

## Comprehensive look at hospice use shines light on opportunities to improve access and costs:

- 4 out of 10 hospice patients got no more than 10 days of care
- Only 16% of hospice patients get 60 to 180 hospice days, the range that improves quality and costs
- Minority access to hospice care trails access for whites by 25%
- States where hospices have significant cap issues do best job of serving minorities but access is declining. Will these hospices survive?

### NAHA Report - Barriers to Access: Medicare Hospice Access and Length of Stay, 2003 - 2007<sup>1</sup>

This is the first in a series of NAHA reports that synthesizes NAHA's findings from Avalere's<sup>2</sup> modeling of 2003 – 2007 hospice Access<sup>3</sup> and Length of Stay<sup>4</sup>. Our objective is to better inform end-of-life care policy by providing rigorous, transparent and data-driven analysis of the opportunities to improve patient access to hospice care *and* to save Medicare money.

NAHA's analysis of five years of 100% of Medicare hospice patients' Access and Length of Stay data compiled and modeled by Avalere suggests there are systemic 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 and Chronic Heart and Lung Disease) and the 14% of Medicare decedents who are non-white. Based on our analysis to-date, we see at least three key barriers to patient access to cost-effective end of life care: (i) the absence of evidence-based Local or National Coverage Determinations has resulted in a morass of arbitrary hospice admissions standards that vary widely by state, by hospice, by diagnosis, and possibly by race, and that inappropriately restrict Access, (ii) the aggregate hospice Cap is harming non-cancer and non-white Access, (iii) Access is higher, more timely and more equal across race and diagnosis in states with more independent hospices; Timely Access<sup>5</sup> is generally lower and less equal in states with Certificate of Need limitations or in which hospices are predominantly owned by or closely affiliated with hospitals. Hospice choice improves Access.

1. **Access to hospice was 41.3% nationally in 2007;** 775,294 terminally ill Medicare beneficiaries were admitted to hospice in 2007, but 1.1 million seniors died without hospice care. Access varied widely by state, by diagnosis and by race, suggesting there are systemic barriers to patient access to cost-effective end-of-life care.
  - Access ranged from 62% in Arizona to 24% in New York State, a 38 point gap
  - Cancer patient Access was 66%, non-cancer Access was 34%, a 32 point gap
  - Access for white Medicare beneficiaries was 43%, non-whites 33%, a 10 point gap
  - Access for white cancer patients was 67%, non-white, non-cancer Access was 25%, a 42 point gap
  - Access was highest for white cancer patients in Arizona at 83%, and lowest for non-white, non-cancer patients in New York at 8%, a 75 point gap.
  - The Access gap between non-cancer and cancer patients is lowest in Utah, New Mexico, Mississippi, Kansas, Alabama, Arizona, Oklahoma, Texas, Idaho and Wyoming. All of these states have significant Cap issues.
  - The Access gap between non-cancer and cancer patients is highest in North Carolina, Arkansas, Tennessee, Kentucky, West Virginia, Minnesota, North and South Dakota and Nebraska, which are either Certificate of Need states and/or states where hospices are predominantly affiliated with hospitals.
2. **Access growth trends** slowed dramatically over the 2003 to 2007 period, especially for non-white and non-cancer patients. In fact, 2007 Access declined for the first time on record in the four states most affected by the aggregate hospice Cap, and Access for non-white, non-cancer patients declined in 10 states, again for the first time on record.
  - Growth in total hospice admissions slowed from 8% in 2005 to less than 5% in 2007.
  - Non-cancer admissions growth slowed from 11% in 2005 to 6% in 2007.
  - Non-white, non-cancer admissions growth slowed from 13% in 2005 to 4.5% in 2007

