) than nonprofit hos-

pices. However, there are important policy implications if hospice agencies differentially enroll more patients with dementia and other noncancer diagnoses, who require fewer visits from skilled personnel such as nurses and social workers. Patient selection of this nature leaves nonprofit hospice agencies disproportionately caring for the most costly patients—those with cancer and those tending to begin hospice very late in their course of illness; as a result, those hospices serving the neediest patients may face difficult financial obstacles to providing appropriate care in this fixed per-diem payment system.

Our findings are timely, complement the findings of the Medicare Payment Advisory Committee (MedPAC) reports,<sup>2,16</sup> and can help inform the current debate around payment reform in the Medicare Hospice Benefit. MedPAC has recommended that, as of 2013, reimbursement rates for hospice reflect a U-shaped pattern that considers the intensity of care required at the beginning and end of hospice, with higher per diem rates during the first 30 days of enrollment and a standard payment at the time of death. Given that approximately 1 million Medicare beneficiaries use hospice each year and that the for-profit hospice industry continues to expand rapidly, future research is needed to understand more fully the association of profit status with quality of care and patient and caregiver experiences at the end of life.

**Author Contributions:** Dr Wachterman had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

**Study concept and design:** Wachterman, McCarthy.  
**Acquisition of data:** Wachterman, McCarthy.

**Analysis and interpretation of data:** Wachterman, Marcantonio, Davis, McCarthy.

**Drafting of the manuscript:** Wachterman, McCarthy.  
**Critical revision of the manuscript for important intellectual content:** Wachterman, Marcantonio, Davis, McCarthy.

**Statistical analysis:** Wachterman, Davis, McCarthy.  
**Obtained funding:** Wachterman.

**Administrative, technical, or material support:** Wachterman, Marcantonio, Davis, McCarthy.

**Study supervision:** Marcantonio, McCarthy.

**Conflict of Interest Disclosures:** All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

**Funding/Support:** Dr Wachterman received support from grant 6T32HP12706-02-01 from the Health Resources and Services Administration of the Department of Health and Human Services to support the Harvard Medical School Fellowship Program in General Medicine and Primary Care.

**Role of the Sponsor:** The funding organization had no role in the design and conduct of the study; in the collection, analysis, and interpretation of the data; or in the preparation, review, or approval of the manuscript.

**Previous Presentation:** An earlier version of this work was presented at the national meeting of the Society of General Internal Medicine; Minneapolis, Minnesota; April 30, 2010; and at the national meeting of Academy Health; Boston, Massachusetts; June 28, 2010.

**Disclaimer:** The study contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services.

**Additional Contributions:** We thank Benjamin Sommers, MD, PhD, Harvard School of Public Health, for his editing assistance and helpful comments on the manuscript. He did not receive compensation for the contribution.

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In our flowing affairs a decision must be made—the best, if you can, but any is better than none. There are twenty ways of going to a point, and one is the shortest; but set out at once on one. A man who has that presence of mind which can bring to him on the instant all he knows, is worth for action a dozen men who know as much but can only bring it to light slowly.

—Ralph Waldo Emerson (1803-1882)

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## **Hospice of Michigan Announces Decreased Patient Costs from Innovative Home Care Program**

***Pilot study funded by Blue Cross Blue Shield of Michigan Foundation in collaboration with Wayne State University demonstrates higher quality, lower cost, for patients with advanced illnesses***

**DETROIT, MI, March 13, 2012** -- Persons with advanced illness experienced decreased medical care costs while participating in an innovative home care program, according to a research study released today by Hospice of Michigan. By shifting a number of services to the home environment through the @HOMe Support™ Program, patient costs were reduced significantly, for one group by over \$3,000 per month.

This independent pilot study on advanced illness management strategy was funded by a grant from the Blue Cross Blue Shield of Michigan Foundation and conducted by Hospice of Michigan's Maggie Allesee Center for Quality of Life in collaboration with Wayne State University's School of Social Work.

