



# In Hospice Care, Longer Lives Mean Money Lost



Ozier Muhammad/The New York Times

For Charles Brown Jr., 81, with his wife, Cora, growing old in Wilcox County, Ala., means care from Hometown Hospice. [More Photos >](#)

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CAMDEN, Ala. — Hundreds of [hospice](#) providers across the country are facing the catastrophic financial consequence of what would otherwise seem a positive development: their patients are living longer than expected.

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[Uncertainty at Hometown Hospice](#)

Over the last eight years, the refusal of patients to die according to actuarial schedules has led the federal government to demand that hospices exceeding reimbursement limits repay hundreds of millions of dollars to [Medicare](#).

The charges are assessed retrospectively, so in most cases the money has long since been spent on salaries, medicine and supplies. After absorbing huge assessments for several years, often by borrowing at high rates, a number of hospice providers are bracing for a new round that they fear may shut their doors.

One is Hometown Hospice, which has been providing care here since 2003 to some of the most destitute residents of

Wilcox County, the poorest place in Alabama.

The locally owned, for-profit agency, which serves about 60 patients, mostly in their homes, had to repay the government \$900,000, or 27 percent of its revenues, from its first two years of operation, said Tanya O. Walker-Butts, a co-owner. Its profits were wiped out in the time it took to open the demand letters, Ms. Walker-Butts said.

Hometown paid its first assessment with a bank loan. When the bank declined credit for the second year, the hospice structured a five-year payment plan with the Centers for

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Medicare and [Medicaid](#) Services, the federal agency that administers the program, at 12.5 percent interest.

The next bill is expected any day.

“If they hit us with a number in the several hundred-thousand range, I just don’t see how we can survive,” said Gaines C. McCorquodale, Hometown’s other owner.

In the early days of the Medicare hospice benefit, which was designed for those with less than six months to live, nearly all patients were [cancer](#) victims, who tended to die relatively quickly and predictably once curative efforts were abandoned.

But in the last five years, hospice use has skyrocketed among patients with less predictable trajectories, like those with [Alzheimer’s disease](#) and [dementia](#). Those patients now form a majority of hospice consumers, and their average stays are far longer — 86 days for Alzheimer’s patients, for instance, compared with 44 for those with lung cancer, according to the Medicare Payment Advisory Commission.

The commission, which analyzes Medicare issues for Congress, recently projected that 220 hospices — about one of every 13 providers — received 2005 repayment demands totaling \$166 million. The National Alliance for Hospice Access, a providers’ group that is lobbying for a three-year moratorium on the collections, places the numbers at 250 hospices and \$200 million.

Because fewer than a tenth of all hospice providers have faced repayment, Medicare officials suggest that management might have been an issue. But Lois C. Armstrong, president of the hospice access alliance, said that if the cap on Medicare reimbursements was not lifted, the availability of care would tighten at a time when demand for hospice care was exploding and when new research suggests it saves money for the runaway Medicare program.

Many elderly people here in the remotest reaches of the state’s Black Belt would most likely live out their last days alone if not for Hometown Hospice nurses like Meg Appel Youngblood.

One recent autumn morning, Ms. Youngblood forded the Alabama River by ferry and set off on her rounds of the storied quilting enclave of Gees Bend, looking in on old women who had grown too feeble to quilt or to care for themselves.

Inside a clapboard house, she checked the vital signs of Loretta L. Pettway, a former farmhand whose stitchwork has been celebrated in postage stamps and picture books, and found that her [blood pressure](#) was a bit high.

“Miss Loretta, have you had your medicine?” she asked, and Ms. Pettway, 65, weary from chronic heart disease, shook her head no. “I didn’t think so,” Ms. Youngblood said, as she started to inventory the 14 pill bottles Ms. Pettway had stowed in a plastic bag.

Medicare’s coverage of hospice, which began in 1983, has become one of the fastest growing components of the government’s fastest growing entitlement. Spending nearly tripled from 2000 to 2005, to \$8.2 billion, and nearly 40 percent of Medicare recipients now use the service.

