# Trends-in-Medicine

**February 2006**

*by Lynne Peterson*

**SUMMARY**

Competition has increased overall. Not-for-profit hospices are trying to target more non-cancer patients, and for-profit hospices want to enroll more cancer patients. ♦ The key cost cutting area for 2006 is pharmacy. Hospices are increasingly using a pharmacy to help manage pharmacy costs, with inappropriate use of brand name drugs the key target, especially Johnson & Johnson's Duragesic. ♦ A nursing shortage is affecting the entire industry. ♦ Educating some referral sources – especially oncologists, cardiologists, and pulmonologists – is proving difficult, and experts plan to redouble their efforts. ♦ Palliative care is a growing trend, but it isn't clear whether that will be a positive or a negative for hospice. It could feed in more patients or cause them to enter hospice much later. ♦ The outlook is for more consolidation in the hospice field, more professionalism, and more use of nurse practitioners. Changes in reimbursement are also expected, but no one knows what they will be.



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## TRENDS IN THE HOSPICE INDUSTRY

The Hospice and Palliative Care Nurses Association (HPNA) and the American Academy of Hospice and Palliative Medicine (AAHPM) held a joint meeting in Nashville TN from February 8-11, 2006. Twenty-five hospice medical directors and nurses as well as officials of several companies serving the hospice industry were interviewed.

There were some interesting differences between this meeting and the one two years ago. In 2004, the large for-profit hospice chains – and several wannabes – all had a prominent presence and large booths on the exhibit floor. This year, there were attendees from each of the major for-profit companies, but their presence was low-key, and none of them had a booth. The National Hospice and Palliative Care Organization (**www.nhpco.org**) meeting is April 26-28, 2006, in San Diego, but none of the for-profit chains is listed as exhibitors at that meeting either.

While the industry continues to be dominated by not-for-profit hospices, the for-profit chains – RotoRooter/Vitas, Odyssey, VistaCare, HCR Manor Care, Southern Care, and Hospice South – are having a growing influence. And new players, both large and small, continue to enter the market. For example, United Healthcare is poised to become a major player, and small hospices are getting licensed with the goal of making money for their founders by getting bought.

Yet, there is room for all of these players. An expert estimated that only about 20% of eligible patients currently take advantage of their hospice benefit. Nationally, the average length of stay was 57 days in 2004. And nationwide one-third of patients entering hospice have an average length of stay of only seven days. An expert estimated that more than 50% of cancer patients – but only 10% of terminal heart patients – die on hospice.

**The Hospice Industry**

| Business model | 2004 | 2002 |
|---|---|---|
| Not-for-profit | 63% | 78% |
| For-profit | 31% | 17% |
| Government | 6% | 5% |

*Source: National Hospice and Palliative Care Organization (NHPCO)

Medical directors generally indicated their 2006 budgets are flat to slightly up (3%-5%) compared to 2005. The key focus this year is cost-savings, and the areas getting the most attention are pharmacy and labor, in that order. Interestingly, most not-for-profit medical directors did not know what their per-day cost per patient is. A for-profit medical director said, "Our cost is $6.47 per day today, but not-for-profits don't know theirs." And he was right.

## PHARMACY

Pharmacy costs are the primary area where hospices hope to cut costs and save money in 2006. The drugs most commonly used by hospices are pain killers, particularly morphine in its various dosage forms, oxycodone, and hydromorphone. The medical director of a New Hampshire not-for-profit hospice said, "Most physicians don't pay attention to pharmacy costs…We need to educate doctors who start patients on these medications." A Michigan doctor said, "It is a struggle to find a balance between open access and the management of chemotherapy, marrow stimulators, etc. We are trying to apply evidence-based criteria for effectiveness. Where there are no good data, we challenge the physician on why something is being used…If people believe that to get all the hospice benefits they have to give up a chemotherapy drug with a 1 in 50 chance, our problems will only get worse. It is a dilemma for us because I know a lot of people who could be helped with hospice but don't want our help. They want something else. Traditional medicine dangles that 1 in 50 chance in front of them." A Texas doctor said, "Hospice patients come with a 'last prescription for the road.' Often, they haven't even started the medications, but their referring doctor wants them to leave with something."

Most sources said they would like to decrease their use of morphine and increase their use of methadone. The medical director for a California not-for-profit hospice said, "There isn't much patient or family resistance to methadone. They accept it when they see the efficacy. I rarely change a medication just because of cost, but methadone is more effective and less expensive." The medical director of a New England not-for-profit hospice said, "We've been trying to promote methadone for 2-3 years, but we've been very unsuccessful. There is a lot of anxiety over use. Even our pharmacy management company is antsy over it."

Medical directors also said they are trying to educate referring physicians that the most expensive, brand-name drugs are not necessarily the best agents or most-cost effective drugs for hospice patients. The medical director of a Maryland not-for-profit hospice said, "Primary care physicians often use more expensive drugs when you can use older and generic medications. A lot of education of attending physicians is needed."

