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. The location of care may change depending on the nature of a patient’s disease progression, medical needs of the patient, as well as the plan of care established between the patient and the hospice. An interdisciplinary team of professionals is responsible for the care of each hospice patient, regardless of the patient’s setting (see Figure 1). In 2013, 66.6% of patients were receiving hospice care at their place of residence at the time of death.

Table 1. Location of Hospice patients at Death

<table>
<thead>
<tr>
<th>Location of Death</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Place of Residence</td>
<td>66.0%</td>
<td>66.6%</td>
</tr>
<tr>
<td>Private Residence</td>
<td>41.5%</td>
<td>41.7%</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>17.2%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Residential Facility</td>
<td>7.3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Hospice Inpatient Facility</td>
<td>27.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>6.6%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

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

Figure 1. Interdisciplinary Team

WHO RECEIVES HOSPICE CARE

A patient is eligible for hospice care if two physicians determine 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 2013, an estimated 1.5-1.6 million patients received services from hospice. According to the Medicare Payment Advisory Commission (MedPAC), in 2013, 47.3% of Medicare decedents utilized hospice care.2
HOSPICE RESULTS IN COST SAVINGS FOR MEDICARE AND BETTER PATIENT OUTCOMES

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 2. Incremental Effect in Cost Between Hospice and Non-Hospice Groups

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 3. Incremental Effect in Days Between Hospice and Non-Hospice Groups

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.

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 2013 was 18.5 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 72.6 days.

Approximately 34.5% of hospice patients receive care for just seven days or less. 48.8% of patients die or are discharged within 14 days of admission. Only 11.5% of patients remain under hospice care for longer than 180 days.

Figure 4. Proportion of Patients by Length of Hospice Service

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. 87.2% of hospice patients were covered by the Medicare Hospice Benefit in 2013, versus other payment sources. 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. 94.1% of hospice care is provided at the routine home care level, which is reimbursed at approximately $156 per day.

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

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>95.0%</td>
<td>96.5%</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>2.7%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Continuous Care</td>
<td>0.5%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Respite Care</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

MARGINS & MEDICARE EXPENDITURES

According to recent MedPAC testimony, the projected hospice margin for 2015 is 6.6%, or 4.9% once all statutorily mandated services are taken into consideration. Note: This estimate includes the 2% cut to reimbursements to Medicare providers as mandated by sequestration.

Medicare hospice spending on hospice in 2013 was approximately approximately $15 billion, which still comprises only about 2 percent of Medicare expenditures. Medicare spending on hospice remained flat between 2012 and 2013 due to sequestration and similar length of stay patterns. The overall growth in spending on hospice care until this point reflects several important factors, including greater awareness of hospice
care, which has led to increased utilization of the Medicare hospice benefit. Additionally, hospices have grown as they are serving 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, 30% of providers hold not-for-profit tax status and 66% 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%.10

**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 7.4 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.

**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 3. Cumulative Rate Cuts Affecting Hospice**

<table>
<thead>
<tr>
<th>Rate Cut</th>
<th>Amount</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Neutrality Adjustment Factor</td>
<td>-4.2% overall</td>
<td>2011-2016</td>
</tr>
<tr>
<td>ACA Productivity Adjustment Factor</td>
<td>-7.4% overall</td>
<td>2013-2022</td>
</tr>
<tr>
<td>Sequestration</td>
<td>-2% per year</td>
<td>2013-2024</td>
</tr>
</tbody>
</table>

**RECENT CHANGES: REGULATORY REQUIREMENTS**

Five 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. Additionally, these changes are happening with payment reform looming in the background. 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.

**Filing of Notice of Election (NOE) and Notice of Termination/Revocation (NOTR):** Effective October 1, 2014, hospices have a maximum of 5 days to submit the NOE and/or NOTR and have the form(s) accepted by their Medicare contractor. Late filing of the NOE will result in the hospice remaining responsible for providing all care and services as detailed in the plan of care but without reimbursement from the Medicare Hospice Benefit for those days.

**Patient Designation of Attending Physician:** As of October 1, 2014, CMS now requires the name of each patient’s attending physician to appear on the NOE, along with an acknowledgement that the identified physician was the patient’s choice. To change the attending physician, the patient or legal representative must provide the hospice with a signed document when the patient decides to change their attending physician.

**Hospice Cost Report:** CMS implemented a new cost report for free-standing hospice providers for cost reporting periods beginning October 1, 2014. Hospice providers will be required to overhaul their charts of accounts in order to collect data on expenses based on level of care. Other changes in forms and data requirements also exist.

**Focused Medical Review:** The ACA incorporated a 2009 recommendation of the Medicare Payment Advisory Commission (MedPAC) that hospice programs with a high percentage of patients qualifying as long lengths of stay (more than 180 days) should have additional oversight through focused medical review. NHPCO has since supported this recommendation. The IMPACT Act provided technical fixes to the ACA language and the provision is now ready for CMS to set the threshold, or percentage, which will trigger medical review.

**Hospice Payment Reform:** The ACA transferred hospice payment authority from Congress to the Secretary of Health and Human Services. The ACA statute requires the Secretary to collect and analyze extensive data prior to implementing a new payment system for hospice. To date, CMS has not identified a specific payment reform proposal for implementation. Action on payment reform is expected as early as 2015.
WAYS TO PRESERVE, PROTECT, AND STRENGTHEN THE MEDICARE HOSPICE BENEFIT

Access. Expand patient and family access to hospice and palliative care across all settings. This includes the exploration/creation of a model of care which allows patients and families to benefit from the coordination and supportive services offered by the Interdisciplinary Team (IDT) earlier in the patient’s disease trajectory, and efforts supporting earlier and routine opportunities for advance care planning.

Workforce. Ensure quality and access throughout the hospice community by: 1) Breaking down barriers health care professionals experience working in hospice through aligning their responsibilities with those they have in other health care sectors; 2) Supporting patient preferences for attending physicians; and 3) Working toward greater hospice and palliative care training across education curriculums.

Reimbursement. Protect Medicare reimbursement levels for hospice. Emphasize targeted, data- and policy-driven reforms that take into account the increasing regulatory and administrative burden for hospices while preserving patient access to hospice services.

Program Integrity. Support an aggressive program integrity approach focused on ensuring the quality of providers by targeting any inappropriate behaviors by providers, and promoting transparency, accountability, and patient choice.

CITATIONS
1. 2013, NHPCO National Data Set and/or NHPCO Member Database.
5. 2013, NHPCO National Data Set and/or NHPCO Member Database.
7. 2013, NHPCO National Data Set and/or NHPCO Member Database.