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Response to Wall Street Journal Article on Hospice

NHPCO offers some insight and key message points about hospice

(Alexandria, Va) – Today’s edition of the Wall Street Journal looks at long-stay hospice patients receiving care under the Medicare hospice benefit. The National Hospice and Palliative Care Organization offers some additional thoughts that are helpful in understanding hospice care provision in the U.S.

The Medicare hospice benefit was designed in 1982 to be the first “managed care” program within Medicare. A flat per diem payment was envisioned, to provide a pool of funds for the hospice program to manage virtually ALL of the patient’s and family’s terminal illness needs.

While designed initially for cancer patients, the Medicare hospice benefit has the flexibility to adapt to changing patient demographics, with hospices caring for a full range of terminal patients and their families. Now, cancer accounts for just over 36 percent of patient diagnoses. With Alzheimer’s and dementia leading the list of non-cancer diagnoses, the hospice patient of today can be far more complex than only a decade ago. It is NHPCO’s belief that the overwhelming majority of hospice programs are striving to be fully compliant while offering a high quality of end-of-life care.

Accounting for long-stay patients is an issue that has drawn both media and regulatory attention and attempts to understand length of service are understandable.

However, the Wall Street Journal article ignores the fact that fully one-third of hospice patients die within seven days, and almost two-thirds of patients die within 30 days. From a financial standpoint, the longer stay patients, assuming they meet eligibility requirements, are the “balance” against the higher cost short stay patients.

And in fact, short stay patients and their families are denied the benefit of the full range of hospice services; what is intended to be compassionate care often evolves into crisis care.

NHPCO has been a long-term advocate calling for increased transparency, program integrity, and accountability and cites the passage of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 as an important advancement for the field that brings more timely and appropriate oversight. A provision requiring CMS to conduct a medical review of providers with patient stays longer than 180 days is an additional safeguard that is still new to the provider community and one we have supported.

The hospice community also supports the newly enacted payment reform that went into effect on January 1, 2016. It pays a higher per diem rate for the first 60 days of care and a lower rate for subsequent days. In addition, the new payment rates provide for reimbursement of additional clinical visits in the last seven days of life.
Additionally, the Centers for Medicare and Medicaid Services has instituted the “face-to-face” rule, requiring physicians to conduct face-to-face visits for recertification of patients who have been under care 180 days and for who continued hospice care is required.

While these measures will not address every outlier of concern, they are important provisions to increase compliance.

NHPCO has consistently stressed that compliance and quality are not optional. If hospice programs are abusing the system, then they ought to be singled-out and their practices corrected.

“Improper admissions or practices by any provider should not be tolerated. Period. That said, care of the dying can be a difficult issue to understand. The journey that every human being takes at the end of life is unique to that person – it cannot be predicted with complete certainty,” said J. Donald Schumacher, president and CEO of NHPCO.

“Research into the provision of end-of-life care is critically important but we must never forget to factor in the myriad of issues that makes a death different from any other. Ultimately, providing the highest quality care possible to dying Americans, which at times can be hard to quantify, must always be at the foundation of a discussion of hospice,” stressed Schumacher.

Hospice care is patient/caregiver/family-directed care with a plan of care unique to each patient delivered by an interdisciplinary team of professionals that includes nurses, social workers, physicians, allied therapists, home health aides, chaplains, bereavement counselors, and trained volunteers. Hospice cares for the “whole” person focusing not only on the physical needs of the patient but also the psychosocial and spiritual needs as well and bereavement services are provided to family caregivers.

**KEY MESSAGE POINTS**

The Medicare hospice benefit is the primary source of reimbursement for hospice care in this country, any a deep examination require analysis of many factors, none of which should be taken lightly when the future outcome – whether imminent or longer term – is death. NHPCO offers some additional points about hospice care in the U.S.

**Dying has Always Accounted for Significant Healthcare Spending**

- Caring for dying patients and the associated costs did not originate with hospice care, although, hospice provides the most appropriate, highest quality, patient-and-family centered care available for people at life’s end.
- Prior to hospice, patients died in hospitals and other settings that cost the government billions.
- Approximately 30% of all Medicare expenditures are attributed to the 5% of beneficiaries that die each year, with a third of that cost occurring in the last month of life; those costs are not solely for hospice care.
Hospice Accounts for 2 to 3 Percent of Medicare Spending

- Yes, there has been growth in hospice care yet it should be stressed that hospice represents only two – three percent of Medicare spending and is serving more than 1.5 – 1.6 million patients every year.

Short-stay and Long-stay Patients are Both Important

- NHPCO reports that in 2014, 35.5 percent of hospice patients receive care for seven days or less; almost two-thirds die within 30 days. This is far too short a period for the patient and family to fully benefit from the services hospice offers.
- As a “managed care type benefit,” the economic assumption underlying the Medicare hospice benefit is that payments will either track or somehow balance out with costs. Higher cost patients would be balanced against lower cost patients. And, there are additional safeguards built into the Medicare hospice benefit to protect against abuses.
- Typically, hospice costs are higher at the beginning of care (when a patient is admitted, stabilized and services are arranged) and at the end of care (when the patient is actively dying).

Existing Compliance Measures on LOS

- The IMPACT Act of 2014 contains an important provision requiring CMS to conduct a medical review of providers with patient stays longer than 180 days is an additional safeguard that is still new to the provider community and one the hospice community supported.
- Payment reform that went into effect on January 1, 2016, pays a higher per diem rate for the first 60 days of care and a lower rate for subsequent days.
- The CMS “face-to-face” rule requires physicians to conduct face-to-face visits for recertification of patients who have been under care 180 days and for who continued hospice care is required.

Six-Month Life Expectancy can be Complicated and Misunderstood

- The Medicare hospice benefit does require a six-month prognosis in order for a person to begin care – but that should not be confused with a limit to care.
- People do not come with an expiration date, nor does their end-of-life-care. Predicting a six-month life expectancy, even on an ongoing basis as required by the federal hospice regulations, is a complex and inexact art and science.
- Ensuring patients are appropriately eligible for hospice must not become a barrier to accessing care for the dying.

Research Confirms Benefits of Hospice Care

- A study from the Icahn School of Medicine at Mt. Sinai, clearly demonstrates higher quality services and better outcomes for the patient and family.
- The provision of quality end-of-life care can reduce hospital costs by reducing readmissions, emergency department visits and intensive care stays.
NHPCO, on behalf of the hospice community, continues to work closely with both MedPAC (a Congressional advisory body) and the Centers for Medicare and Medicaid Services (the hospice community’s principal regulator) to identify problems and fashion responsible and reasonable safeguards to correct gaps in the regulations.

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