The medication costs that most concern medical directors are high-priced brand name drugs, particularly pain killers and antibiotics. Overall, they want to use more generics wherever possible and reduce use of inappropriate brand name opioids and fentanyl. A speaker said, "Unless there is a good reason to be on fentanyl (e.g., not able to swallow or significant renal insufficiency), I leave them where they are, but the next time it doesn't work, I ask if we can try something else. When it is time to change, I move them to a morphine." The general manager of a Louisiana for-profit hospice said, "We were spending an ungodly amount on pharmacy, but we found a pharmacist to work with us and developed our own formulary, and we will continue this effort."

The drug that sources most often said they want to use less of this year is: **Johnson & Johnson's Duragesic** patch (fentanyl transdermal system). This is the No. 1 problem drug for most hospices. Not only is it expensive, but it can be diverted. In illegal use, it is sometimes frozen and cut into small squares referred to as "chiclets." Some medical directors said they have had problems getting patients off fentanyl, especially patients in group homes, but an expert said, "I don't have trouble getting patients off." A Midwest doctor said, "We are not trying to cut back on Duragesic overall but just to be sure it was chosen in a deliberative process. There are times when it is absolutely the right thing and avoiding it would be the wrong thing." A not-for-profit medical director said, "Duragesic is a very popular drug in long-term care. It is hard to change nursing home behavior on that, but we try to get patients on more appropriate medications. We try to use Duragesic only when the patient can't swallow."

Duragesic is not the only drug being targeted. Medical directors said they hope to reduce their use of a variety of other medications this year, including:

- **Bisphosphonates.** A speaker said, "One argument for using them was pain reduction, but a recent article said they don't contribute that much to pain relief…For patients with hypercalcemia, it depends on the patient's performance status. If the performance status is good, then it may be reasonable to continue a bisphosphonate in a preventive fashion – but not for prevention of osteoporosis."
- **Atypical antipsychotics.** Sources insisted that Haldol (haloperidol) is usually a better and less expensive drug for nausea and agitation in hospice patients than Lilly's Zyprexa (olanzapine), Johnson & Johnson's Risperdal (risperidone), etc.
- **Alzheimer's Disease and ALS drugs.** An expert said, "Aricept (Pfizer, donepezil) and Reminyl (Johnson & Johnson, galantamine) have no role. Even if the family wants one of these drugs, you are not, as a hospice, required to cover the cost because they are not considered effective. The same is true for riluzole (Sanofi-Aventis's Rilutek)."
- **Other brand name medications.**
  - **Amgen's Apogent** (erythropoietin)**.** Sources were mixed on the value of this. A speaker said, "A recent article found EPO doesn't help fatigue." But other sources pointed out that EPO can make some patients feel better.
  - **Boehringer Ingelheim/Pfizer's Spiriva** (tiotropium).
  - **Cephalon's Actiq** (oral transmucosal fentanyl citrate). A not-for-profit medical director said, "Actiq is never on our formulary. I don't think it is appropriate."
  - **Johnson & Johnson's Levaquin** (levofloxacin).

- **Lilly's Vancocin** (vancomycin).
- **Novartis's Sandostatin** (octreotide acetate).
- **Pfizer's Neurontin** (gabapentin). Several experts said this drug is over-used in hospices, and one recommended using Pfizer's Lyrica (pregabalin) instead since it is similar but cheaper.
- **Roche's Kytril** (granisetron hydrochloride).
- **Sepracor's Xopenex** (levalbuterol hydrochloride).
- **Wyeth's Ativan** (lorazepam).

➢ **Certain combination therapies.** A speaker suggested watching:

- Combination therapies for nausea.
- More than one opiate in the same patient. She said, "There is no science yet to support adding a morphine to fentanyl or combining sustained release opioids."
- A proton pump inhibitor plus an H2 blocker. She said, "You only need one of these, not both. You should question why the patient is on both."

However, statins are not generally a target. None of the medical directors mentioned statins. Statins are covered under Medicare Part D or a patient's drug plan, not the hospice benefit, so changing the statin prescription does not affect the hospice's bottom line. Yet, Dr. Susan LeGrand, an oncologist from the Cleveland Clinic, urged hospice medical directors to eliminate Pfizer's Lipitor (atorvastatin) and other statins, not just switch patients to generic statins. She said, "Lipitor is the first thing that can go as far as I'm concerned…Statins are the easiest thing not to cover."

Dr. LeGrand warned medical directors that writing an order "titrate to comfort" is ethically inappropriate. She explained, "Other than advanced practice nurses, nurses don't have a license that lets then choose the dose. When you give a range, you are asking a nurse to step outside her license parameters and pick a dose, and that is really not appropriate. Instead, you can say a specific dose for mild patients and another dose for severe patients…Or, you can say to start with one dose and increase to a higher dose if the first dose is not effective in 15 minutes. Ranges are not appropriate. Titration is not appropriate except for advanced practice nurses."