Dottie Deremo, RN, MSN, MHSA, FACHE, President and Chief Executive Officer of Hospice of Michigan, said "This is a groundbreaking study that has significant implications for reducing high-cost medical services during the last 24 months of life and addresses the desire of older adults to receive care at home." Michael Paletta, MD, Co-Principal Investigator of the study and Vice President of Medical Affairs and Executive Director of the Maggie Allesee Center notes that "these results were achieved through a program that provides 24/7 access and comprehensive support to patients and their caregivers."

The study examined changes in service utilization and costs during patients' advanced stages of illness in four primary areas: inpatient, outpatient, emergency room, and inhome support. The costs of inpatient, outpatient, and emergency room visits were significantly reduced following program enrollment, while the cost of at-home care rose as expected when patients were managed in their own homes. Most importantly, even with some costs shifted to the home environment, overall costs decreased significantly. One group of @HOMe Support™ patients, which included both Medicare and non-Medicare adult patients with a variety of illnesses, experienced an average reduction in total costs of \$3,416 per month (from an average cost of \$9,294 per month) for a cost savings of more than 36 percent. The program provides 24/7 access to professionals for

education, counseling, and home visits at times when they are needed most – times of medical crisis occurring after hours, on weekends, and during holidays.

The U.S. Department of Health and Human Services estimates that a typical four-day hospital stay costs more than \$20,000. This equates to 22 months of advanced illness management at home or five full months in hospice care. An aging population and rising end-of-life expenditures generate significant challenges for the future of health care and health care reform. Medical care costs during the last year of life consume approximately 10% of the US health care budget and about 27%-30% of costs for those aged 65 and older. As a growing population of baby boomers approaches retirement age, the prevalence of chronic disease and advanced illness conditions is expected to rise exponentially along with costs. Family caregivers, who are often female, provide the bulk of care to people with chronic illness. They are faced with the often stressful task of helping their loved ones navigate the health care system and cope with progressive illness while dealing with their own careers and medical challenges.

Hospice of Michigan – the oldest and largest hospice organization in the state – introduced its “@HOMe” program in 2007 and is a pioneer and leader of in-home patient care. Hospice of Michigan’s @HOMe Support™ Program provides an interdisciplinary, comprehensive, home-based program for persons with advanced chronic illness intended to integrate services focused on disease management, symptom relief, health care system navigation, and psychosocial and caregiver support to augment the disease-focused model of the current health care system.

The @HOMe Support™ program is a unique delivery model that is neither home care nor hospice, but a home-based delivery model with an advanced illness management focus. Services are provided by an interdisciplinary team of registered nurses, social workers, patient-family assistants, and other members (e.g. patient-family advocates, volunteers) trained in a group of interventions known as “Advanced Illness Management (AIM) strategies.” AIM strategies are based on creating a safety net for patients and families by providing 24/7 accessibility to staff along with information, education, and counseling focused on addressing and managing the trajectory of advancing illness.

Services are primarily home-based but, by design, support and services continue across the care continuum as needed. Services are delivered as an enhancement or addition to the current treatment plan, and in collaboration with the patient’s primary care physician.

Up to this point, very little information has been available concerning program outcomes in terms of service use and cost. The new study was designed to obtain information on service use and cost trends associated with @HOMe Support™ participation, as a means of informing future program development and intervention efforts.

“Because our @HOMe Support™ Program provides 24/7 access to professional guidance and at-home assistance, we’re able to reduce emergency room visits as well as unwanted tests and treatments while assisting the patient’s primary caregivers – a husband, wife, adult child, or other loved one – to make decisions and do the things necessary to make the patient comfortable without frequent, stressful trips back and forth to the doctor or the hospital,” said Dr. Paletta.

Roxanne Roth, RN, Corporate Director of Innovative Programs at Hospice of Michigan, comments: “Since most patients express a strong desire to be at home rather than in a

hospital or other care facility, these results point to a better patient quality-of-life and reduction of stress on their caregivers who are often the decision makers.”

