National Hospice and Palliative Care Organization

Hospice Action Network

THE MEDICARE HOSPICE BENEFIT

The National Hospice and Palliative Care Organization (NHPCO) is the largest membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 3,800 hospice programs that care for the vast majority of hospice patients in the U.S. NHPCO is committed to improving end-of-life care and expanding access to hospice so that individuals and families facing serious illness, death, and grief will experience the best care that humankind can offer.

The Hospice Action Network, an NHPCO affiliate and national hospice advocacy organization, is dedicated to preserving and expanding access to hospice care in America. Our mission is to advocate, with one voice, for policies that ensure the best care for patients and families facing the end of life.

We fight to ensure compassionate, high-quality care for all Americans facing a life-limiting illness by:

- Expanding an ongoing and influential presence on Capitol Hill,
- Mobilizing a growing network of Hospice Advocates throughout the nation,
- Empowering, through new and innovative techniques, an interactive community connecting the public with Hospice Advocacy, and
- Cultivating relationships with the media to highlight issues impacting end-of-life care.

The Medicare Hospice Benefit was established in 1983 to provide Medicare beneficiaries with access to high-quality end-of-life care. Considered the model for quality care for people facing a life-limiting illness, hospice is a patient-centered, cost-effective philosophy of care that utilizes an interdisciplinary team of healthcare professionals to provide compassionate care including expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Patients may receive care at their place of residence (including their private residence, nursing home, or residential facility), a hospice inpatient facility or an acute care hospital. 66% of patients choose hospice care where they reside.

Table 1. Location of Hospice Patients at Death[1]

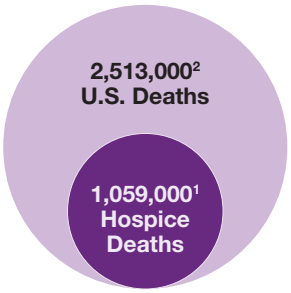
Location of Death	2011	2010
Patient's Place of Residence	66.4%	66.7%
Private Residence	41.6%	41.1%
Nursing Home	18.3%	18.0%
Residential Facility	6.6%	7.3%
Hospice Inpatient Facility	26.1%	21.9%
Acute Care Hospital	7.4%	11.4%

Figure 1. Interdisciplinary Team

An interdisciplinary team of professionals is responsible for the care of each hospice patient.

Hospice focuses on caring, not curing. Under hospice, support is provided to the patient's loved ones as well.

Figure 2. Hospice Utilization in the U.S.[1, 2]



WHO RECEIVES HOSPICE CARE

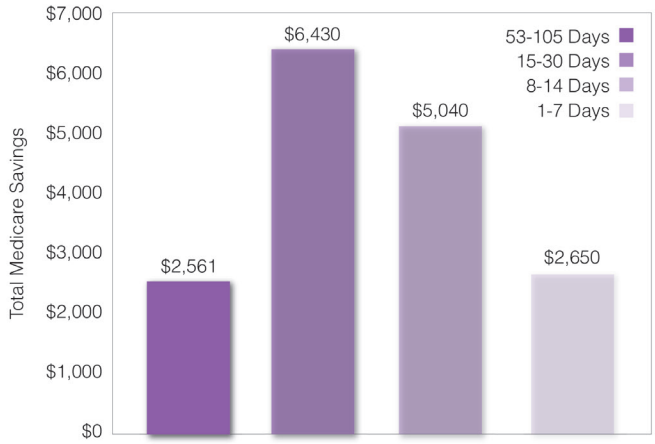
A patient is eligible for hospice care if a physician determines that the patient has six months or less to live if the terminal illness runs its normal course. Patients must be re-assessed for eligibility at regular intervals, but there is no limit on the amount of time a patient can then spend under hospice care. In 2011, an estimated **1.65 million patients received services from hospice.** NHPCO estimates that 44.6% of all deaths in the U.S. were under the care of a hospice program.

1. 2011, NHPCO National Data Set and/or NHPCO Member Database.
2. Hoyert DL, Xu J. Deaths: Preliminary Data for 2011, National Vital Statistics Reports, vol 61 no6. National Center for Health Statistics, CDC, available online at: http://www.cdc.gov/nchs/dta/nvsr61/nvsr61_06.pdf.

HOSPICE RESULTS IN COST SAVINGS FOR MEDICARE

New research out of Mount Sinai's Icahn School of Medicine, published in the March 2013 issue of *Health Affairs*, found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries across a number of different lengths of services.