What should a hospice do about a patient that is already on expensive brand name drugs when requesting hospice care? An expert advised several medical directors to either turn those patients down or be prepared to pay for the high-priced medications because switching the patient after admission to hospice may be difficult. An expert said, "Don't cover a drug until you have discussed it thoroughly because it is hard to take coverage away." Dr. LeGrand said, "You can refuse a patient, but you can't take a patient and refuse a therapy." A medical director said, "We turn down patients if they want aggressive therapy and are really not interested in hospice and palliative care."

Will there be a backlash against restrictive hospice formularies as baby boomers age? An expert doesn't think so. He said, "The workforce today accepts managed care and managed care formularies, and that is what hospice is. Baby boomers will be more conditioned to managed care and accepting of it in hospice." Another source said, "Baby boomers lived well, and they will want to die well."

## Chemotherapy

Most hospices simply can't afford to take patients on high-priced chemotherapy drugs such as Genentech's Tarceva (erlotinib) for non-small cell lung cancer (NSCLC) – and those drugs are generally not considered part of hospice care. Only when Medicare patients are ready to give up on those therapies can hospices take them, though several sources said they would like to see a Medicare carve-out in the future that allowed patients to get some of these medications and still qualify for hospice if the life expectancy is less than six months. However, some private carriers will cover ongoing chemotherapy in hospice, usually as a carve-out, and some hospices are beginning to take patients on certain chemotherapy treatments. A speaker said, "One of the newer drugs that will be problematic for you is sorafenib (Bayer/Onyx's Nexavar, a newly approved oral therapy for renal cell carcinoma). It makes people stable for a long time, so it may not be appropriate for hospice. The reason for approval was stability of disease, so you really need to look at coverage of that."

## Pharmacy management

Nearly every hospice has a formulary, but those formularies can differ dramatically.

- **Symptom-based formularies.** These are generally less irritating to physicians, can be an educational tool, and integrate with pain and symptom management treatment guidelines. The approval of the medical director or pharmacist is required for: third-line agents, HIV antivirals, injectable drugs, compounded medications, and symptom-related medications not on the formulary.
- **Diagnosis-based formularies.** These cover medications related to the terminal illness, but are not necessarily related to a symptom. For example, a diagnosis of terminal heart failure may cover calcium channel blockers, beta blockers, and digitalis.
- **Open vs. closed formularies.** Closed formularies are the most cost effective, but the experience with HMO closed formularies turned many people off them. Opening a formulary "a little" is often the compromise – patients and physicians like that, though it doesn't save the hospice as much money.

**Open vs. Closed Formularies**

| Issue | Open formulary | Closed formulary |
|---|---|---|
| Positives | • Flexible<br>• Patients happier<br>• Physicians less threatened<br>• Allows education | • Follows organization's treatment guidelines<br>• Less costly |
| Negatives | • Treatment guidelines not always followed<br>• More costly | • Physicians feel frustrated<br>• Patients doing well don't want to change<br>• May negatively affect referrals |

The five most common approaches to pharmacy management are:

1. **Self-management.** This really is not only an option for a large group/chain or an academic center, but smaller hospices said they are finding that they are not as good at it as they thought. A doctor from a large medical center that chose this option explained, "We looked at national pharmacy management companies and stayed with our own pharmacy. We don't want to do mail order, which the large pharmacy management companies want. That is how they save money. We do seven-day fills. They could get our per day cost to $11-$12, but we got it to less than $9.50-$10 a day ourselves."
2. **Hospice groups** that get together as a consortium to buy drugs. They get better pricing but have to negotiate with local pharmacies on where to storage, inventory, stocking, etc.
3. **Owning the pharmacy**. This is really only an option for big hospices.
4. Contract with a **pharmacy management provider** either as:
   - Fee-for-service with a negotiated price for the medication, generally something less than average wholesale price (AWP) + a fill charge.
   - Per diem, with a set amount per day that fixes costs. There are generally incentives for staying in formulary and extra charges for going out of formulary.
5. **Mail order.** Large pharmacy providers use this cost-effectively, and it solves delivery issues for chronic pain.

Half of the hospices questioned said they use a pharmacy management company, and nearly all of these have contracted with Omnicare/ExcelleRx's Hospice Pharmacia. A few sources said they use HospiScript, PharMerica, and Mary Pharmacy. For example, VistaCare uses Caremark, and Vitas uses Hospice Pharmacia. A Vitas source said, "We have modified Hospice Pharmacia's formulary some to accommodate our practice patterns but not entirely. We are reviving our Pharmacy and Therapeutic Committee and will work with Hospice Pharmacia on our practice patterns and guidelines. A VistaCare source said, "What we do differently is open access. If someone has true benefits from a truly expensive drug, we cover it." Another medical director said, "Our parent has a pharmacy program, but we have our own local pharmacy. I looked at Hospice Pharmacia, but it is much more expensive than what we do locally."