“The findings of this research study support the notion that at-home care is the best solution for most patients with advanced illnesses who are at or near the end-of-life,” said Ira Strumwasser, PhD, Executive Director and CEO of the Blue Cross Blue Shield of Michigan Foundation. “But, this is a pilot study, and more comprehensive research is needed to verify and expand on these results. If we get the same or similar results, this research may trigger an entirely new approach to making patients’ last two years of life better for themselves and their families and will reduce health care costs for everyone.”

Faith Hopp, PhD, faculty member at the Wayne State University School of Social Work and Co-Principal Investigator on the study, adds that “these results are exciting and promising, and point to the need for further research on the outcomes from @HOME Support™ compared with advanced care patients with similar illness severity and mortality risk. We look forward to future collaborations with Hospice of Michigan, with the goal of helping to improve the lives of patients with advanced illness and their families, both by reducing their costs as well as by improving the quality of the end-of life experience.”

# # #

#### **About Hospice of Michigan**

A nationally recognized leader in end-of-life care, Hospice of Michigan (HOM) is the original hospice in the state of Michigan, and is the largest. The non-profit organization cares for more than 900 patients each day in 56 counties. HOM takes a leadership position in end-of-life care with innovative programs to enhance quality of care for people at the end of life, education programs for physicians and healthcare professionals, caregiver education materials, cultural diversity programs for end-of-life care, and research and education programs at the Maggie Allesee Center for Quality of Life.

Hospice of Michigan was founded in 1980 by volunteers. Today, the organization delivers care to a large geographic area that includes underserved urban and rural communities. With a mission to serve all who need and seek care regardless of their ability to pay, Hospice of Michigan raises more than \$4 million annually to cover the cost of care for the uninsured, underinsured, and for innovative programs.

For more information, call Hospice of Michigan’s CARE Center 24/7 at 888-247-5701, or go to [www.hom.org](http://www.hom.org).



## Mount Sinai Researchers Find Vast Majority of Americans Have Access to Hospice Care

**A new study shows that 98 percent of Americans live within 60 minutes of hospice services, indicating that disparities in enrollment are not likely related to access.**

**NEW YORK, NY – November 3, 2010 /Press Release/ —**

Researchers at Mount Sinai School of Medicine have found that 98 percent of the U.S. population lives in communities within 60 minutes of a hospice provider, suggesting that disparities in use of hospice are not likely due to a lack of access to a hospice provider. The results are published in the current issue of the *Journal of Palliative Medicine*.

"Despite a significant increase in the availability of hospice services during the past decade, the majority of Americans die without hospice care," said Melissa D.A. Carlson, PhD, Assistant Professor of [Geriatrics and Palliative Medicine](#) at Mount Sinai School of Medicine. "Our data show that proximity to a hospice provider is not a likely barrier to hospice enrollment, as the vast majority of Americans have a hospice nearby."

Studies have shown that enrollment in hospice helps address end-of-life concerns facing patients and their caregivers. Hospice services offer symptom management, medication delivery, home crisis intervention, and psychosocial support during one of the most difficult and emotionally demanding phases of the patient's illness.

Dr. Carlson's research team studied data from the 2008 Medicare Provider of Services data, U.S. Census data, and geographic mapping software. Census tract characteristics evaluated included population per mile, population over the age of 65, median household per capita income, percentage over the age of 18 with less than a high school education, black population percentage, and census region. The team determined that 98 percent of the U.S. population lives within 60 minutes of a hospice, and 88 percent live within 30 minutes from one.

The average number of minutes between a community center and a hospice was 15 minutes. The number of minutes to the nearest hospice was lower in communities with several characteristics, including: higher population per square mile, higher median household income, lower percentage with less than a high school education, and a higher black population percentage. Communities with higher percentages of the population who are black are more likely to have geographic access to hospice, but previous research has shown that people who are black are less likely to use hospice compared with people who are white.

