National Hospice and Palliative Care Organization

Hospice Action Network

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 4,000 hospice programs that care for the majority of hospice patients in the US. 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

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 professionals to provide compassionate and 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 2014, 58.9 percent[1] of hospice patients received care at their place of residence at the time of death.

Table 1. Location of Hospice Patients at Death

Location of Death	2014	2013
Patient's Place of Residence	58.9%	66.6%
Private Residence	35.7%	41.7%
Nursing Home	14.5%	17.9%
Residential Facility	8.7%	7.0%
Hospice Inpatient Facility	31.8%	26.4%
Acute Care Hospital	9.3%	7.0%

Hospice focuses on caring, not curing. Hospice supports the patient's loved ones as well.

WHO RECEIVES HOSPICE CARE

Figure 1. Interdisciplinary Team

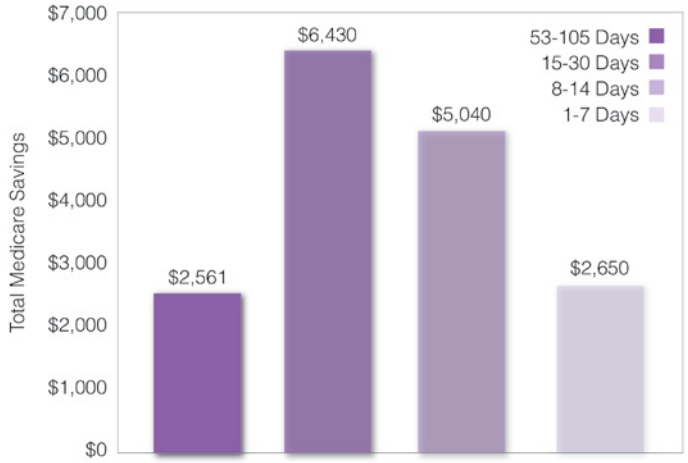
A patient is eligible for hospice care if two physicians determine that the patient has a prognosis of six months or less to live. Patients must be re-assessed for eligibility at regular intervals, but there is no limit on the amount of time a patient can spend under hospice care. In 2014, an estimated **1.6–1.7 million patients received hospice services.** According to the Medicare Payment Advisory Commission (MedPAC), 47.3 percent of Medicare decedents utilized hospice care in 2013.[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 service.

A 2007 Duke University study published in *Social Science & Medicine* shows that hospice care reduces Medicare program expenditures during the last year of life by an average of $2,309 per hospice patient.[3]

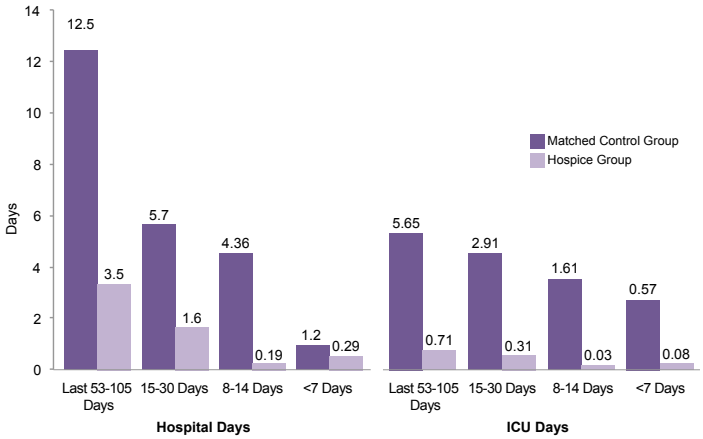
Figure 2. Total Medicare Savings Between Hospice and Non-Hospice Groups[4]



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.

