Medicare Hospice Benefit Payment Reform

Following the American Psychological Association's Guidelines

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Hospice is compassionate care that is administered to the terminally ill and their loved ones. In Medieval times, this word was used to describe a resting place, a safe haven, a shelter while on a journey (National Hospice and Palliative Care Organization, n.d.). The intent of the modern day hospice was to offer individuals and their loved ones with quality time at the end of life—meaning true peace and contentment while on their final journey in this existence. It is no surprise, therefore, that at the core of hospice was the vision to gift individuals with home—the very place where such sentiments of serenity and comfort are nourished, cherished and realized. Giving patients and their families this special, beautiful, yet terribly bittersweet rite of passage was the inspiration upon which hospices throughout the United States embraced and implemented their mission of compassionate end of life care. Individuals, motivated by experiences with dying loved ones, wanted to make a difference. Iowa City Hospice was no exception. A small group of women came together wanting to serve the community. This service grew to meet the needs of the Iowa City area, establishing the reputation as the original, and still, the go-to leader in end-of-life care (Iowa City Hospice, n.d.).

“Because care of the body means nothing without first easing the soul, hospice workers are not hired. They are called.” (High Peaks Hospice & Palliative Care, n.d.). This statement by an unknown author summarizes the uniqueness of hospice work—not hospice as a “business.” Hospice is a calling, not a job. Hospice is a much needed service, not a stock dividend. I know firsthand the impact that a non-profit, compassionate organization such as Iowa City Hospice can make on a patient and a family. Two of my grandparents were served by Hospice of Dubuque. I still savor the memories that my family and I were privileged to make with our loved ones. I was given the gift of saying goodbye. Hospice gave us precious guidance and support in holding on
and yet, at the same time, letting go. My grandparents were comfortable during their final days. The generosity and expertise of Hospice of Dubuque made all the difference, as this organization espoused the hospice philosophy in its original, pure form. Sadly, in recent years, some hospices have taken up business with a different intent—to maximize profits at the expense of the federal government and unsuspecting patients and families. The United States Congress must implement payment reform for the Medicare Hospice benefit in order to eliminate the corporate fraud and abuse committed by for-profit hospices. Although payment reform will result in reduced revenues for all hospices, including non-profit agencies such as Iowa City Hospice, it will allow hospice as an industry to continue to serve patients, untainted by those who game the system.

Iowa City Hospice began serving the community in 1983, the same year that Medicare began reimbursing hospices for their care of the terminally ill (Iowa City Hospice, n.d.). Most hospice patients at that time were receiving care for various terminal cancer diagnoses. The Healthcare Finance Administration, which administered Medicare at that time, determined that many terminal cancer patients were frequently hospitalized and receiving futile treatments. Not only was this very costly to the Medicare program, the majority of patients were dissatisfied with their comfort level and also expressed a strong desire to remain at home. In the early 1980s, a few hospices entered into a test group to evaluate a Medicare Hospice Benefit. Because hospice utilizes an interdisciplinary team that, in conjunction with the patient and his or her family, determines each individualized plan of care, the concept of a per diem reimbursement model was explored. Hospices certified under the Medicare regulations would receive a set amount of money for each day a patient is enrolled in the hospice program. The onus would then be upon the hospice provider to determine the appropriate level of care to meet the needs of each patient. The reimbursement amount would be fixed for every patient, regardless of the expected duration...
of hospice care, the type of terminal illness that the patient may have and the overall amount of
resources necessary to maintain the patient comfortably at home. Since establishing the Medicare
Hospice Benefit in 1983, this rate, which varies by region, has been adjusted each year for
inflation and currently is at approximately $140 per patient per day. Thus, hospices that are
certified by Medicare are able to bill for and receive this reimbursement (Kennedy, 2011).

Such a system has given, and in some respects is still able to give, hospices the authority
in decision-making and resource utilization to provide the best possible care to patients. By
allowing hospices to case manage, patients can truly have individualized care. Physicians,
nurses, social workers, chaplains, therapists, aides and volunteers—all required disciplines for
any hospice to operate under the Medicare regulations—utilize their expertise by assessing each
patient, and then working together to formulate a comprehensive plan of care for the patient
(U.S. Department of Health & Human Services, 2011). Virtually all hospices were nonprofit in
1983 and through the late 1990s, a fact which is accentuated by the Medicare requirement that
volunteer services be a part of the hospice provision of care (National Hospice and Palliative
Care Organization, n.d.). The non-profit structure was complimentary to the per diem
reimbursement structure as the provision of patient care was tailored to each patient's and
family's needs, based upon the hospice's desire to meet its mission rather than to maximize
profits. The intention of the Medicare benefit was that hospices would ensure all end-stage
cancer patients under their care had the necessary assistance, medications and equipment, while
compensating employees and covering overhead costs; at the end of each year this would net out
to approximately a breakeven point (Medicare Payment Advisory Commission, 2004). In years
where the reimbursement exceeded the cost of providing care, the "profit" would remain in the
hospice for lean years when the opposite occurred. And because all hospices were nonprofit,
guided by a desire to provide a needed service in their community, no one even thought about the potential for abuse of this benefit (Hoyer, 2007).