"Our data suggest that the growth in the number of hospices since 2000 has improved access to hospice care as the closest hospice for approximately one-third of the population, in both rural and urban areas, is a relatively new hospice, certified by Medicare since 2000," said Dr. Carlson. "However, more research is needed to determine why more patients and their families are not under the care of a hospice at the end of life, including hospice admission criteria and patient financial and cultural factors that may present barriers to hospice use."

Co-authors on the study were R. Sean Morrison, MD, Professor, Geriatrics and Palliative Medicine, and Ms. Qingling Du, Senior Research Analyst, both of Mount Sinai School of Medicine and Elizabeth H. Bradley, PhD, Professor of Public Health at Yale University.

### **About The Mount Sinai Medical Center**

The Mount Sinai Medical Center encompasses both The Mount Sinai Hospital and Mount Sinai School of Medicine. Established in 1968, Mount Sinai School of Medicine is one of few medical schools embedded in a hospital in the United States. It has more than 3,400 faculty in 32 departments and 15 institutes, and ranks among the top 20 medical schools both in National Institute of Health funding and by U.S. News & World Report. The school received the 2009 Spencer Foreman Award for Outstanding Community Service from the Association of American Medical Colleges.

The Mount Sinai Hospital, founded in 1852, is a 1,171-bed tertiary- and quaternary-care teaching facility and one of the nation's oldest, largest and most-respected voluntary hospitals. U.S. News & World Report consistently ranks The Mount Sinai Hospital among the nation's best hospitals based on reputation, patient safety, and other patient-care factors. Nearly 60,000 people were treated at Mount Sinai as inpatients last year, and approximately 530,000 outpatient visits took place.

For more information, visit [www.mountsinai.org](http://www.mountsinai.org). Follow us on Twitter @mountsinainyc.

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## 'Best Care' may be dying well, say hospice, palliative docs

By [Janice Lloyd](#), USA TODAY

Updated 3/6/2012 6:12 PM

Medical advances help people live longer and longer, but too few physicians help people understand that longer is not always better, according to two new books.



Mark Washburn, Dartmouth Hitchcock

Dr. Ira Byock MD counsels patient David Plant and wife Bette Jean Plant. Most doctors have been trained to treat diseases and not deal with end-of-life issues, according to Byock.

Ira Byock says he wants "to raise people's expectations" about the end of life and to change the conversation about dying in America.

"It's not easy to die well in modern times," says Byock, director of palliative medicine at Dartmouth-Hitchcock Medical Center in Lebanon, N.H., and author of *The Best Care Possible, a Physician's Quest to Transform Care Through the End Of Life*.

Karen Wyatt, physician and author of *What Really Matters, 7 Lessons for Living from the Stories of the Dying*, describes a "horrifying night" she experienced as a resident at a hospital.

"A man came into the hospital and his heart arrested five times in the course of the night," she says. "We resuscitated him four times before he finally died with us pounding on his chest. It was so sad, and what makes me so passionate about hospice care, where people can die very comfortably at home with their loved ones around them."

Byock says the needless suffering at the end of life is partly a result of a current political climate that accuses palliative care doctors and hospice physicians of promoting a "culture of death" or "death panels." Rather, he writes, he is one of the compassionate experts who are "pro-life" and insist people get the best care possible — basically what

they want for themselves — and no extra care.

"Most doctors have been trained to treat diseases and not deal with end-of-life issues," he says. "American medical prowess is wonderful, but we have yet to make a person immortal. At some point, more disease treatment is not better care."

People have to think about quality of life but also quality of death, he says, adding that it's important that doctors don't give up too soon on someone while also knowing the limitations of treatment.

"I think physicians have really fallen short on that obligation," says Wyatt. "They haven't been as helpful to patients as they could have been."

Byock writes that throughout the ages people have held common fundamental values: to live as long and as well as possible, and eventually, to die gently. In his book, he shares poignant, complex conversations he has had with families and patients about knowing when to say "enough is enough," and letting health care professionals help keep a dying person comfortable with medications.