Hospice Pharmacia and HospiScript, the two leading pharmacy management firms, differ markedly in their approach to pharmacy management. Hospice Pharmacia customers were generally very happy with the service, and none have plans to change pharmacy management companies. An ExcelleRx official estimated that from 25%-33% of hospice patients in the U.S. get their medications from his company, which operates in 47 states and has a daily census >50,000. He said the challenges for pharmacy management include:

- Getting the medication in a patient's hands.
- Compliance with the medication regimen. This was described as an underappreciated issue.
- Growing the evidence base. The official said, "The evidence base is growing by leaps and bounds, but it is undeveloped compared to cardiology, for example."
- Efficiency. He said, "There is a potential to be more efficient in getting patients the medications they need in the time frame they need."

In addition to mail order, Hospice Pharmacia offers a prescription card that allows a four-day supply of medications for emergencies. An official said, "We also provide and encourage use of a 'Comfort Pak.'" There also is no penalty or added cost if a hospice wants a short supply (e.g., 7 days) of a medication.

Hospice Pharmacia is participating in two CMS chronic care improvement projects, one with American Healthways and another with Cigna. An official said the hope is that these studies will lead to "an integration of the good symptom management from the hospice world to palliative care (pre-hospice)." A pilot study also is in the discussion stage that will look at performance scores and Karnofsky scores and the amount of medication that was needed or discarded. The goal is to see if there is a certain level of disability where the drug supply should be reduced.

Hospice Pharmacia also appears to be benefiting from the experience its new parent, Omnicare, has in nursing home pharmacy administration. ExcelleRx and Omnicare are working closely together this year on the next version of Hospice Pharmacia guidelines, which include the formulary, and these are due out in October 2006.

A HospiScript official claimed his company is becoming a more serious competitor, with ~350 customers in 43 states. He claimed to be in negotiation right now with four large for-profit hospices, including one of the major public companies.

He said his company is just starting to market itself and cited these advantages to HospiScript:

- **Flexibility.** "We say a hospice needs freedom. We make recommendations, but we are more open access. There is no penalty for choosing a certain medication. Our formularies are designed to fit each hospice. More than 50% of our customers choose to use our formulary, but we also offer a custom formulary, and even if a customer is on our formulary, they can go inside or outside the formulary without a financial penalty."
- **Local pharmacy participation.** "We encourage the participation of local pharmacies. We have mail order on request, but we think local pharmacy is important."
- **Medication discounts.** "We don't charge a per diem, just a discounted price for the medications. The least savings we can achieve for a customer is 19%, and often it is far more."

### Other pharmacy cost control measures

➢ **Emergency kits.** Many hospices are now using what they call "comfort care kits." These are prepackaged kits with small doses of medications to anticipate patient emergency needs, things that might be needed in a crunch. A speaker said, "I think it is very hard not to have emergency kits unless there is a pharmacy next door…What we did is have one-fill charge for four medications. We save three-quarters of the fill charges by doing the four medications together. It is sometimes wasteful, but we don't waste a huge amount because the doses are small."

➢ **Fill time.** Decreasing the length of medication fills is a way to save money – e.g., prescribing just three days of a new medicine or seven days of a proven medication. This approach also reduces diversion.

## LABOR ISSUES

A national nursing shortage makes labor a big problem, but it appears to be a problem for everyone, not just not-for-profit hospices. Several not-for-profit hospice sources said they continue to lose nurses to larger for-profit hospices, particularly chains, but most insisted the real problem is an overall shortage of nurses, not any "raiding" by the for-profit hospices. Among the comments by medical directors on nurse staffing were:

- *California not-for-profit:* "Nurses do musical chairs, not just for money but also for professional growth or life circumstances. Some want upward mobility or a lifestyle change." The medical director of a West Coast for-profit hospice said, "We are not losing nurses to for-profit chain hospices. Just the opposite. We have nurses come to us from giant for-profits who feel they were pressured to take care of too many patients, felt depersonalized, didn't like the time pressures or the decrease in quality."
- *Hawaii not-for-profit:* "We have a big nursing problem in Hawaii. Hospital nurses are heavily unionized, and we had a traumatic nursing strike. Hospice nurses are not unionized, so recruiting is difficult."
- *Texas for-profit:* "Staff turnover is a big problem. We lose staff because of RNs who want to stop nursing, go back to a hospital environment, or go to another hospice to avoid call. We aren't paying much more than non-profits."
- *Ohio for-profit:* "There are retention issues everywhere. If a nurse doesn't like what she is doing, she can leave and have another job in 15 minutes, so there is no incentive to work through issues."
- *Maryland not-for-profit:* "We are always looking for RNs. It is always hard to find the right nurses."
- *Michigan not-for-profit:* "The for-profit chains are actively and aggressively trying to hire our nurses. Their strategy is to hire the staff from a non-profit, which gives them a capable work force and cripples the competitor. And they can pay more than we can."
- *Louisiana for-profit:* "Our nursing shortage was compounded by Hurricane Katrina. We don't pay more than other hospices, but we get nurses who like our tuition assistance, support for certification, benefits, and more one-on-one workload."

