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### **Hospice Study Reveals Opportunities to Improve Access, Reduce Costs**

Washington, D.C., June 15, 2009 -- Timely access to hospice care is scarce and may be deteriorating, particularly for minorities, according to a comprehensive study of hospice use released today by the National Alliance for Hospice Access (NAHA).

The study identifies significant barriers to timely patient access to hospice care, especially for the 78% of Medicare decedents who die of non-cancer causes such as Alzheimer's, heart and lung disease and the 14% of Medicare decedents who are non-white.

The massive first-of-its-kind study looked at Medicare claims for the 3.5 million individuals who used hospice care from 2003 to 2007. Data were compiled and modeled by researchers at Avalere, a leading Washington D.C. advisory firm specializing in research, analysis, insight, and strategy for leaders in healthcare business and policy.

Over the five years studied, researchers found that 63% of all Medicare beneficiaries who died of cancer got some hospice care while only 30% of those who died of non-cancer causes received any hospice days. Of all people dying from non-cancer causes, those in Utah, Arizona, Florida, Colorado, Oklahoma, New Mexico, Alabama, Oregon, Iowa, Texas, Missouri and Mississippi stood the best chance of getting hospice care.

Ethnic disparities in the distribution of hospice care were also evident. Nationally, minority access to hospice care trailed access for whites by 23%. Once again, performance varied widely by state. For example, in Mississippi, 42% of non-white, non-cancer decedents received hospice care. The worst performance was in New York where only 8% of non-white, non-cancer patients got any hospice care, nearly half of them for no more than 10 days.

David Daucher who co-founded NAHA, a coalition of 500 family-owned and community-owned hospices in 31 states, said the study was undertaken so there would be a base of rigorous, transparent and data-driven analysis that could be used in formulating major improvements in patient access to hospice care, while reducing the costs of Medicare services.

"Recently, researchers at Duke University proved what was generally believed, that hospice saves thousands of Medicare dollars each time a beneficiary elects the benefit," Daucher said, referring to a 2007 landmark study led by Dr. Donald Taylor, Jr. "But policy-makers have had only national averages to rely on. We knew that a state-by-state, segment-by-segment look at hospice use would shine light on which states demonstrate the best practices for realizing these savings. But we also discovered that minority access to hospice lags well behind access for whites. This must be fixed."

In addition to access, NAHA's study also looked at timeliness of admission to hospice and found that the length of stay for patients in hospices is persistently low for the vast majority of hospice patients, and varies by state, by diagnosis and by race. Nationally, only 16% of hospice patients received 60 to 180 days of care, the range in which, according to the Duke study, quality converges with improving Medicare's total end-of-life care costs.

"The Duke researchers proposed that effort should be spent on lengthening short hospice stays rather than on shortening the long ones," Daucher said, "and they were right. Thirty-eight percent of hospice patients got less than 10 days of hospice care but this varies by state." The best performers, in terms of timely admissions, are hospices in Utah, Arizona, Mississippi, Alabama and Oklahoma.

"Sadly, superior performance may be short lived," Daucher continued. "The best performing states across all dimensions are the same states where relatively longer patient stays put hospices at odds with an outdated 1982 Medicare law that subjects them to harsh demands to return funds they were paid to care for dying patients."

Daucher said that the cap on patient length of stay severely penalizes hospices, regardless of the medical eligibility of their patients and regardless of the fact that, since 1998, beneficiaries have been guaranteed unlimited days of hospice care as long as they meet Medicare's own eligibility guidelines.

In 2000, Medicare clearly laid out the rules; former CMS Administrator, Nancy Ann DeParle sent a message to the nation's hospices to encourage them to care for all terminally ill patients, regardless of how long they might live. "There is a disturbing misperception that hospices and beneficiaries will be penalized if a patient lives longer than six months," she wrote in a letter dated September 12, 2000. "Nothing could be further from the truth. . . In no way are hospice beneficiaries restricted to six months of coverage. There is no limit on how long an individual beneficiary can receive hospice services as long as they meet the eligibility criteria."

Medicare released its own hospice eligibility criteria for non-cancer patients in the late 90's but the criteria were never empirically tested. In fact, according to Daucher, a growing body of research indicates that these "local coverage determinations" for hospice care, are non-predictive of a terminal prognosis. "In the absence of evidence-based Local or National Coverage Determinations, hospices have developed arbitrary hospice admissions standards that vary widely by state, by hospice, by diagnosis, and possibly by race, and that arbitrarily restrict access," Daucher said. "How else can you explain why minorities are served relatively well in Mississippi, and yet so poorly in New York?"

According to NAHA, providers are hitting the hospice cap at an escalating rate. Estimates for 2006 suggest CMS demanded repayment of hundreds of millions of dollars from hundreds of hospices in over 30 states. For example, 30% of New Mexico hospices, 33% of Utah hospice, 40% of Oklahoma hospices, 50% of Alabama hospices and 60% of Mississippi hospices exceeded the cap in 2006.

"We are seeing independent hospices close their doors under the weight of retrospective cap demands," Daucher said. "Our study shows that hospice access declined for the first time on record in 2007 in Alabama, Mississippi, New Mexico and Oklahoma, the very states that were doing the best job of serving non-cancer and minority patients."

Since 2007, NAHA has been seeking the help of Congress and public policy makers to stem the closing of the independent hospices that have fueled access for non cancer and minority patients. At the same time, MedPAC, the commission that advises Congress on how to spend its Medicare dollars, undertook a study of the Medicare hospice benefit and its growth. In its analysis, MedPAC never revealed the wide gaps in access among states, diagnoses and races, or that the states with the most rapidly growing use of hospice care were also those where access for non-cancer patients and minority patients was the most robust.

“I don’t think MedPAC purposefully set about restricting access for minorities.” said Daucher, “I think they were dealing with limited information and drew some hasty conclusions. NAHA warned them that the hospice cap policy would cause access to decline. Sadly, our study indicates that non-white, non-cancer access did decline in 2007 for the first time ever in Alabama, Arizona, California, Mississippi, New Mexico, North Carolina, Oklahoma, Oregon, and Utah.”

To safeguard access to hospice care NAHA has crafted 2009 hospice reform legislation that will ensure continued patient access, stabilize independent hospices, and save taxpayers billions of dollars. Within the plan, NAHA calls for evidence-based eligibility guidelines that will improve access for all dying patients and proposes replacing the existing retrospective cap with a “pay as you go” reduction in reimbursement for longer-living patients.

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