Additionally, he calls for changes in how doctors are educated (most medical schools do not require hospice or palliative care rotations, he notes) and changes in letting patients guide their own care at the end of life — Medicare and Medicaid, for instance, don't allow older people to have hospice care until they drop medical treatments.

Wyatt says her goals are to help people learn how to live and to face death. She offers spiritual lessons she learned while director of a hospice program in Ogden, Utah, from 1992 to 1999. One lesson centers on impermanence.

"Everything around us is going to have an end," she says. "Once we know that, as the dying person does, we savor life more, instead of focusing on what will happen down the road. It can be such a peaceful, beautiful passing."

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Posted 3/6/2012 6:12 PM | Updated 3/6/2012 6:12 PM



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## Average hospice length of stay is falling

Patients typically die within three weeks of admission. A 2011 rule requires physicians to see residents every 180 days to re-evaluate eligibility.

By KEVIN B. O'REILLY, amednews staff. Posted Feb. 1, 2012.

Amid scrutiny from regulators and researchers about potential abuse of the Medicare hospice benefit, data released in January show that patient lengths of stay in hospice fell slightly in 2010.

The average length of stay in hospice care decreased to 67.4 days, down from 69.5 in 2008, according to data collected by the National Hospice and Palliative Care Organization, which represents about two-thirds of the nation's more than 5,000 for-profit and nonprofit hospices.

Though the average length-of-stay figure was drawn higher by the 12% of patients who remain in hospice longer than 180 days, half of patients spend 19.7 days or less in hospice. That figure also is down since 2008, when the median hospice stay was 21.3 days, said the report ([See site](#)).

The figures cover hospice care delivered at patients' homes and in inpatient settings. The data do not reflect the first year of experience with a Medicare regulation that took effect in January 2011. The rule requires a physician or nurse practitioner to evaluate a hospice patient in a face-to-face meeting after 180 days and certify that the patient remains terminally ill and eligible for hospice care.

Medicare covers 84% of the patients in hospice, and the stricter standards are forcing organizations to make sure that the patients they care for belong in hospice, said J. Donald Schumacher, president and CEO of the National Hospice and Palliative Care Organization.

"What this regulation is doing is raising awareness that the admission procedures of all hospices have to be within Medicare guidelines," he said. "Programs -- if over the long term they are going to be forced to answer questions about the patients being admitted -- are being incredibly more thoughtful and diligent about what those numbers are."

### Hospice costs explode

Patients admitted to for-profit hospices typically stayed there longer, were likelier to remain in hospice for more than a year, and were more likely to have dementia and other noncancer diagnoses, said a Feb. 2, 2011, study in *The Journal of the American Medical Association* ([See site](#)).

Some critics of commercial hospices say such facilities are more willing than nonprofits to admit patients with lower demands for skilled care and whose terminal prognosis is less certain, making it easier for these organizations to score profits on the flat daily rate the Medicare hospice benefit pays. Nearly 60% of hospices are for-profit, up from virtually none in the early 1980s. Medicare payments for hospice rose fourfold to \$12 billion annually between 2000 and 2009, according to the Medicare Payment Advisory Commission. Four in 10 Americans who die each year do so under hospice care.

The new Medicare regulation, known as the face-to-face rule, applies to all hospices regardless of profit status. Schumacher said he has not seen much evidence to indicate that the standard is discouraging appropriate use of hospice, or that it is placing an undue burden on physicians.

"At the very beginning, there was concern about the amount of energy it would take to do this," he said. "But people are integrating this into their regular workflow."