Labor costs are a major area where hospices would like to save money, not by lowering salaries, but by making their staff more efficient. A California doctor said, "We are trying to reduce emergency visits by training nurses to anticipate after-hours situations." A Texas medical director said, "Pharmacy is under control. Now our problem is call (emergency patient visits), which has to do with how well nurses anticipate patient needs. Even with Comfort Paks, there is often a need for a nurse to be there. Night and weekend nurse calls are an issue we think we can address with more nurse training."

## COMPETITION

Competition has increased, with 3,650 hospice programs across the country. In some areas, up to 40 different hospices competing for the same patients. Sources did not report any significant changes in who their competitors are from last year, though a Louisiana hospice manager said she is starting to do more advertising because local competitors are advertising heavily. The medical director for another for-profit hospice said, "The market is becoming relatively saturated around the country. In some areas 60% of deaths have hospice involved. The rising tide raises all boats analogy doesn't apply because the tide is not getting higher. People are competing more with each other. Only 70%-80% of deaths really could be served by hospice." The medical director of another for-profit hospice said, "Competition has increased,

but the competition raises awareness, and raising awareness helps everyone."

Many of the differences between public (for-profit) and private (not-for-profit and some for-profit) hospice businesses are starting to blur. A California not-for-profit hospice doctor commented, "These days the differences are disappearing because the not-for-profit hospices are picking up the same business model to survive and be competitive…The major difference today is not the for-profit or not-for-profit status but whether the hospice is national or regional. There is some advantage to being a national company that can hold people to national standards. Some of the for-profit chains have pushed for standards, and they hire national level people who look at the bigger picture." Another West Coast for-profit hospice doctor said, "Functionally, there is very little difference, though the obvious difference is the financial structure."

Everyone is competing for the same patients, sources generally agreed. And that means targeting any patients eligible for hospice. However, some hospices, particularly smaller hospices, specialize. A source explained, "Some hospices are better at one patient than another. Some focus on cancer; others expand to dementia or nursing homes. I see some niche process occurring."

**Hospice Patient Profile**

| Business model | 2004 |
|---|---|
| Cancer | 46% |
| End-stage heart disease | 12.2% |
| Dementia | 8.9% |
| Debility | 8.2% |
| Lung disease | 7.1% |
| End-stage kidney disease | 3.1% |
| Other | 14.5% |

*Source: NHPCO

Two years ago, not-for-profit medical directors were accusing for-profit chains of cherry picking the most profitable patients while they had to take all comers. Now, the shoe is on the other foot. A for-profit medical director accused not-for-profit hospices of cherry picking, "We have open access, but local not-for-profits are picking and choosing their patients. One won't take anyone without a caregiver. And I have to take all HIV patients, and they won't."

Some hospices, most notably some large for-profit chains, have gotten into trouble with Medicare caps, and sources said this was the result of an effort to build their census with nursing home patients who lived too long (> 6 months). The medical director of a not-for-profit hospice said, "The cap issue has stabilized. The fiscal intermediaries are better educated, so the issue has improved, but it isn't going away. Most hospices, regardless of size, will continue to struggle with this. They won't have the growth explosion they had in the past, but growth will continue." Another medical director said, "Some for-profit chains got in trouble by pushing for long-term care patients, and the focus is now changing to look at more shorter term patients, more home patients instead of long-term care facility patients. Nursing home patients increased the census quickly, but they didn't die, and some are very expensive, and they get very expensive as they start to die."

A common theme among medical directors, whether from not-for-profit or for-profit hospices, was the need to educate physicians – particularly oncologists and cardiologists – better about hospice. A source said, "As we educate doctors, more community doctors are making referrals from their office instead of from the hospital, those hospital referrals are still No. 1." Another medical director said, "Physician marketing is really tough. Physicians are inundated with pharmaceutical and DME (durable medical equipment) sales reps, so it is a challenge to educate them."

The most profitable patients were described as non-cancer patients with relatively long (but less than six months) stays and little need for expensive medications. A Maryland medical director said, "The most profitable patients are non-cancer diagnoses like dementia and stroke where the need for expensive treatment or medications is generally lower." A California medical director said, "The most profitable patients are the ones who live the longest…with low resource utilization – for example, heart failure or Alzheimer's Disease patients…On cancer patients, we generally break even or make a small profit. We are growing our number of non-cancer patients, but cancer patients are still 80% of our census." A Tennessee doctor said, "Heart failure patients are more profitable because they have a longer length of stay." A Michigan doctor added, "Patients with dementia or debility who are in long-term care or assisted living facilities are the most profitable." A Texas doctor said, "Dementia patients are the most profitable – if we don't get into cap problems."