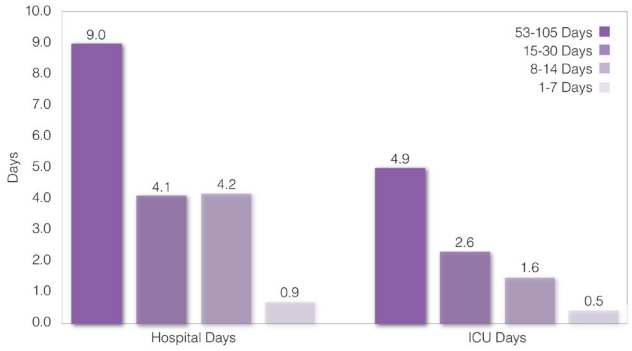
Figure 3. Incremental Effect in Cost Between Hospice and Non-Hospice Groups[3]



Among the key findings:

- Medicare costs for hospice patients were lower than non-hospice Medicare beneficiaries with similar diagnoses and patient profiles.
- Hospice enrollment is associated with fewer 30-day hospital readmissions and in-hospital deaths.
- Hospice enrollment is associated with significantly fewer hospital and ICU days.

Figure 4. Incremental Effect in Days Between Hospice and Non-Hospice Groups[3]



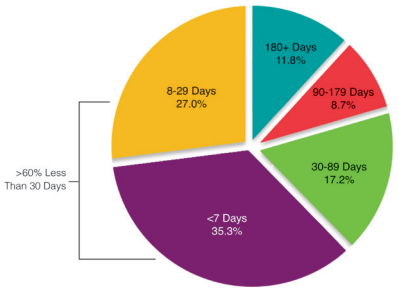
A 2007 Duke University Study published in *Social Science & Medicine*, shows that hospice care in America reduces Medicare program expenditures during the last year of life by an average of $2,309 per hospice patient.[4]

LENGTH OF SERVICE

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay). LOS can be influenced by a number of factors including disease course, timing of referral, and access to care. **The median (50th percentile) LOS in 2011 was 19 days.** This means that half of hospice patients receive care for less than three weeks and half receive care for more than three weeks. **The average LOS is 69 days.**

Approximately 35.3% of hospice patients receive care for just seven days or less.[5] 50.1% of patients die or are discharged within 14 days of admission.[6] Only 11.4% of patients remain under hospice care for longer than 180 days.

Figure 5. Proportion of Patients by Length of Hospice Service[7]



This high percentage of shorter LOS is consistent over the past several years.

LEVELS OF CARE

Medicare pays hospice a flat, per-diem rate that covers all aspects of the patient's care, including all services delivered by the interdisciplinary team, drugs, medical equipment and supplies. 84.1% of hospice patients were covered by the Medicare Hospice Benefit in 2011, versus other payment sources.[8] While the number of beneficiaries using hospice has more than doubled since 2000, hospice comprises only 2 percent of total Medicare expenditures, the least of any direct patient service provider under the program.

Because patients require differing intensities of care during the course of their disease, the Medicare Hospice Benefit affords patients four levels of care to meet their needs: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. **97% of hospice care is provided at the routine home care level, which is reimbursed at approximately $153 per day.**

Table 2. Percentage of Patient Care Days by Level of Care

Level of Care	2011	2010
Routine Home Care	97.1%	95.7%
General Inpatient Care	2.2%	2.9%
Continuous Care	0.4%	1.2%
Respite Care	0.3%	0.2%

3. Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay." Health Affairs 2013; 32(3): 552-561.
4. Taylor DC, Osterman J, et al., "What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?" Social Science & Medicine 2007; (65): 1466–1478.
5. Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay." Health Affairs 2013; 32(3): 552-561.
6. 2011, NHPCO National Data Set and/or NHPCO Member Database.
7. Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay." Health Affairs 2013; 32(3): 552-561.
8. 2011, NHPCO National Data Set and/or NHPCO Member Database.

MARGINS & MEDICARE EXPENDITURES

According to recent MedPAC data, the projected hospice margin for 2013 is 6.3%, or 4.6% once all statutorily mandated services are taken into consideration.[9] Note: This estimate does not include the 2% cut to reimbursements to Medicare providers as mandated by sequestration.

Medicare spending on hospice has risen to nearly $14 billion per year, which still comprises only about 2 percent of Medicare expenditures.[10] This growth in spending on hospice reflects several important factors, including greater awareness of hospice care, which has led to increased utilization of the Medicare Hospice Benefit. Additionally, hospices now serve more patients with non-cancer terminal diagnoses, such as heart disease, COPD and Alzheimer's.