### How long patients stay in hospice

The typical patient spends 19.7 days in hospice care, down from 21.3 days in 2008. A breakdown of patient stays in hospice:

35.3%: Fewer than seven days

27.0%: Eight to 29 days

17.2%: 30 to 89 days

8.7%: 90 to 179 days

11.8%: 180-plus days

Source: "NHPCO Facts and Figures: Hospice Care in America, 2011 Edition," National Hospice and Palliative Care Organization, January ([See site](#))



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## CENTERS FOR MEDICARE & MEDICAID SERVICES



# Medicare Hospice Benefits

This [official government](#) booklet includes information about Medicare hospice benefits:

- ★ Who is eligible for hospice care
- ★ What services are included
- ★ How to find a hospice program
- ★ Where to get more information



# Welcome

Choosing hospice care is a difficult decision. The information in this booklet and the support given by a doctor and trained hospice care team can help you choose the most appropriate health care options for someone who is terminally ill.

Whenever possible, include the person who may need hospice care in all health care decisions.



*“Medicare Hospice Benefits” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.*

The information in this booklet was correct when it was printed. Changes may occur after printing. Visit [www.medicare.gov](http://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

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## Hospice Care

Hospice is a program of care and support for people who are terminally ill. Here are some important facts about hospice:

- Hospice helps people who are terminally ill live comfortably.
- The focus is on comfort, not on curing an illness.
- A specially trained team of professionals and caregivers provide care for the “whole person,” including his or her physical, emotional, social, and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for the terminal illness and related condition(s).
- Care is generally provided in the home.
- Hospice isn’t only for people with cancer.
- Family caregivers can get support.

## Medicare Hospice Benefits

You can get Medicare hospice benefits when you meet **all** of the following conditions:

- You’re eligible for Medicare Part A (Hospital Insurance).
- Your doctor and the hospice medical director certify that you’re terminally ill and have 6 months or less to live if your illness runs its normal course.
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal illness. (Medicare will still pay for covered benefits for any health problems that aren’t related to your terminal illness.)
- You get care from a Medicare-approved hospice program.

## How Hospice Works

Your doctor and the hospice team will work with you and your family to set up a plan of care that meets your needs. Your plan of care includes hospice services that Medicare covers. For more specific information on a hospice plan of care, call your state or national hospice organization (see pages 12 and 14–15).

If you qualify for hospice care, you will have a specially trained team and support staff available to help you and your family cope with your illness.

You and your family members are the most important part of the team. Your team may also include some or all of the following people:

- Doctors
- Nurses
- Counselors
- Social workers
- Physical and occupational therapists
- Speech-language pathologists
- Hospice aides
- Homemakers
- Volunteers

In addition, a hospice nurse and doctor are on-call 24 hours a day, 7 days a week to give you and your family support and care when you need it.

A hospice doctor is part of your medical team. Your regular doctor or a nurse practitioner can also be part of this team as the attending medical professional to supervise your care. However, only your regular doctor (**not a nurse practitioner that you've chosen to serve as your attending medical professional**) and the hospice medical director can certify that you're terminally ill and have 6 months or less to live.

The hospice benefit allows you and your family to stay together in the comfort of your home unless you need care in an inpatient facility. If the hospice team determines that you need inpatient care, the hospice team will make the arrangements for your stay.

## What Medicare Covers

You can get a one-time only hospice consultation with a hospice medical director or hospice doctor to discuss your care options and pain and symptoms management. You don't need to choose hospice care to take advantage of this consultation service.

Medicare will cover the hospice care you get for your terminal illness, but the care you get must be from a Medicare-approved hospice program.

**Important:** Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness, such as care for an injury.

Medicare covers the following hospice services when they're needed to care for your terminal illness and related condition(s):

- Doctor services
- Nursing care
- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control or pain relief (may need to pay a small [copayment](#))
- Hospice aide and homemaker services
- Physical and occupational therapy
- Speech-language pathology services
- Social worker services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care (for pain and symptom management)
- Short-term [respite care](#) (may need to pay a small copayment)
- Any other Medicare-covered services needed to manage your pain and other symptoms related to your terminal illness, as recommended by your hospice team

## Respite Care

You can get inpatient respite care in a Medicare-approved facility (such as a hospice inpatient facility, hospital, or nursing home) if your usual caregiver (such as a family member) needs a rest. You can stay up to 5 days each time you get respite care. You can get respite care more than once, but it can only be provided on an occasional basis.

