The Centers for Medicare & Medicaid Services' Office of Research, Development, and Information (ORDI) strives to make information available to all. Nevertheless, portions of our files including charts, tables, and graphics may be difficult to read using assistive technology.

Persons with disabilities experiencing problems accessing portions of any file should contact ORDI through e-mail at ORDI_508_Compliance@cms.hhs.gov.

REPORT TO CONGRESS

Evaluation of the Rural Hospice Demonstration

Kathleen Sebelius
Secretary of Health and Human Services
2011

Report to Congress: Rural Hospice Demonstration Project

Section 409 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-173 requires that the Secretary provide a report to Congress upon completion of the Rural Hospice Demonstration Project under Medicare. The demonstration was to include no more than three hospice programs over a period of no longer than five years each. The project was intended to provide Medicare beneficiaries who live in rural areas and lack an appropriate caregiver, the option of receiving hospice care in a facility of 20 or fewer beds which offers within its walls the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act. Section 409 of the MMA permitted exceptions to the requirement that hospices provide care in the patient's home and to the requirement that each hospice be subject to the 20 percent aggregate cap on the days of inpatient care reimbursed. Payment would be made at rates otherwise applicable to such care under title XVIII of the Social Security Act. The legislation also allowed the Secretary to require providers under the project to comply with additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate. Upon completion of the project, the Secretary was required to submit a report to Congress on the project that included recommendations regarding extension of such project to hospice programs serving rural areas.

This report includes a summary of the Medicare hospice program, a description of the Rural Hospice Demonstration, changes in hospice utilization during the demonstration, and lessons learned from the demonstration. It also includes the Secretary's recommendation concerning the extension of the demonstration. It was prepared by CMS staff, using findings from the evaluation prepared by researchers at the University of Colorado Health Science Center under a contract with CMS.[1]

[1] The evaluation report is available from the authors. Levy, C., Kutner, J., Fish, R., Hittle, D., Radcliff, T., Walker, B. and Kramer, A. *Evaluation of the Rural Hospice Demonstration.* Division of Health Care Policy and Research, University of Colorado Denver. Aurora, CO, March 2010.

Medicare Hospice Program Background

The Medicare hospice benefit, covered under Medicare Part A, provides palliative care to individuals with a terminal diagnosis who have a prognosis of living six months or less if the illness follows its expected course. It is an elective benefit, which the Medicare beneficiary may revoke at any time. Care is typically provided in the patient's home. Home is defined as the location where the individual resides and may include a private residence, assisted living facility, nursing home, hospice facility, or other location where the patient lives. Caregivers may be a combination of any of the following: the patient themselves, family, friends, volunteers, and paid caregivers. Patients who lack such caregivers may need more support from hospice staff. Medicare services for medical conditions completely unrelated to the terminal condition remain covered for the Medicare beneficiary if he or she is eligible for such care.

An interdisciplinary team consisting of a physician, registered nurse, social worker, and pastoral care or other type of counselor must establish, maintain, and follow a written plan of care for each patient enrolled in the hospice according to Medicare's current requirements in the law for hospices. Hospices are also required to use volunteers to provide services equal to at least 5 percent of total paid patient care hours.

The provision of care varies depending upon the patient's needs and abilities at any given time. Payments under the Medicare hospice benefit are based on four levels of care intensity and resource use: 1) routine home care, 2) continuous home care, 3) inpatient respite care, and 4) general inpatient care. The hospice is required to provide all four levels of care. If the hospice does not operate its own inpatient facility, it must contract with other Medicare-certified providers, such as skilled nursing facilities or hospitals, to provide general inpatient and respite care. Hospices are limited in the number

of days they may bill for inpatient care. During a 12-month period, the aggregate number of general inpatient and respite care days may not exceed 20 percent of the aggregate total number of hospice care days provided to all Medicare beneficiaries by a given hospice agency. Thus, hospices have an incentive to use general inpatient and respite days sparingly. Typically, the general inpatient level of care is used for short periods of time when crises arise in the management of pain or other symptoms. Respite care provides relief to caregivers and is provided for no more than five days at a time in a Medicare-certified facility. Nationally, the distribution of hospice days by level of care in 2007 was: 97.2 percent for routine home care, 2.2 percent for general inpatient care, and the remaining 0.6 percent for continuous care and respite care.

Rural Hospice Demonstration Project Description

The demonstration began October 1, 2005, with an end date of September 31, 2010. Three hospice sites were chosen to participate in the project. Selected demonstration sites were: 1) Haven Hospice located in Gainesville, Florida with two of its rural inpatient facilities, one located in Chiefland and the other in Palatka, Florida, and 2) Sanctuary Hospice House, located in Tupelo, Mississippi.

