Medicare Commission Flags Rising Hospice Costs

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — Staggering growth in the popularity of hospice services—and in the rise of for-profit hospice providers—has caught the attention of the Medicare Payment Assessment Commission.

At their recent meeting, MedPAC commissioners debated the potential impact of rising hospice costs on the Medicare program. The hospice benefit began in 1983 with the idea that it would cost Medicare less to provide hospice than conventional end-of-life treatment, which is usually delivered in the hospital, said MedPAC staff member James Mathews, Ph.D.

But there is some evidence indicating that hospice use may actually result in higher spending, said Dr. Mathews.

According to MedPAC's analysis of Medicare claims data, hospice spending tripled from 2000 to 2007, when Medicare spent $10 billion on hospice services. The mean length of hospice stay increased 30% from 2000 to 2005. It's not clear why length of stay is increasing, although data have shown that some illnesses—such as Alzheimer's disease and ischemic heart disease—tend to result in longer stays, Dr. Mathews said.

One explanation may be that hospice care tends to be more expensive at the beginning and the end of the service; interim days are more profitable, so there is an incentive to lengthen stay, he said.

But it appears that much of the growth in costs and length of stay is due to the huge increase in for-profit hospice facilities in the market. From 2000 to 2007, very few nonprofit hospices entered the market, while the for-profit sector grew 12% a year, Dr. Mathews said. There were a little more than 1,600 for-profit hospices in 2007, compared with about 1,200 nonprofit and 400 government-run facilities, according to the MedPAC analysis.

In addition, the analysis determined that profit margins are also much higher at for-profit hospice facilities. In 2005, the last year in the analysis, for-profit margins were about 12%, while nonprofits had negative margins. MedPAC also found that hospices that entered the market since 2000 had higher margins—and these were mostly for-profit operations.

Some hospices, only about 9%, are subject to a cap that limits the length of stay, but even those facilities have found a way to profit from Medicare, Dr. Mathews said.

"Clearly, people see an opportunity—a financial opportunity—here," commented MedPAC chairman Glenn Hackbarth, a health care consultant based in Bend, Ore. He said that the commission needed to find a way to keep the hospice program from spiraling out of control.

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Commissioner Jack Ebeler suggested Medicare "may need blunter instruments for slowing the growth," but also added that the health program should not do anything to lose "an extraordinarily valuable benefit."

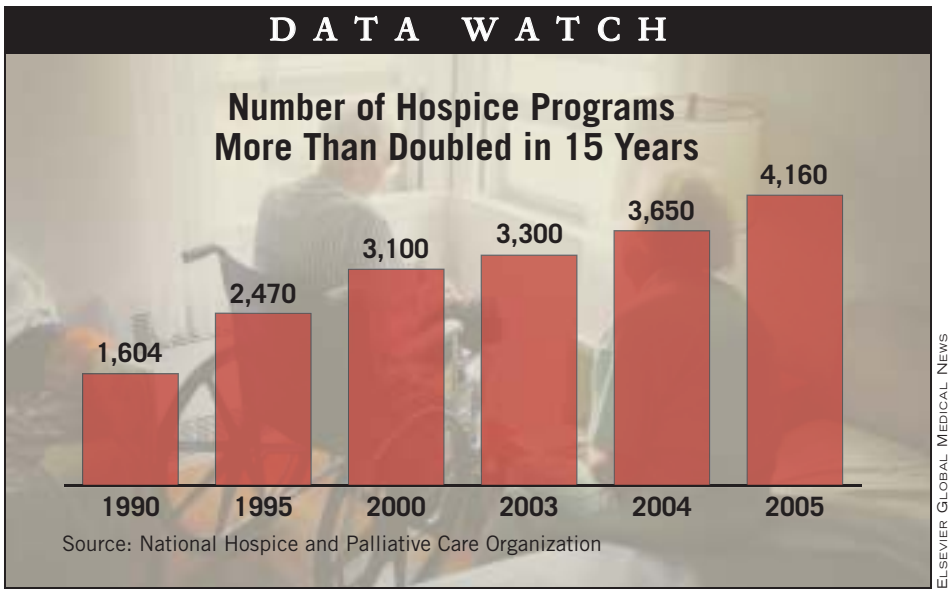
MedPAC vice chairman Robert Reischauer, Ph.D., suggested that Medicare payment could be refined to buy more appropriate care.

"It strikes me that there's probably an easy way to do this," said Dr. Reischauer, who is also president of the Urban Institute in Washington.