## What Medicare Won't Cover

When you choose hospice care, you've decided that you no longer want care to cure your terminal illness and/or your doctor has determined that efforts to cure your illness aren't working. Medicare won't cover any of the following once you choose hospice care:

- **Treatment intended to cure your terminal illness**

Talk with your doctor if you're thinking about getting treatment to cure your illness. As a hospice patient, you always have the right to stop hospice care at any time.

- **Prescription drugs to cure your illness (rather than for symptom control or pain relief)**

- **Care from any hospice provider that wasn't set up by the hospice medical team**

You must get hospice care from the hospice provider you chose. All care that you get for your terminal illness must be given by or arranged by the hospice team. You can't get the same type of hospice care from a different provider, unless you change your hospice provider. However, you can still see your regular doctor if you've chosen him or her to be the attending medical professional who helps supervise your hospice care.

- **Room and board**

Medicare doesn't cover room and board if you get hospice care in your home or if you live in a nursing home or a hospice inpatient facility. However, if the hospice team determines that you need short-term inpatient or **respite care** services that they arrange, Medicare will cover your stay in the facility. You may have to pay a small **copayment** for the respite stay.

- **Care in an emergency room, inpatient facility care, or ambulance transportation, unless it's either arranged by your hospice team or is unrelated to your terminal illness**

**Note:** Contact your hospice team **before** you get any of these services or you might have to pay the entire cost.

## What You Pay for Hospice Care

Medicare pays the hospice provider for your hospice care. There is no [deductible](#). You will have to pay the following:

- **No more than \$5 for each prescription drug and other similar products for pain relief and symptom control.**
- **5% of the [Medicare-approved amount](#) for inpatient [respite care](#).** For example, if Medicare pays \$100 per day for inpatient respite care, you will pay \$5 per day. The amount you pay for respite care can change each year.

## Hospice Care if You're in a Medicare Advantage Plan or Other Medicare Health Plan

All Medicare-covered services you get while in hospice care are covered under [Original Medicare](#), even if you're in a Medicare Advantage Plan (like an HMO or PPO) or other [Medicare health plan](#). That includes any Medicare-covered services for conditions unrelated to your terminal illness or provided by your attending doctor.

A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. However, if your plan covers extra services not covered by Original Medicare (like dental and vision benefits), your plan will continue to cover these extra services.



## Care for a Condition Other than Your Terminal Illness

You should continue to use **Original Medicare** to get care for any health care needs that aren't related to your terminal illness. You may be able to get this care from the hospice team doctor or your own doctor. The hospice team determines whether any other medical care you need is or isn't related to your terminal illness so it won't affect your care under the hospice benefit.

You must pay the **deductible** and **coinsurance** amounts for all Medicare-covered services. You must also continue to pay Medicare premiums, if necessary.

For more information about Original Medicare, Medicare Advantage Plans, and other **Medicare health plans**, look in your copy of the "Medicare & You" handbook, which is mailed to every Medicare household in the fall. If you don't have the "Medicare & You" handbook, you can view or print it by visiting [www.medicare.gov/publications](http://www.medicare.gov/publications).

## Information about Medicare Supplement Insurance (Medigap) Policies

If you have Original Medicare, you might have a **Medigap policy**. Your Medigap policy covers your hospice costs for drugs and respite care, and still helps cover health care costs for problems that aren't related to your terminal illness. Call your Medigap insurance company for more information.

To get more information about Medigap policies, visit [www.medicare.gov/publications](http://www.medicare.gov/publications) to view or print the booklet "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## How Long You Can Get Hospice Care

Hospice care is intended for people with 6 months or less to live if the disease runs its normal course. If you live longer than 6 months, you can still get hospice care, as long as the hospice medical director or other hospice doctor recertifies that you're terminally ill.