TAX STATUS

Hospice agencies are organized into three tax status categories:

1. Not-for-profit (charitable organization subject to 501(c)3 tax provisions)
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality)

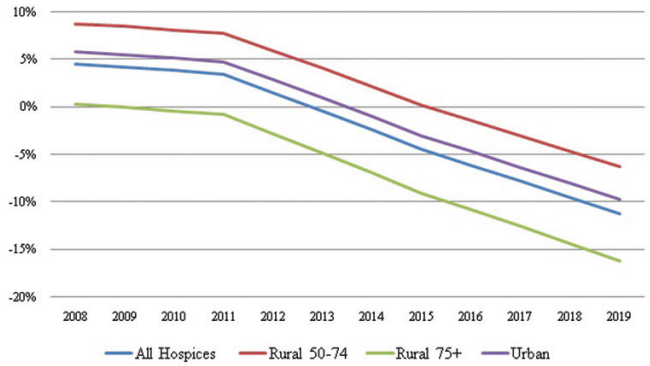
Based on NHPCO membership and survey data, 34% of providers hold not-for-profit tax status and 60% hold for-profit status. Government-owned programs, such as U.S. Department of Veterans Affairs medical centers and county-run hospices, comprise the smallest percentage of hospice providers at about 5%.[11]

RECENT CHANGES: THE PRICE OF CARE

Rate Cuts: A 2009 CMS rule implemented a seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), a key element in the calculation of the Medicare hospice wage index. **Elimination of the BNAF will ultimately result in a permanent reduction in hospice reimbursement rates of approximately 4.2 percent.**

The Affordable Care Act (ACA) further altered the Medicare hospice rate formula through the introduction of a "productivity adjustment factor," that will reduce annual hospice payments by an additional 11.8 percent over the next ten years. Hospice is a highly labor-intensive model of care where productivity gains are not as achievable relative to other areas of our health care system. The Moran Company recently conducted an analysis of the impact of these two cuts on hospice margins over the next decade.

Table 3. Moran Company Analysis - Estimated Median Profit Margins, 2008-2019 (All Hospices, Urban, and Rural Hospices)



Sequestration: Sequestration reductions affect several areas of federal spending, including cuts to Medicare:

- Reductions of 2.0% each year in most Medicare spending, including hospice (total savings: $123 billion)
- Reductions in premium support (resulting in increased beneficiary costs) for Medicare Part B and other spending changes (savings: $31 billion)

Table 4. Cumulative Rate Cuts Affecting Hospice

Rate Cut	Amount	Timeline
Budget Neutrality Adjustment Factor	-4.2% overall	2011-2016
ACA Productivity Adjustment Factor	-11.8% overall	2013-2022
Sequestration	-2% per year	2013-2022