Many hospices also are increasing their focus on patients diagnosed with (a) "failure to thrive" and (b) "end-stage senescence." A Texas doctor said, "These are not difficult to target. We can find them through physicians and through family referrals." These are both considered valid diagnoses.

In this environment, referral patterns have changed somewhat from two years ago. **Not-for-profit** medical directors said their hospices are now targeting more non-cancer patients in an effort to ***increase*** the length of stay. Their comments included:

- *Missouri:* "We have too many oncology patients, and we want to focus on non-cancer patients. We need longer lengths of stay, but they are getting shorter and shorter. So, we are focusing on earlier enrollment…We created a team geared at long-term hospice to focus on nursing homes, assisted living facilities, etc."

- *Maryland:* "We just focus on whether the patient is appropriate for hospice…Length of stay is still ***way*** too short. We want to lengthen it to closer to six months… We'd like to increase the number of non-cancer patients because there are more non-cancer patients. There are lots and lots of non-cancer patients (not in hospice)…Our patients come mainly from hospitals, community nursing homes, and private physicians with nursing home patients."
- *California #1:* "Hospices are trying to reach out to non-cancer patients, but the fiscal intermediaries still are stuck on historical trends. It is easier to justify cancer patients to them. When a non-cancer patient lives more than six months, then the fiscal intermediaries red flag the charts, so some large hospices decided the risk is too high with non-cancer patients, but nationally most hospices are not reacting by targeting more cancer patients…Good hospices are trying to increase their mix by targeting certain groups, facilities, or physicians – for example, by marketing to neurologists or psychiatrists to try to get Alzheimer's patients."
- *New Hampshire:* "We are trying to increase length of stay, but we can't ignore that oncologists are doing a better job of maintaining patients longer, so when they send them to us, it is not just for medical management but for end of life issues for the family."
- *Tennessee:* "We are taking on a lot of nursing home patients to increase our length of stay."
- *Michigan:* "We are plagued with low length of stay."
- *California #2:* "Most of our patients come from our HMO contracts. That is our area of growth. A good deal of our patients come from a health system alliance."

In contrast, officials of each of the large **for-profit** chains said they are now targeting a ***more balanced mix*** of patients. For for-profit hospices that have focused in the past on longer-term patients, especially nursing home patients, this means a shift to more focus on cancer patients. One of the problems they face in doing this is hospices with hospital in-patient units which have visibility they don't. Comments included:

- *California for-profit:* "Most of our patients are frail elderly in nursing homes, and we are looking to find patients with a longer length of stay."
- *Texas #1:* "What we've done is emphasize home care and we are opening in-patient units to balance our mix. Most in-patient units generate short length of stay patients; ~50% never go home."
- *Texas #2:* "We started targeting shorter lengths of stay patients in 2002 to get doctors in the habit of thinking of hospice. Many doctors don't think of us at all. We found some thought it was too late to call…They are less profitable but they increase awareness and referrals."
- *Texas #3:* "We are targeting patients with longer length of stay, particularly pulmonologists for COPD patients and geriatricians to get dementia patients earlier. Pulmonologists are reluctant to give up their COPD patients because they are profitable for them, and cardiologists think their patients will never die."
- *Florida:* "Only 44% of cancer patients in the U.S. die on hospice, so it is an underserved market. Oncology patients are harder to get. Often they are at home, so you have to go to the doctor's office and meet with the doctor. Dementia and Alzheimer's patients tend to be in nursing homes."

Few sources said they had found any new loopholes in terms of patients to target or in reimbursement. However, a Texas doctor said he is doing more pre-hospice consults, "A Pre-hospice consult is paid by Medicare. At the patient's request, we can go in and do one pre-hospice consult in a patient's lifetime. The consults are not well reimbursed, so we lose money on that visit, but if we find a patient, it lets me call the doctor and discuss the case."

A poster presented by Vitas researchers (Barry Kinzbrunner MD and David Tanis PhD) found that patients who are younger, an ethnic minority, or have cardiovascular disease are the most likely to revoke hospice services. They also found that cancer patients who revoke have a relatively higher risk of dying soon after revocation, and respiratory and neurological patients had the best survival. They examined records of 1,082 patients in Florida who revoked hospice services from 1999-2002. Dr. Tanis said, "We should work harder to keep cancer patients, and possibly we are getting respiratory and neurodegenerative patients too early."