**Important:** Hospice care is given in benefit periods. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period, the hospice medical director or other hospice doctor must recertify that you're terminally ill, so you can continue to get hospice care. A benefit period starts the day you begin to get hospice care and it ends when your 90-day or 60-day period ends.

## Stopping Hospice Care

If your health improves or your illness goes into remission, you no longer need hospice care. Also, you always have the right to stop hospice care at any time for any reason. If you stop your hospice care, you will get the type of Medicare coverage you had before you chose a hospice program (such as treatment to cure the terminal illness). If you're eligible, you can go back to hospice care at any time.

**Example:** Mrs. Jones has terminal cancer and got hospice care for two 90-day benefit periods. Her cancer went into remission. At the start of her 60-day period, Mrs. Jones and her doctor decided that, due to her remission, she wouldn't need to return to hospice care at that time. Mrs. Jones' doctor told her that if she becomes eligible for hospice services in the future, she may be recertified and can return to hospice care.

## Your Medicare Rights

As a person with Medicare, you have certain guaranteed rights. If your hospice program or doctor believes that you're no longer eligible for hospice care because your condition has improved and you don't agree, you have the right to ask for a review of your case. Your hospice should give you a notice that explains your right to an expedited (fast) review by an independent reviewer hired by Medicare, called a [Quality Improvement Organization \(QIO\)](#). If you don't get this notice, ask for one.

For more information about your Medicare rights, visit [www.medicare.gov/publications](http://www.medicare.gov/publications) to view or print the booklet "Medicare Appeals." You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have a complaint about the hospice that is providing your care, contact your State Survey Agency. Visit [www.medicare.gov/ombudsman/resources.asp](http://www.medicare.gov/ombudsman/resources.asp) and select "Filing a Complaint or Grievance" to find the number of your State Survey Agency. You can also call 1-800-MEDICARE.

## Changing Your Hospice Provider

You have the right to change providers only once during each benefit period. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods.

## Finding a Hospice Program

To find a hospice program, talk to your doctor, or call your state hospice organization. See pages 14–15 for the phone number in your area. The hospice program you choose must be Medicare-approved to get Medicare payment. To find out if a certain hospice program is Medicare-approved, ask your doctor, the hospice program, your state hospice organization, or your state health department.

## For More Information



1. Call National Hospice Associations, or visit their Web sites.

**National Hospice & Palliative Care Organization (NHPCO)**

1731 King Street  
Suite 100  
Alexandria, Virginia 22314  
1-800-658-8898

[www.nhpco.org](http://www.nhpco.org)

**Hospice Association of America**

228 7th Street, SE  
Washington, DC 20003  
1-202-546-4759

[www.nahc.org/haa](http://www.nahc.org/haa)

2. Visit [www.medicare.gov](http://www.medicare.gov).
3. Call 1-800-MEDICARE (1-800-633-4227).  
TTY users should call 1-877-486-2048.

**Note:** At the time of printing, these phone numbers and Web sites were correct. This information sometimes changes. To get the most updated phone numbers and Web sites, visit [www.medicare.gov/contacts](http://www.medicare.gov/contacts), or call 1-800-MEDICARE.

## Definitions

**Coinsurance**—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Copayment**—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit or prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription.

**Deductible**—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

**Medicare-approved Amount**—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you’re responsible for the difference.

**Medicare Health Plan**—A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare Health Plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medigap Policy**—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

**Original Medicare**—Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

**Quality Improvement Organization (QIO)**—A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

**Respite Care**—Temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient’s caregiver can rest or take some time off.

## State Hospice Organizations

This page has been intentionally left blank. The printed version contains phone number information. For the most recent phone number information, please visit [www.medicare.gov/contacts/home.asp](http://www.medicare.gov/contacts/home.asp). Thank you.

## State Hospice Organizations (continued)

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CMS Product No. 02154  
Revised August 2011



This booklet is available in Spanish. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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