In 2005, Medicare revised the hospice benefit by allowing individuals with a variety of non-cancer diagnoses to be admitted into hospice care (Medicare Payment Advisory Commission, 2004). Medicare had realized that individuals with end-stage diseases other than cancer were also frequenting the hospital and often receiving treatments that were expensive and proved to ultimately be futile. Surely, hospice could provide care that would be more cost-effective and more desirable to consumers. Additionally, Medicare had observed a shift in the dying population. With the effectiveness of many cancer treatments, people were in general living longer and dying from conditions such as congestive heart failure, chronic lung disease and Alzheimer's (Medicare Payment Advisory Commission, 2004). Not surprisingly, around this time, for-profit hospices began to grow exponentially (Kennedy, 2011.)

Most for-profit hospices focused on nursing homes for perspective patients. Due to the around-the-clock professional care that nursing home patients already have in place, for-profit hospices did not have to deal with calls in the middle of the night when a patient or his family needed assistance. Furthermore, travel time between patient visits was virtually eliminated; a nursing home offered a true "one-stop shop," with virtually every resident a potential hospice patient. Those with a goal of making big profits, versus serving a community need, found a virtual gold mine in Medicare hospice reimbursement for nursing home patients. Receiving approximately $140 a day for every day the nursing home resident is enrolled in the program would more than cover one quick weekly visit to a dementia patient. A dementia patient requires little, if any interaction, and very few medications or costly medical interventions. Additionally, due to the limited presence of family members in nursing homes during usual working hours, no
need exists to spend time processing with loved ones (Mahar, 2009). For-profit hospices generally do not want to deal with complex and expensive patients; instead they focus on a business model of snagging quick, easy, low resource, high-profit patients. Thus, a 40-year-old soon to be widow with three young children and a husband dying of metastatic cancer in the living room would not be considered a good prospect. No. This type of patient would require expensive medications for pain management and the family dynamic would need extensive staff support; therefore this would not be a “profitable” patient. So, in the event of a for-profit hospice being called in to do an assessment for such a patient, the response would essentially be uniform. “We don’t specialize in this kind of care…you should check with the other hospice (the non-profit).” Indeed, many for-profit hospices have even advertised that they specialize in caring for elderly dementia patients residing in nursing facilities (Liberty Home Care & Hospice Services, n.d.). They might as well say what their true “specialty” or “motto” is: Cha ching, cha ching.

From a business standpoint, this mindset makes perfect, absolute sense. A patient with higher needs can be viewed as a money pit or a bad investment. Hold it. This isn’t about marketing a new technologically advanced gadget, or producing widgets in the most cost effective manner. This is about a human being—a suffering individual who needs help, who needs true care. This is about a family who is hurting and just trying to survive grueling days, already experiencing the raw pain of grief and loss. In these moments, the cliché “time is money” could not be further from the truth. Time is a gift. True hospices provide this inclusively for the entire community—for all terminally ill individuals and their loved ones. Non-profit hospices often lose money on patients due to their unique needs and unstable conditions. However, non-profit hospices also serve “profitable” patients such as those the for-profit hospices exclusively target. This blend of high and low intensity patients enables the non-profit to balance overall
patient costs with the agency’s available reimbursement. As stated by Maggie Elliott, executive
director of Iowa City Hospice, “We are able to break even with payments from Medicare,
Medicaid and third party payments” (M. Elliott, personal conversation, October 30, 2011).
Because of reaching out to all patients, and thus serving a varied mix of patients in terms of
diagnoses, age, family dynamics and needs, non-profit hospices continue to embrace and follow
the breakeven model originally envisioned by Medicare.