**Patients Who Revoked Their Medicare Hospice Benefit**

| Measurement | Patients who revoked to seek traditional care n=1,082 | Patients who died on hospice n=36,006 |
|---|---|---|
| Average age | 74.8 years | 78.1 years |
| Black or Hispanic | 44% | 27% |
| CV disease | 16% | 13% |
| Average days of care before revocation | 60.3 days | --- |
| Admitted to home care | 59% | 37% |
| Admitted to in-patient hospice care | 21% | 43% |
| 90-day survival | 65.8% (48% of these were cancer patients) | --- |
| 90-day survival for cancer patients | 42% | --- |
| 180-day survival | 58.4% | --- |
| 270-day survival | 50.5% | --- |
| 360-day survival | 50.3% | --- |
| 360-day survival for cancer patients | 41.7% | --- |
| 360-day survival for patients with debility or neurodegenerative disease | 60.6% | --- |

Some **health plans** also are looking at the hospice space. United Healthcare opened its first hospice a couple of years ago in Phoenix, but the company has indicated it intends to get into the hospice business more aggressively. Most medical directors interviewed at the AAHPM meeting knew very little about United Healthcare's plans, but they did have some concerns.

- *Maryland not-for-profit:* "United probably will change the competitive landscape. My impression is that there are so many as yet unserved patients who are eligible for hospice, that they won't squeeze us. I wonder if they will have self-referral issues."
- *Texas:* "United is struggling to figure out the best way to do this, but I think they've decided to focus on providing a service to their enrollees instead of marketing to a broader market – at least initially."
- *California not-for-profit:* "They will change the landscape. They have a captive patient population they can tap into, so they will be less dependent on community referrals."
- *Michigan not-for-profit:* "If they have the ability to execute contracts with major health systems and nursing homes where we draw patients, it could hurt us."

### Acquisitions

Most of the medical directors questioned had no interest in having their hospice acquired by a larger hospice, but several said they have seen other, generally small, hospices that were trying to position themselves as acquisition targets in what was described as a "profiteering strategy." No source could point to any pending acquisitions, however.

### Public for-profit hospices

What kind of growth can be expected from public companies? A not-for-profit medical director said, "With baby boomers aging, I think they will continue to grow." A California doctor said, "I think they will see significant growth because they make money." Another source said, "The fastest growing segment of hospice is for-profit. I think there is space for all of us."

## Foundations

Often, hospices set up subsidiary foundations that allow them to accept donations, but the practice remains controversial, especially when the hospice is a for-profit business. One concern is that the foundation money might be used to lower the hospice's costs (e.g., the CEO's salary or heating bills). A speaker described another concern, "Foundations can create ethical issues for medical directors, especially if the money comes from patient donations…For-profit hospice foundations are concerning."

## Regulatory Issues

Most sources do not believe CMS is overly concerned with fraud and abuse in the hospice field. A source said, "CMS is more concerned with home healthcare…Home health palliative care is new and not on the CMS radar. Home health has convinced CMS that palliative care is a skilled need." However, a medical director of a for-profit said, "CMS scrutiny of hospice has increased. They are looking at the percent of patients with particular diagnoses and documentation. But it is not a huge issue."

CMS reportedly has proposed a new rule that would require that a physician be at a patient's bedside within one hour of prescribing a medication as a form of restraint, and the proposed rule would mandate that the medication order is only good for four hours. A speaker called the proposed rule a "nightmare," predicting it would make palliative sedation difficult, especially for amyotrophic lateral sclerosis (ALS) patients. She said, "I hope we can talk CMS out of this one."

What will Medicare Part D do to hospice? Dr. LeGrand said, "I'm sure it will help to a degree," but it still leaves the donut hole problem. Part D also is not a way for hospices to get out of paying for medications to which hospice patients are entitled.

Board certification is both increasing and changing. Many nursing homes – particularly large for-profit chains – are more frequently requiring that their medical directors be certified. Currently, doctors who already are board certified in a medical specialty such as family medicine, geriatrics, internal medicine, etc., can get certified in hospice and palliative care by taking an exam offered by the American Board of Hospice and Palliative Medicine (ABHPM), but this is the last year ABHPM is offering a certification exam.

In the future, hospice and palliative medicine will be a subspecialty overseen by the American Board of Medical Specialties. The first ABMS exam will be given in 2008. Doctors who are already certified by ABHPM will have five years to take the new ABMS exam and get a new certification. After that, only doctors who have completed a two-year residency in hospice and palliative medicine will be eligible to take the ABMS certification exam. However, only MDs (not DOs) who are already certified in one of seven specialties are eligible for ABMS certification in hospice and palliative medicine: anesthesiology, family medicine, internal medicine, physical medicine and rehabilitation, psychiatry and neurology, surgery, and pediatrics. However, ABHPM officials said they expect an osteopathy certification will be developed through the American Osteopathic Association Bureau of Certification.

### THE FUTURE

Over the next five years, sources predicted the hospice industry would continue to grow. A source said, "Growth has been 10%-20% a year for the last five years, and I think that will continue. The census of most hospices is going up despite a very competitive marketplace."

Sources pointed to several trends they expect to occur in hospice over the next five years:

1. **Consolidation will continue.** Sources predicted that Mom & Pop hospices will disappear. One oft-cited advantage to large hospice groups/chains is their greater ability to pay for things that smaller not-for-profit hospices can't afford. The medical director of a Texas for-profit hospice said, "Our owners have had a lot of offers." A Midwest doctor said, "The hospices that will be left will be affiliated with or owned outright by the local health system, by a large for-profit, or a regional non-profit. Mom & Pops will be gone…It will be much like what Wal-Mart does to Mom & Pop stores when it comes to a town."