Haven Hospice has operated in North Central Florida since 1979 with facilities now serving 18 counties and over 13,000 square miles.[2] As stated in their application to participate in the demonstration, they sought to increase outreach efforts, increase inpatient facility occupancy rates, and improve care in the rural communities of Palatka and Chiefland, Florida. Haven Hospice did not request either of the exceptions available as terms of the Rural Hospice Demonstration. They planned to continue providing care in the patient's home as they had done before the demonstration and, because only 6.7 percent of that care was provided at the general inpatient level, they did not request the

[2] Haven Hospice (2010). Overview. Retrieved February 2, 2010 from the Haven Hospice Web Site: http://www.havenhospice.org/about_overview.html.

exception to the 20 percent per-hospice cap on inpatient days of care reimbursed. Few patients were enrolled (participated) in the demonstration at Haven Hospice.

Sanctuary Hospice House sought to provide care exclusively in a facility, as there was a high concentration of hospices providing care in the patient's home in Mississippi, but none of those hospices operated their own inpatient facility in what would become Sanctuary Hospice House's service area. Sanctuary House raised the funds necessary to build a 16-bed, Medicare-certified hospice facility, which was completed in late 2005. They applied for and received the two following exceptions to the Medicare requirements allowed under section 409 of the MMA: the exception that hospices provide care in the patient's home and the exception to the 20 percent cap on inpatient care days reimbursed. The demonstration allowed the hospice to provide the levels of care normally available for the patient in his/her usual home of routine care and continuous home care within their facility, along with general inpatient care. In September 2009, Sanctuary Hospice House became a traditional Medicare hospice by obtaining Medicare certification to provide hospice care in the patient's home.

Findings of the Hospice Program Evaluation

The evaluation team at the University of Colorado Health Science Center examined Medicare benefit claims information and summarized the use of hospice services before (2005) and during the demonstration (2007)[3], in geographic areas affected by the demonstration ("demonstration communities") and in rural areas not affected but in the same state ("comparison communities"). The

[3] The pre-demonstration time period included beneficiaries who died between January 1, 2005 and December 31, 2005. This time period was selected because Sanctuary Hospice House did not begin admitting patients until December 2005, and only five patients were admitted during December 2005. Haven Hospice did not enroll any patients in the demonstration before 2006. The demonstration period (studied by the University of Colorado) included beneficiaries who died between January 1, 2007 and December 31, 2007. The demonstration time frame was chosen to capture utilization patterns that occurred once the demonstration program was fully operational in the second year following demonstration implementation. Calendar years were chosen for analysis to closely match the timeframe when the hospices began enrolling beneficiaries in the demonstration.

evaluation team also collected information to document whether the demonstration sites were able to implement and utilize quality assessment and performance improvement programs. Evaluation findings addressing changes in hospice utilization and responses to the demonstration's terms are briefly summarized below.

Changes in Hospice Utilization

For the nation as a whole, the percent of Medicare decedents using hospice increased from 33.4 percent in 2005 to 38.9 percent in 2007.[4] In Mississippi, the percent of Medicare decedents enrolled in hospice increased significantly during the demonstration in both the Sanctuary Hospice House demonstration community, and in the Mississippi comparison community (not served by Sanctuary Hospice House). However, the increase was larger in the demonstration community. In the Sanctuary Hospice House demonstration community, hospice enrollment rose from 576 to 715, 28 percent of Medicare decedents in 2005 to 38 percent in 2007 (about the national average). In the comparison community, enrollment decreased slightly from 803 to 773, however, the enrollment rate increased from 28 percent of decedents in 2005 to 31 percent of decedents in 2007. As Sanctuary Hospice House did not exist prior to the demonstration, 2005 hospice enrollees in the demonstration community were served by other hospices in that community. In 2007, Sanctuary Hospice House served 154 enrollees, 22 percent of Medicare hospice decedents in its community, while other hospices served the remaining 78 percent of hospice decedents. The type of hospice utilization changed somewhat during the demonstration period relative to before the demonstration in the Sanctuary Hospice House demonstration community. In 2005, 99.6 percent of hospice days in the demonstration community were at the routine level of care, and 0.2 percent was provided at the general inpatient level. In 2007, after the start of the demonstration, 98.5 percent of hospice days in this community were provided at the routine

[4] MedPAC, *Report to Congress: Medicare Payment Policy,* Washington, D.C., March 2010.

level and 1.4 percent of days were provided at the general inpatient level. The percent of total days of care for routine home care was 98.9 percent and 0.9 percent for general inpatient care for the demonstration community excluding Sanctuary Hospice House. And 95.8 percent for routine home care and 4.1 percent for general inpatient care for Sanctuary hospice House. (Refer to the table below.)

Distribution of Total Hospice Days for Medicare Decedents in 2007 (in percents)			
	Demonstration Community	Demonstration Community except Sanctuary Hospice House	Sanctuary Hospice House
Routine Home Care	98.3	98.9	95.8
Continuous Care	0.1	0.1	0.0
General Inpatient Care	1.5	0.9	4.1
Respite Care	1.3	0.1	0.1

Source: Levy, C., Kutner, J., Fish, R., Hittle, D., Radcliff, T., Walker, B. and Kramer, A. *Evaluation of the Rural Hospice Demonstration.* Division of Health Care Policy and Research, University of Colorado Denver. Aurora, CO, March 2010.