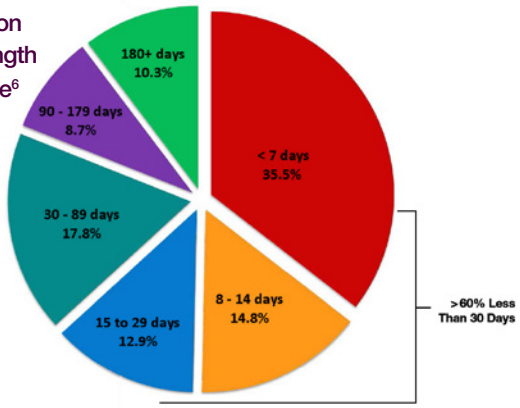
Figure 3. Difference in Number of Hospital and ICU Days between Hospice and Non-Hospice Groups at Different Lengths of Service[4]



LENGTH OF SERVICE

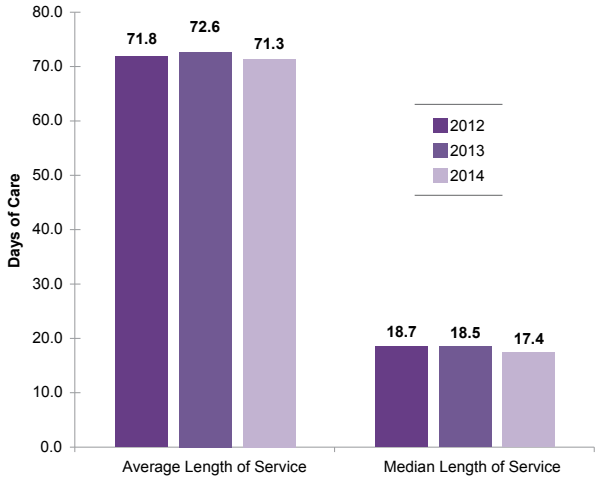
The total number of days that a hospice patient receives care is referred to as the length of service (LOS). LOS can be influenced by a number of factors including disease course, timing of referral, and access to care. **The median (50th percentile) LOS in 2014 was 17.4 days.** This means that half of hospice patients received care for less than three weeks and half received care for more than three weeks. **The average LOS was 72.6 days.**[5]

Figure 4. Proportion of Patients by Length of Hospice Service[6]



In 2014, 35.5 percent of hospice patients receive care for just seven days or less; 50.3 percent of patients died or were discharged within 14 days of admission.[7] This high percentage of shorter LOS is consistent over the past several years. Only 10.3 percent of patients remain under hospice care for longer than 180 days.

Figure 5. Length of Service by Year



LEVELS OF CARE

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. In 2014, **93.8 percent of care was provided at the routine home care level.**

Table 2. Percentage of Patient Care Days by Level of Care[8]

Level of Care	2014	2013
Routine Home Care	93.8%	94.1%
General Inpatient Care	4.8%	4.8%
Continuous Care	1.0%	0.8%
Respite Care	0.4%	0.3%

HOSPICE MEDICARE EXPENDITURES[9]

MedPAC's projected hospice margin for 2015 is 6.6 percent, or 4.9 percent once all statutorily mandated services that are not reimbursed by Medicare are taken into consideration.[9] Medicare does not reimburse hospice providers for bereavement services (1.4 percent) and volunteers (0.3 percent). Note: MedPAC's estimates include the 2 percent cut to reimbursements to Medicare providers as mandated by sequestration.

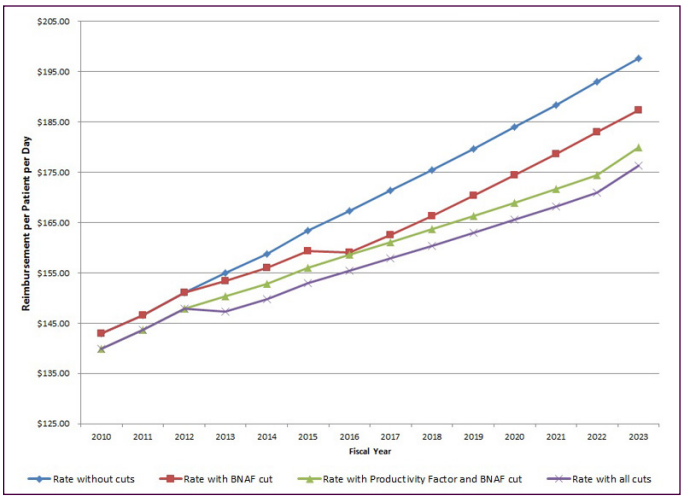
Medicare spending on hospice in 2013 was approximately $15.1 billion. Medicare spending on hospice remained flat between 2012 and 2013, and LOS patterns have remained steady. The overall growth in hospice spending suggests greater awareness of hospice care, which has led to increased utilization of hospice. Additionally, hospices have grown as they are serving more patients with non-cancer terminal diagnoses such as heart disease, COPD, and Alzheimer's.