J. Donald Schumacher, Psy.D., president and CEO of the National Hospice and Palliative Care Association, acknowledged that there has been a "huge growth spurt" in the hospice field. Facilities are worried that the Centers for Medicare and Medicaid Services or Congress might clamp down, using a "blunt instrument," Dr. Schumacher said at the meeting.

The commissioners and Dr. Schumacher agreed that a first step to a solution is getting more data on the hospice sector. CMS has already started down that path. In July, hospices will begin submitting data to CMS on the types of services they provide and which practitioners are delivering them. ■

DATA WATCH



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POLICY & PRACTICE

FDA Hiring Experts

The Food and Drug Administration has begun a multiyear hiring initiative and plans to fill more than 1,300 positions within the next several months—nearly triple the number hired during the period spanning 2005 to 2007, the FDA said. The agency said it plans to hire hundreds of individuals with science and medical backgrounds, including biologists, chemists, medical officers, mathematical statisticians, and investigators, in part to implement the FDA's Food Protection Plan and the Import Safety Action Plan. Because of the critical need for scientific personnel, the federal Office of Personnel Management has granted authority to the FDA to expedite hiring of qualified candidates by eliminating certain rating and ranking preferences, which will make it possible for qualified candidates to start work in as little as 3 weeks.

RUC Recommendations Submitted

The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has submitted recommendations on the new Medicare medical home demonstration project to the Centers for Medicare and Medicaid Services. The RUC recommendations are specific to the development of the reporting mechanism and underlying data that CMS will use to determine payments in the medical home demonstration project. These data include physician work relative value and practice expense input recommendations, such as electronic medical record costs and coordination of nursing care. The 3-year medical home demonstration project, which was mandated by Congress in 2006, is slated to begin on Jan. 1, 2009.

Report: Food Safety in Crisis

Approximately 76 million Americans—one in four—are sickened by foodborne illnesses every year, and of these, an estimated 325,000 are hospitalized and 5,000 die, according to a report from the advocacy group Trust for America's Health. Medical care and lost productivity resulting from foodborne illnesses in the United States are estimated to cost $44 billion annually, the report said. The report blamed obsolete laws, the misallocation of resources, and inconsistencies among major food safety agencies for leaving Americans vulnerable to foodborne illnesses. "We can't adequately protect people from contaminated foods if we continue to use 100-year-old practices," said Dr. Jeff Levi, executive director of the group. "We need to bring food safety into the 21st century. We have the technology. We're way past due for a smart and strategic upgrade." The report noted that inadequate resources are allocated to fighting modern bacteria threats. It also said that no single agency has ultimate authority or responsibility for food safety, resulting in the fragmentation of federal food safety efforts.

GAO: Prioritize Infection Control

The federal government is not doing enough to prevent hospital-acquired infections, and the Department of Health and Human Services needs to identify priorities and establish greater consistency in reporting rates, the U.S. Government Accountability Office found in a report. The report, "Health-Care–Associated Infections in Hospitals," notes that the Centers for Disease Control and Prevention has 13 guidelines for hospitals on infection control and prevention, but HHS has not prioritized these practices. Also, although CDC's guidelines describe specific clinical practices recommended to reduce infections, the infection control standards that CMS and the accrediting organizations require of hospitals describe the fundamental components of a hospital's infection control program. The GAO concluded that the lack of department-level prioritization of CDC's large number of recommended practices has hindered efforts to promote their implementation.

Insurance Cost Rises Fast

Americans who get health insurance for their families through their jobs have seen their premiums increase 10 times faster than their incomes in recent years, according to an analysis of government data. The study, supported by the Robert Wood Johnson Foundation and conducted by researchers at the University of Minnesota, showed that the proportion of insurance premiums that workers pay for family coverage has remained constant over the years, but the dollar amount that workers contribute has increased substantially. The amount workers pay for family coverage nationwide rose by 30% (from $8,281 in 2001 to $10,728 in 2005), while employee income rose by only 3% in the same time period. Meanwhile, the average cost employers pay for their share of family coverage increased by 28% (from $6,360 to $8,143) during the same time period.

Part D Helps Adherence

The Medicare Part D drug benefit has made it less likely that elderly beneficiaries will forego basic needs such as food or housing in order to pay for medications, a study published in JAMA found. In addition, the study found a small but significant decrease in cost-related medication nonadherence (that is, beneficiaries who fail to adhere to their medication regimens because of cost) among patients with good to excellent health. However, there was no net decrease in cost-related medication nonadherence among the sickest beneficiaries, the study found. Overall, 14% of beneficiaries reported skipping medication doses in 2005, but that figure dropped to less than 12% in 2006 after Part D was introduced.

—Jane Anderson

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