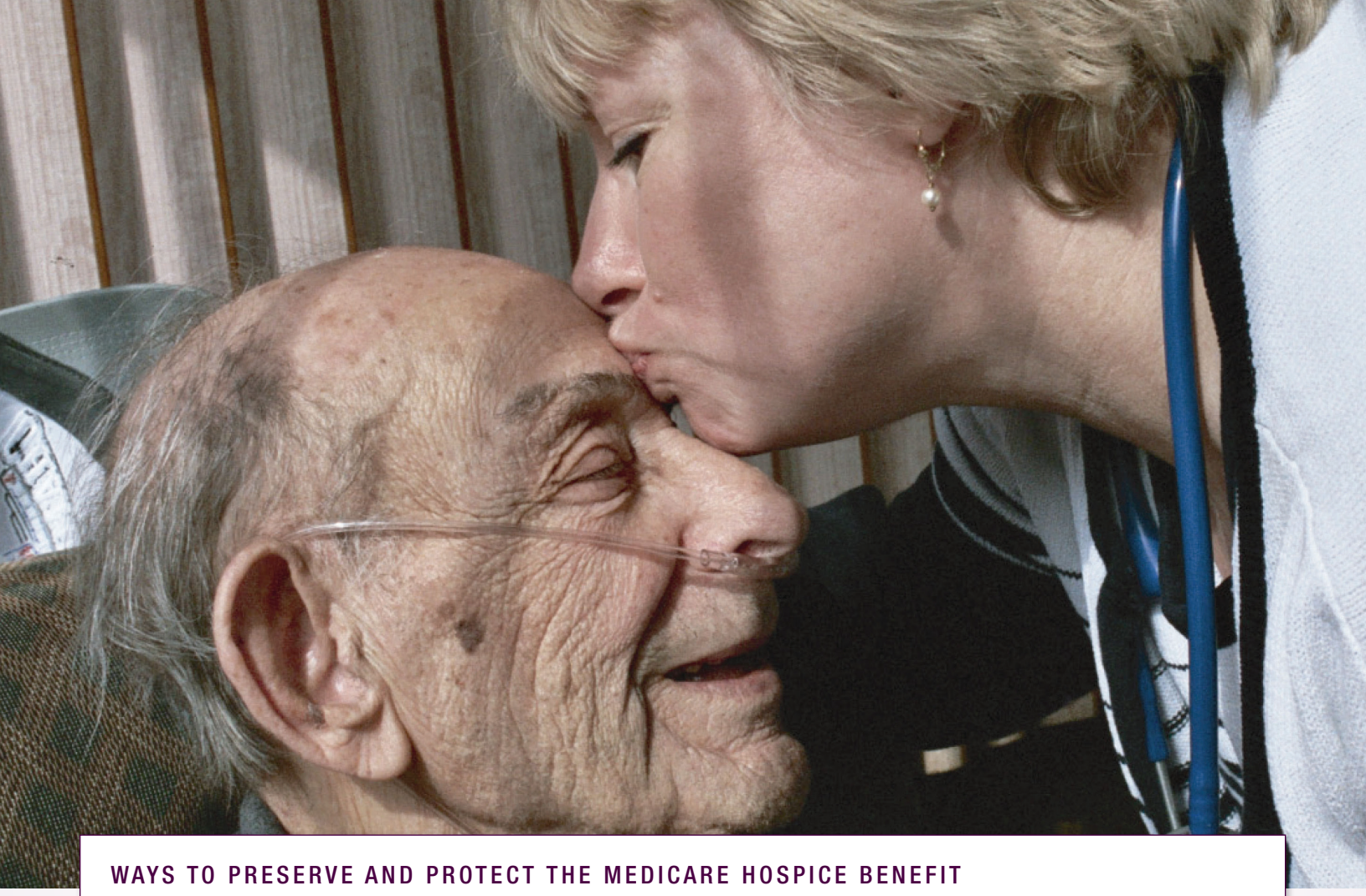
RECENT CHANGES: REGULATORY REQUIREMENTS

Three Medicare hospice requirements around certification and recertification as well as medical review of patients have laid the regulatory groundwork to better ensure that hospice programs are serving only patients who are eligible and appropriate for hospice care. If given the proper time to be impactful and implemented correctly, these requirements should meet the goal of ensuring that appropriate and eligible patients are served by hospice, while also ensuring that hospice programs are able to provide the quality that patients and families desire at the end of life.

Brief Physician Narrative: Effective October 1, 2009, this Medicare requirement calls for the hospice certifying physician to provide a brief narrative statement to explain the clinical findings that support the certification and recertification of terminal illness. The intent is for the physician to record, in their own words, the reasons they believe each patient continues to be eligible for the Medicare Hospice Benefit in each benefit period.

Face-to-Face Encounter: Effective January 1, 2011, Medicare requires that after a hospice patient has completed the first two 90-day benefit periods, the patient must have a face-to-face visit with a hospice physician or nurse practitioner prior to being recertified for the third and any subsequent periods, in order to determine whether the patient continues to be eligible for hospice care.

9. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2013.
10. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2013.
11. 1st Quarter 2012, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).



WAYS TO PRESERVE AND PROTECT THE MEDICARE HOSPICE BENEFIT

- **Enact sensible entitlement reform rather than raising revenue through additional cuts to the Medicare provider community.** Hospices are struggling to absorb the series of regulatory and legislative changes already in place by reducing staff and cutting back on services. Access to high quality and cost effective care will be further jeopardized if the hospice community is subject to additional Medicare reimbursement reductions.

- **Support the HELP Hospice Act.** The hospice community is deeply concerned about the effect further modifications to the Medicare Hospice Benefit will have on quality patient care and access to these valuable services. We ask that the 113th Congress support the Hospice Evaluation and Legitimate Payment (HELP) Act (S. 1053/H.R. 2302), legislation that will (1) require the Secretary to establish a payment reform demonstration program to test and evaluate proposed hospice payment reform, (2) increase hospice survey frequency to every 3 years, and (3) amend the new face-to-face encounter requirement to reflect operational realities for hospice programs, and the needs of the patients and families they serve. The HELP Hospice Act is sponsored by Senators Wyden and Roberts, and Representatives Reed and Thompson and enjoys robust bipartisan support.

Hospice Action Network

1731 King Street • Suite 400 • Alexandria, VA 22314
Tel. 703-837-1500 • Fax. 703-837-1233
www.hospiceactionnetwork.org • info@nhpcohan.org