RATE CUTS AFFECTING HOSPICE

BNAF. 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 by 2016.**

The Affordable Care Act (ACA) further altered the Medicare hospice rate formula through the introduction of a "productivity adjustment factor," which will reduce annual hospice payments by an additional 7.4 percent by 2022. Hospice is a labor-intensive model of care where productivity gains are not as achievable relative to other areas of the health care system.

Figure 6. Hospice Rate Cuts for One Day of Routine Home Care



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

- Reductions of 2.0 percent 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

Rate Cut	Amount	Timeline
Budget Neutrality Adjustment Factor	-4.2% overall	2011-2016
ACA Productivity Adjustment Factor	-7.4% overall	2013-2022
Sequestration	-2% per year	2013-2025

RECENT CHANGES: PAYMENT REFORM[10]

Historically, Medicare pays hospices a flat, per-diem rate that covers all aspects of the patient's care related to the terminal prognosis, including all services delivered by the interdisciplinary team, drugs, medical equipment and supplies. The Medicare Hospice Benefit covered 85.5 percent of hospice patients in 2014.[11] While the number of beneficiaries using hospice has more than doubled since 2000, hospice comprises only 2 to 3 percent of total Medicare expenditures.

For the first quarter of federal fiscal year 2016 (FY2016), the routine home care rate will be $159.34 per day. Beginning January 1, 2016, hospices will experience a new two-tiered payment model for patients served under routine home care. Hospices will be reimbursed $183.17 per day for the first 60 days of a patient's care. The routine home care rate will drop to $143.94 per day for days sixty-one (61) and forward.

Also beginning January 1, 2016, a service intensity add-on (SIA) payment will be made for visits conducted by an RN and/or social worker for up to 4 hours a day (combined) during the last seven days of a hospice patient's life. To qualify for SIA payments for a patient's care, the patient must be receiving routine home care, and the RN and/or social worker must provide direct patient care. The SIA payment equals the continuous home care hourly rate, and is disbursed in addition to the routine home care rate for the days the RN and social worker visits are made.

RECENT CHANGES: REGULATORY REQUIREMENTS

Medicare hospice requirements around certification and recertification, as well as medical review of patients, have laid the regulatory groundwork to better ensure that appropriate and eligible patients are served by hospice, and that hospice programs are able to provide the quality that patients and families desire at the end of life.

Hospice Item Set. Hospice must complete a standardized Hospice Item Set (HIS) for all patients admitted to hospice. Hospices submit HIS data online on a rolling basis within 30 days of each patient's admission and discharge. The HIS includes a set of data elements that CMS will use to calculate scores for the 7 NQF endorsed quality measures. Hospices that failed to report quality data via the HIS in 2014 will see their market basket reduced by 2 percent in FY2016.

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.

Focused Medical Review. The ACA incorporated a 2009 MedPAC recommendation 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 supports 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.

Photo Credit: Harmony Hospice & Palliative Care, Pittsburgh, PA

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 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. 2014, NHPCO National Data Set and/or NHPCO Member Database.
2. Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.
3. 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.
4. 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.
5. 2014, NHPCO National Data Set and/or NHPCO Member Database.
6. 2014, NHPCO National Data Set and/or NHPCO Member Database.
7. 2014, NHPCO National Data Set and/or NHPCO Member Database.
8. 2014, NHPCO National Data Set and/or NHPCO Member Database.
9. Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.
10. All reimbursement rates listed in this section are the national base rates. All rates will be subject to local wage index and sequestration adjustments.
11. 2013, NHPCO National Data Set and/or NHPCO Member Database.

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