For profit hospices argue, however, that they are offering the same services as non-profit
hospices. Yes, for-profit and non-profit hospices must meet the same Medicare regulations.
However, the disparity occurs in the admission practice of cherry-picking profitable patients
(Almberg, 2011). Proponents of Medicare reimbursement reform, such as myself, are simply
proposing new payment mechanisms by which all hospices will have to abide. Therefore, such
changes cannot be referred to as a punishment of some sort. Rather, the implementation of more
appropriate reimbursement would renew and reestablish the true mission of hospices nationwide.
If this mission does not meet the financial goals of certain corporations, it is irrelevant. Hospice
started with like-minded compassionate individuals who just wanted to make a difference. I
suggest a career change for those such as a nurse for Vitas, one major national for-profit hospice
chain, who is quoted as stating, “Our job is not to prepare them (patients) to live. It is to prepare
them to die” (Waldman, 2011). This misrepresents the fundamental purpose of hospice care and
undermines the vision of many tireless staff members nationwide who strive to gift patients and
loved ones with final, memorable experiences before death. This claim does not align with
hospice’s mission to meet the goals of the family, such as going fishing one final time, or getting
to one last Iowa game. In the same way, the for-profit’s obsession with the financial aspects of
hospice care are misconstrued and misguided. Payment reform is the only way to hold all hospice providers accountable for truly serving their respective communities.

For-profit hospices would likely say that the Medicare Hospice Benefit should remain as is. After all, this reimbursement method has not only been profitable for them, but, in terms of administration and billing ease, it has been user friendly for all hospices. When examining websites, the for-profit corporations look very similar to their non-profit counterparts, using words such as community, compassion and care. Based upon website presentation, an individual seeking hospice care for a loved one would really have no idea whether the hospice provider was for-profit or non-profit. For-profit websites rarely address fundraising and donations, which is an integral element of successful non-profit organizations. However, if charitable giving is addressed, the for-profits either direct potential donors to a foundation that they have established or they argue that they utilize their staff for patient care rather than fundraising. For-profits could argue that they are more financially sound and fiscally prudent than a smaller non-profit organization that needs monetary donations from community members to survive and at the same time uses limited resources to promote fundraising activities. These corporations would also want to emphasize a key difference between themselves and non-profits, that is, their civic responsibility of paying taxes, thus making them better corporate citizens. So, although non-profits are often recognized for giving back to the community, for-profits could argue that they do the same by paying taxes. Also, for-profits, such as Iowa City Hospice’s main, for-profit competitor, Iowa Hospice, tend to put a great deal of emphasis on the size of their hospice chain, which is never referred to as a corporation or business on their website (Iowa Hospice, n.d.). The for-profit structure allows for, and in fact, encourages expansion and ultimately the creation of the large chain. For-profit hospices point out that they are bigger and better, offering services
across a state or even nationwide. Much like any other profitable business, the product must be prevalent and accessible; this brand-recognition is the primary means by which a for-profit hospice establishes credibility. Beyond that, for-profits argue that their superior financial structure, magnitude of services and regional or national presence contribute effectively to the delivery of end-of-life care.

Due to the fraud and abuse that has occurred in recent years with the growth of for-profit hospices, the whole concept of hospice care is somewhat tainted (Hoyer, 2009). As noted in a national report regarding this scenario, “Ethical and quality concerns grow as end-of-life hospice care, once the province of charitable organizations, is increasingly dominated by investor-owned chains that cherry-pick patients and cut labor costs in order to maximize profits” (Almberg, 2011). The public is confused with the recent arrival of for-profit hospices. The practices and motives of for-profit hospices undermine the reputation of hospice as a valid healthcare option. The overall integrity of care, especially at such a tender time—the end of one’s life—demands ethical business practices. A fairer set of Medicare reimbursement policies would level the playing field for all hospices. By specifying the situations and the reimbursement that specific scenarios warrant, Medicare payment would serve a more appropriate purpose. Care of less expensive patients would be reimbursed at a lower rate, thus the selective admission practices of the for-profits would be thwarted. Likewise, services provided to more intense, costly patients would receive reimbursement more appropriate to the level of care. Iowa City Hospice and non-profit hospices nationwide would benefit immensely from reimbursement reform by gaining credibility and reasserting their presence in administering end-of-life care. For-profit hospices would, in turn, be required to shape up or shut down. They would not be unfairly penalized. After all, non-profit hospices would have to abide by the same rules. The payment structure
would simply be adjusted to recognize the variance in the cost of providing care to patients in different settings and with different diagnoses, effectively ending the "gaming" that currently exists. Medicare payment reform must occur to provide fair compensation for the services offered by hospices (Hoyer, 2009).