This small but significant increase in general inpatient days as a fraction of total hospice days is attributed to an increase in the number of Medicare hospice enrollees who received general inpatient care, and not to an increase in the average general inpatient length of stay by enrollees using general inpatient days. Prior to the demonstration, 3 percent of hospice decedents in the demonstration community received general inpatient care (while under the care of hospices other than Sanctuary Hospice House). During the demonstration (after construction of Sanctuary Hospice House), the percentage of hospice decedents in the demonstration community receiving general inpatient care increased to 19 percent. Of this group of decedents receiving general inpatient care during the demonstration, 63 percent were provided these services at Sanctuary Hospice House. Even though

Sanctuary House served the majority of decedents receiving general inpatient care, the average days per decedent receiving this level of care was lower at Sanctuary Hospice (5 days) compared to other hospices in the demonstration community (10 days).

It is likely that these noted utilization changes were due, in part, to the demonstration because Sanctuary Hospice did not exist prior to the demonstration. Furthermore, Sanctuary Hospice enrolled virtually all of their Medicare hospice enrollees in the demonstration, utilizing the exception of the provision in the law that requires hospices to provide care in the patient's home. (Sanctuary Hospice House only provided services within their facility during 2007.) By contrast, the Haven Hospice sites in Florida enrolled very few patients in this demonstration, not needing to use the exceptions offered by the MMA. Therefore, any changes in utilization of hospice care in Haven Hospice demonstration communities observed by the evaluators were likely due to factors unrelated to the demonstration.

Lessons from the Demonstration

The demonstration sites in Mississippi and Florida had different experiences in identifying and serving Medicare beneficiaries who lacked appropriate caregivers. Sanctuary Hospice House enrolled virtually all of their Medicare patients in the demonstration after hospice staff determined that the patient did not have an appropriate caregiver.[5] Because Sanctuary Hospice House utilized the exception to the requirement that hospices provide care in the patient's home and only provided care within their facility, it was not expected that Sanctuary staff would attempt to find other caregivers for their patients even though it had a large volunteer base. By contrast, few Medicare beneficiaries were enrolled in the demonstration at Haven Hospice in Florida because facility staff identified caregivers for many of their patients who initially lacked an appropriate caregiver through use of its volunteer base.

[5] Demonstration enrollment information was self reported by Sanctuary Hospice House and Haven Hospice staff. Accuracy of this information could not be verified. Patients had to be treated in a hospice's inpatient facility in order to be enrolled in the demonstration under the terms of the legislation.

Therefore, the large majority of these patients was able to receive hospice care in their home and, therefore, did not participate in the demonstration.

The exceptions provided under the Rural Hospice Demonstration project will not be needed by any of the demonstration sites to continue operations following completion of the demonstration. Sanctuary Hospice House began operations in 2005 using the exception to the requirement in the law that requires hospices to provide care in the patient's home and anticipated only providing care within the facility. Beginning in September 2009, however, Sanctuary Hospice House became a traditional Medicare hospice by obtaining certification to provide hospice care in the patient's home. The exception to this requirement is no longer needed. Furthermore, Sanctuary Hospice House did not exceed the 20 percent per-hospice inpatient cap, for which they had requested an exception, during the demonstration. Four percent of the days of care that they provided were inpatient days during 2007. Therefore, this exception is not necessary for future operations. Haven Hospice did not request exceptions to either of these Medicare requirements referenced above. Therefore, business operations at the Haven Hospice demonstration sites in Palatka and Chiefland, Florida apparently were not altered by participation in the demonstration.

Both hospice programs were able to implement and utilize quality assessment and performance improvement programs (QAPI). Under the demonstration, Sanctuary Hospice House and Haven Hospice collected and aggregated data for eight quality measures on all of their patients, regardless of whether they were enrolled in the demonstration, and they were encouraged to utilize the data as part of their QAPI programs. This point is significant because these hospices demonstrated an ability to operate QAPI programs prior to the effective date of the 2008 CoPs that required, for the first time, that all Medicare-certified hospices implement quality improvement programs.

Finally, it is important to note that findings from this demonstration cannot necessarily be generalized to other hospice programs serving rural areas. Findings are based solely on those sites and surrounding communities that were reflected in the demonstration's evaluation.

Recommendation

The demonstration ended on September 30, 2010, and neither of the two statutory exemptions is needed for either of the demonstration participants to continue operations. While Sanctuary Hospice House used the exception of the requirement to provide care in the patient's home at the outset of demonstration (i.e., when the hospice was first established), the Hospice found that it was not in its business interest to continue operations without providing care in the patient's home.

The findings from this demonstration, as outlined in the evaluation, cannot necessarily be generalized to other hospice programs serving rural areas—they are based solely on those sites and surrounding communities. Therefore, the Secretary does not have enough information to make a recommendation concerning expanding this model to other hospice programs serving rural areas.