- Access declined for the first time on record in 2007 in Alabama, Mississippi, New Mexico and Oklahoma, mainly driven by declines in non-cancer and non-white Access.
  - Non-white, non-cancer Access declined in 2007 for the first time on record in Alabama, Arizona, California, Mississippi, New Mexico, North Carolina, Oklahoma, Oregon, and Utah.
3. **Length of Stay distribution** did not change materially from 2003 through 2007 for the shortest-staying 80% of patients. We found no evidence supporting MedPAC’s anecdotal concerns that hospices are inappropriately “managing up” patient length of stay. (There is evidence that MedPAC did not accurately measure patient length of stay.<sup>6</sup>) In fact, length of stay remained persistently low for the vast majority of hospice patients, and varied by state, by diagnosis and by race.
- 2.6% of patients received only 1 day of hospice care, 24% received 5 days or less, 38% received 10 days or less, 48% received 15 days or less and 72% received 60 days or less.
  - Only 16% of admissions received 60 to 180 days of care, the range in which quality care converges with improving Medicare’s total end-of-life care costs.<sup>7</sup> (16% of hospice admissions equates to only 7% of all Medicare decedents.)
  - 11% of patients received more than 180 days of care.
  - LOS distribution varied widely by state.
    - ✓ 40% of patients received 10 hospice days or less in 18 states including Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, Washington DC, Florida, Ohio, Illinois and Michigan.
    - ✓ Less than 30% of patients in Oklahoma, Mississippi, Alabama, South Carolina and North Carolina died within 10 days of admission.
  - Average length of stay also varied by state, diagnosis and race. ALOS for the 2003 entering class of non-white non-cancer patients was 117 days nationally, ranging from 240 days in Alabama (90 day median) to 52 days in Connecticut. ALOS for white cancer patients was 55 days nationally, ranging from 76 days in Alabama to 41 days in Connecticut. (About 2% of the patients of the entering class of 2003 were still alive at 12/31/07.)
4. **Timely Access** - Only one out of four Medicare decedents received 10 days or more of hospice care. Timely access was 25% nationally in 2007, 16 points below Access, reflecting the high percentage of very short patient stays.
- Timely Access varied from a high of 40% in Utah to a low of 14% in New York
  - Timely non-cancer access exceeded 30% in Utah, Arizona, Mississippi, Alabama and Oklahoma. It was below 15% in New York, Kentucky, Maryland, DC, and West Virginia, all of which are Certificate of Need states

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<sup>1</sup> The National Alliance for Hospice Access ([www.hospiceaccess.org](http://www.hospiceaccess.org)) is a non-profit grassroots coalition of over 500 independent hospices formed in 2007 to offer America’s independent hospices a voice in urgently-needed hospice reform, and especially fiscally-responsible reform of the aggregate hospice Cap. NAHA has commissioned a comprehensive, independent analysis of Medicare beneficiaries’ hospice Access and Length of Stay for the five year period ending December 31, 2007. We asked Avalere to compile and model five-year trends using Medicare’s standard analytic files for 100% of Medicare beneficiaries who elected the hospice benefit from 1/1/2003 through 12/31/2007. The model groups patients into the “entering classes” of 2003, 2004, 2005, 2006 and 2007 based on the date they first elected hospice care, and includes date of admission, total days of hospice care, state, diagnosis, ethnicity and information about the hospices that admitted each patient.

<sup>2</sup> Avalere is a highly-respected Washington DC based consulting organization that focuses on healthcare research, strategic consulting and public policy. ([www.AvalereHealth.net](http://www.AvalereHealth.net))

<sup>3</sup> Access is defined as the number of Medicare beneficiaries electing hospice for the first time, divided by the total number of Medicare decedents. First time Medicare elections are used to avoid the problem of double-counting patients who live across year-end or who are readmissions; double-counting patients appears to be a problem with MedPAC calculations.

<sup>4</sup> Length of Stay is defined as the total number of patient days of hospice care received by a Medicare beneficiary, regardless of whether those days are consecutive or are interrupted by “live discharge” and readmission. Beneficiaries are grouped into “entering classes” of hospice users based on the year in which they first elected hospice. Length of Stay for the entering class of 2003 is therefore the length of stay of all patients first admitted to hospice in 2003. This allows the model to accurately track

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length of stay for each patient and to produce highly accurate analyses of the distribution of length of stay of all users, and by selected segments of users, e.g. by state, by diagnosis, and by race.

<sup>5</sup> Timely Access is calculated in the same manner as Access, except that admissions that result in hospice length of stay of 10 days or less are not counted.

<sup>6</sup> MedPAC Open Meeting November 2007, Transcript pages 224, 225, 226

<sup>7</sup> Duke University 2007 research - Taylor, D. H.Jr, et al. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? Social Science & Medicine (2007)