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Who We Are

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 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 MEDICARE HOSPICE BENEFIT & RECENT CHANGES IMPACTING THE HOSPICE COMMUNITY

The Medicare Hospice Benefit

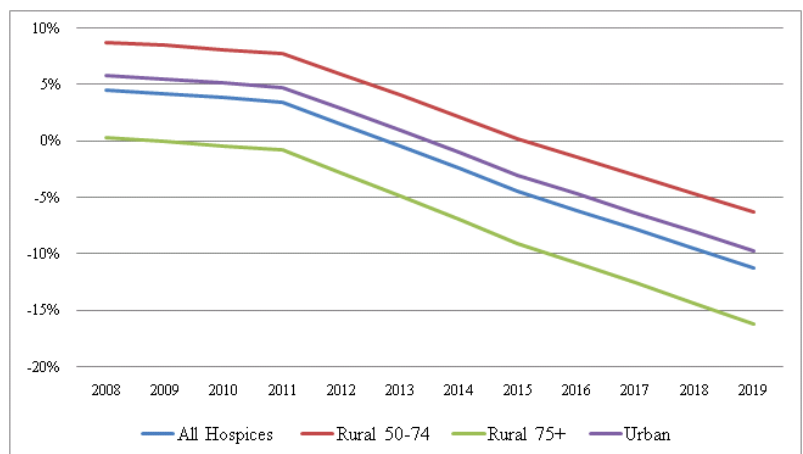
The Medicare Hospice Benefit was established in 1983 to provide Medicare beneficiaries with access to high-quality end-of-life care. **Over 1.5 million Americans and their families benefitted from hospice care last year. Today, more than 88 percent of hospice patients are Medicare beneficiaries.**

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. 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. **According to recent MedPAC data, hospice margins average only 2.8 percent¹.**

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 1).



¹ According to MedPAC’s 2010 projection, the average hospice margin is 4.6 percent. We use the 4.6 percent projection and subtract 1.5 percent (costs related to bereavement services) and an additional .3 percent (costs associated with maintaining volunteer services) to get 2.8 percent. Both services are statutorily mandated but not reimbursable.

Table 1. Moran Company Analysis - Estimated Median Profit Margins, 2008-2019 (All Hospices, Urban, and Rural Hospices)

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Recent Changes: Regulatory Requirements

Three new 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. While NHPCO supports the goal of these recent changes, we know that complying with these requirements, especially given the rate cuts, will be a costly strain on resources and staffing for hospice providers. 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. Please note that all provisions are only recently effective, or effective but not yet fully implemented, so impact on provider behavior is not yet measurable.

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.

100% Medical Review of Certain Patients Effective January 1, 2011, all patients in hospice for over 180 days who are in hospices with a high percentage of such long-stay patients must be medically reviewed by the Medicare Administrative Contractor (“MAC”). MACs have not yet received their instruction from CMS on this review, and CMS has not yet determined the threshold for when a hospice would fall into this 100% Medical Review category. Discussions are continuing internally at CMS on this question.