Let’s say a patient is admitted to hospice with a nagging chronic illness that has intensified, making the inevitability of death now apparent. The first week or so of hospice care would be somewhat expensive, as the patient’s medications change and symptoms become managed, necessary equipment is brought into the home, and the patient and caregivers process the change to a terminal prognosis (Almberg, 2009). After this time, however, the patient might not need as much direct care from the nursing staff until his or her last days, which could be months after being admitted to hospice. Medicare should take this scenario into account, and give a smaller, more appropriate amount of reimbursement to the hospice that served this patient. On the other hand, in the event of hospice serving a patient with a rare condition that demands more care and resources, for perhaps, a much shorter period of time, reimbursement should be increased (Medicare Payment Advisory Commission, 2004). Iowa City Hospice would not have to worry about a financial hit of any kind. If anything, greater balance between high-expense and low-expense patients would be achieved. In addition, Iowa City Hospice’s new for-profit competitors would have a choice. They could continue their discriminatory admission practices but no longer receive superfluous reimbursement or take all patients, regardless of condition, and receive fair and reasonable compensation or, choose a new “industry” that offers greater profitability. (In which case, they should not have chosen to provide a service.)

Payment reform should also be based upon patient location. Nursing home patients, for example, require less supervision and contact with hospices due to the staff that is always
available on site. This results in less of a demand for hospice in terms of travel and on call, two expenses that are also covered by and factored into Medicare’s fixed daily reimbursement rate. Therefore, it is practical that less reimbursement is required for such patients. On the other side of the spectrum of payment adjustment, Iowa City Hospice, which serves many smaller communities in eastern Iowa, should receive more reimbursement for travel to rural areas. For-profits rarely serve such patients; it is not as cost effective as serving nursing home patients and not as profitable as concentrating on more densely populated urban areas. Non-profit hospices such as Iowa City deserve to be compensated for their efforts to serve the larger community, especially considering the long drives to rural areas and the adverse weather conditions that hospice workers often encounter during their travels. In addition, the location of the patient can also present different emotional needs. A patient at home, for example, often has family and loved ones present, who need support in coping with the situation. Social workers are often needed as well as nurses and aides in helping the family to adjust to a new, uncomfortable scenario (Mahar, 2009). Therefore, additional time and resources are needed in order to teach the family how to care for the patient, and how to care for themselves during a very tumultuous time. In contrast, in the nursing home setting, significantly fewer support visits are needed due to less family involvement.

The diagnosis of the patient must also be considered when awarding Medicare reimbursement. In general, intense utilization of resources is necessary to address the emotional and physical needs of a cancer patient, whereas by comparison the needs of a dementia patient are less demanding. Not only does a cancer patient require more treatments and medications than a dementia patient, more staff time is spent processing the terminal illness with the patient and his or her family. Medicare should consider specific illness and reimburse hospices based upon
the amount of care that was needed for the patient (Peterson, 2011). Data that Medicare is already collecting from hospice providers indicates the number of visits made by the hospice clinicians (National Hospice & Palliative Care Organization, n.d.). By also incorporating data collection of the indirect costs of care such as medications, equipment and treatments, or by conducting random review of claims, Medicare could more accurately determine the appropriateness of reimbursement.

By making the aforementioned changes, Iowa City Hospice would be able to continue serving the community, receiving reasonable reimbursement for the care they provide. This would also lead to a renewed sense of integrity for hospice care. Such changes would reestablish hospice’s original purpose, which was and still is to serve the community. This goal is the sole reason why non-profit hospices such as Iowa City Hospice were originally established and have grown and thrived over the past few decades. Non-profit hospices would still have fair compensation for providing much needed end-of-life care. Meanwhile, it is suspected that, if such changes were implemented in Medicare reimbursement, for-profit hospices whose sole purpose is to maximize income would eventually invest their money in other industries that offer greater earnings potential. Unlike the "get rich quick" schemes that motivated the corporate investors in the palliative care arena, Iowa City Hospice will not leave. Regardless of changes in Medicare reimbursement, Iowa City Hospice will continue to serve patients and families according to their strong tradition of end-of-life care. In carrying out its mission for the community, and therefore, for the right reasons, Iowa City Hospice will continue to do whatever they can in order to serve the community. In the words of Iowa City Hospice founder Martha Lubaroff in speaking about the hospice mission, “You love it, believe in it, and want it to keep going…I’d like it to be here for me.” (Iowa City Hospice, n.d.). Payment reform would align
with the values of non-profit hospices, who for three decades have faithfully administered these irreplaceable, community-driven services.