2. **More non-cancer patients** will be treated.

3. Hospice will become **more sophisticated,** with more professionalism and higher quality. A for-profit medical director said, "Compared to not-for-profits, for-profit hospices are more disciplined, more efficient, more interested in professional development, and more evidence based…We want all our medical directors to be board certified. We push for that, and we pay for it."

4. **Hospice will become more "medicalized."** Hospices will try to get more carve-outs approved so they can cost-effectively treat patients with more complex diseases and more costly medications and therapies. A Midwest medical director also predicted that there will be more physician management, not just medical directors. A for-profit medical director wondered, "Should hospice begin to take patients on advanced cancer treatments?"

5. **Changes in Medicare reimbursement** will occur, though sources didn't know what they would be. Where the hospice industry goes in the future is likely to depend on what happens to Medicare reimbursement because that is still the No. 1 payor. A Maryland doctor suggested, "Hospice may have a big contraction if Medicare cuts the hospice benefit, but we are still planning for growth." An Ohio medical director said, "Medicare will reimburse differently, and I don't know if it will cause the industry to grow or die."

6. **Increased education of doctors, patients, and families about hospice.** A medical director said this would "make patients more willing to forego futile care." Another expert said, "We've already gotten the low hanging fruit. Now, we need to figure out how to reach the 60%-65% of the dying population who don't know about or don't choose hospice…We will need to be more flexible and more adaptable." A third source added, "African Americans have not accepted hospice. It is a cultural thing. They have a lack of trust in the medical community. Even with outreach, only 8%-12% of African Americans are in our program, but our area is 46% African American."

7. **Nurse practitioners and advanced practice nurses** will be more widely used.

8. **Alternative therapies** may see greater acceptance.

9. **Expansion of palliative care,** by home health agencies and hospitals. This could be either a positive or a negative for hospice. On the positive side, it could be a bridge that helps educate people about the benefits of hospice and encourage more people to take advantage of hospice. On the other hand, patients could stay in palliative care so long that hospices wind up with mostly very sick, expensive, short-stay patients.

A study by Dr. Dana Lustbader at North Shore University Hospital found that a palliative care team can save a hospital money. She said her team cost $500,000 in calendar year 2005 and did 775 consults (40% cancer, 15% heart failure, 10% COPD, 10% stroke, 25% sepsis and multiorgan failure). Although the team only generated $100,000 in billing, the hospital estimated it saved ~$1.3 million, primarily in reduced length of stay, which declined from an average of 24.4 days to 14.4 days.

Among the comments on palliative care were:

- "Anyone who thinks that in 10-15 years we will, as a standard of care, be running a 85-year-old patient with heart failure for a mega workup and admission to a hospital is wrong…Palliative care will be standard of care for elderly sick patients because our population is exploding, and unless we get a different party in charge of approving the budget quickly, you will see Medicare reimbursement continue to be cut…Palliative care is the way of the future…It is the only way to get quality outcomes and still control costs…Palliative care is a field that is just beginning."
- *California not-for-profit:* "There will be more and more large hospices, and they will provide more aggressive high-end palliative care. Data show that a more open-door policy brings patients in sooner, even if it means a few days of TPN (total parenteral nutrition), Epogen, or more radiation. And this approach captures patients who otherwise wouldn't be captured. You need a large hospice to do that – to spread the cost – but it will bring in more patients…There is growing tension between hospice and palliative care on how palliative care will impact hospice. It could help us or hurt us. Personally, I think it will help increase referrals and the transition to hospice, but the devil is in the details."
- *Florida not-for-profit:* "I think we need to use the hospice benefit properly before we go to palliative care programs."
- *Michigan not-for-profit:* "Palliative care could enhance hospice. As palliative care increases, it will be easier to get CMS changes."

- *Missouri for-profit:* "We did a palliative care service thinking it would increase referrals, but I think the opposite occurred. Some families are choosing palliative care over hospice because they get the same care without the terminal diagnosis."
- *Texas for-profit:* "MD Anderson Cancer Center increased its palliative care program, and now it refers more patients to hospice, and they have longer length of stay. It's only 11 days, but that's much longer than it was."
- *Texas not-for-profit:* "I think we are moving to more palliative care. VistaCare opened a 29-bed palliative care unit with Emory University. Palliative care will change the growth rate. It will be less explosive and more gradual."

A poster by researchers at the Joan Karnell Cancer Center in Philadelphia predicted that hospice length of stay has and will continue to decline because more agents to treat cancer "may increasingly delay referrals to hospice until active disease-remitting treatment is not an economic and philosophical disincentive for hospice referral…Declining performance status as opposed to exhaustion of available therapeutic agents will increasingly become the indicator for hospice referral."

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