To be eligible, patients must be certified by two doctors as having six months or less to live, assuming their illness runs a normal course. They must agree not to bill Medicare for curative procedures related to their diagnosis.

Medicare, which pays the vast majority of hospice bills, reimburses providers \$135 a day for a patient’s routine home care. The hospice is then responsible for providing nurses, social workers, chaplains, doctors, drugs, supplies and equipment, as well as bereavement support to the family.

Studies have reached various conclusions about whether hospice care actually saves money, especially for long-term patients. But a new study by [Duke University](#)

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researchers concluded that it saved Medicare an average of \$2,300 per beneficiary, calling hospice “a rare situation whereby something that improves quality of life also appears to reduce costs.”

In 1998, Congress removed limits on the number of days that an individual could receive Medicare hospice coverage, a move that encouraged physicians to refer terminal patients.

But lawmakers did not remove a cap on the aggregate amount that hospice providers could be reimbursed each year, a measure designed to contain the program’s cost. A hospice’s total annual reimbursement cannot exceed the product of the number of patients it serves and a per-patient allowance set by the government each year (\$21,410 in 2007).

For reasons that are not fully understood, problems with the cap have been most prevalent at small, for-profit hospices in Southern and Western states like Mississippi, Alabama and Oklahoma.

Those programs typically have had higher proportions of noncancer patients and, thus, longer lengths of stay. But the Medicare advisory commission’s analysis also determined that the average length of stay in the cap-busting programs was significantly higher for all types of patients, including those with cancer.

Herb B. Kuhn, the deputy director of the Center for Medicare and Medicaid Services, said that finding was attracting attention at the center, which is eager to keep the hospice care benefit from morphing into a long-term care entitlement. “Well over nine out of 10 hospices seem to be managing well, including the ones in higher-wage areas, so it does raise an issue of management,” Mr. Kuhn said. Mr. Kuhn said it remained a question whether hospice care saved money, but called it “a wonderful benefit” that “probably needs refinement” after nearly 25 years.

Among the matters meriting review, he said, is whether doctors have been premature in certifying patients as terminal. Medicare has issued disease-specific guidelines for the certifications, which must be made by both a personal physician and the hospice medical director.

The medical director at Hometown Hospice, Dr. Sumpter D. Blackmon, said he relied heavily on the judgment of the hospice’s nurses to determine whether prospective patients were rather likely to live longer than six months. But of the 56 patients on the books on Oct. 31, 17 had been there for at least that period, including two for more than 500 days.

“Doing this for 40-something years,” said Dr. Blackmon, a longtime physician here, “every time I think somebody is going to die tomorrow, damned if they don’t live for a year and a half.”

A number of hospice providers said ethical and legal constraints would prevent them from discharging patients who outlived their profit potential. But some said they sometimes delayed admission for those patients with illnesses that might result in longer stays.

Like other providers, Richard R. Slager, the chairman and chief executive of VistaCare, which is based in Arizona and has programs in 14 states, said his company now aimed its marketing at cancer patients.

“In communities where we have had cap issues, we have to really look hard for shorter-length-of-stay patients to offset it,” Mr. Slager said. “It’s a never-ending nightmare.”

After being hit with \$200 million in cap charges over four years — the equivalent of a year’s revenues — Mr. Slager said he chose to close or sell 16 of 58 hospices.

Some providers have survived only by aggressively recruiting new patients, using this year’s Medicare reimbursements to pay off last year’s cap charges, while stalling for

Congressional relief. Ms. Youngblood, the Hometown Hospice nurse, said that after she visited her charges — doling out their pills, and turning the sweet potatoes in their ovens — she trolled for new patients at [nursing homes](#) and senior centers.

At the small hospital here, she said, the nurses joke about her “marketing” forays: “They’ll say, ‘Here comes Nurse Kevorkian. She has no shame.’ And I’ll say, ‘Look, I have to have a paycheck, too.’”

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