Overview

Patients receiving end-of-life care through the Medicare Hospice Benefit beyond 180 days have been a recent focus in the media and policy bodies such as the Medicare Payment Advisory Commission (MedPAC). These groups are concerned with the costs of care for individuals receiving more than 180 days of hospice care and the integrity of programs with a high proportion of longer-stay patients.

But analysis of data from the Centers for Medicare & Medicaid Services (CMS) shows that the majority of hospice patients receive fewer than 180 days of hospice care. In 2012, more than 1 in 3 received care for seven days or less, and nearly 9 in 10 received care for fewer than 180 days. Changing patient demographics – in particular the rising incidence of dementia and chronic obstructive pulmonary disease (COPD) – have also contributed significantly to increased length of stay.

As longer lengths of stay are profiled in the media, equal attention should be focused on the high percentage of very short-stay hospice patients. Although improvements can certainly be made to the Medicare Hospice Benefit, they should be done with the full knowledge of these other pertinent facts. By making decisions based on all relevant information, policymakers can ensure that patients and families receive the right care at the right time for the right reasons.

THE RIGHT CARE AT THE RIGHT TIME:
HOSPICE LENGTH OF STAY

In its March 2013 “Report to Congress: Medicare Payment Policy,” MedPAC notes that “between 2000 and 2011, hospice length of stay at the 90th percentile grew substantially, increasing from 141 to 241 days.” However, data depicting the average and median lengths of stay for hospice beneficiaries have remained relatively steady over the past several years. In 2012, the average length of stay was 71.8 days, up from 67.4 days in 2010. The median (50th percentile) length of stay dropped from 19.7 days in 2010 to 18.7 days in 2012.

A deeper look at data shows that more than 1 in 3 hospice patients (35.3%) spend fewer than seven days in hospice care and nearly 2 in 3 (62.3%) spend fewer than 30 days in hospice care. Of all hospice beneficiaries, nearly 9 in 10 (88.2%) received fewer than 180 days of hospice care in 2012. Therefore, the concern over long-stay hospice patients focuses only on a small subsection of hospice patients.

POLICY BRIEFING - The Right Care at the Right Time 2014
Changing Demographics, Changing Hospice

Length of stay in hospice is a much more complex issue than the number of days a patient is served by hospice. One of the requirements of hospice eligibility is a prognosis of six months or less, which was not as much an issue when the majority of patients served by hospice were dying from cancer. But the demographics of terminal illnesses have shifted over time, and the majority of hospice patients are now dying of progressive chronic diseases, more closely resembling the Medicare decedent population. (Figure 3).

As a result, the incidence of dementia, COPD, and similar conditions has increased in hospices across the country. These diseases, and many other conditions, have less predictable trajectories than other terminal diseases, such as many cancers. In 2011, for example, hospice patients with neurological conditions or COPD had longer lengths of stay than patients with cancer diagnoses (137 and 107 days, respectively, to 52 days). The variable disease trajectories of non-cancer diagnoses create uncertainty regarding a patient’s hospice eligibility, and can also lead to late referrals from physicians. But, in all instances, a hospice patient’s continuing eligibility for services is tested on a regular basis, including an enhanced focus on long-stay patients.

Hospice Saves Money While Improving Care

Although the financial implications of longer lengths of stay are a concern, they should be viewed within the larger context of the economics of hospice care. When Congress established the Medicare Hospice Benefit in 1982, Congress included two limitations, or “caps,” to serve as safeguards on Medicare payments to hospices. One cap limits the share of inpatient care days, with the intent to prevent hospice care from becoming a predominantly inpatient benefit and to preserve the delivery of hospice care in the patient’s home. The second cap limits the average annual payment per patient a hospice can receive from the program, thus discouraging an admission focus on primarily long-stay patients.

Hospice provides significant cost savings to Medicare through a reduction in hospitalizations and heroic end-of-life procedures. This should not be surprising given that 30% of Medicare expenditures are attributable to the 5% of beneficiaries who die each year, about one-third of the expenditures in the last year of life is spent in the last month.

A study published in the March 2013 issue of *Health Affairs* found that hospice enrollment saves money for Medicare and improves quality of care for Medicare beneficiaries across a number of different lengths of stay. The authors found that Medicare accrued $2,561 in savings for each patient enrolled in hospice 53 to 105 days before death. Even higher savings were seen with shorter enrollment periods: $2,650, $5,040, and $6,430 per patient enrolled one to seven, eight to 14, and 15 to 30 days, respectively, prior to death, due to lower rates of hospital service use (Figure 4).

Moreover, 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. “Given that hospice has been widely demonstrated to improve quality of life of patients and family members,” the authors concluded, “the Medicare program appears to have a rare situation whereby something that improves quality of life also appears to reduce costs.”
Improving the Medicare Hospice Benefit

The National Hospice and Palliative Care Organization (NHPCO) supports efforts to address longer hospice lengths of stay that may be due to possible errant business practices. NHPCO supported the majority of MedPAC’s 2009 recommendations that were included in the Affordable Care Act, including:

- **Brief Physician Narrative.** This provision of the ACA requires the certifying physician to provide a brief narrative statement to explain the clinical findings that support the certification and recertification of terminal illness that provides the basis for hospice eligibility.

- **Face-to-Face Encounter.** 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 to continue to receive hospice services.

- **100% Medical Review.** All patients in hospice for more than 180 days must be medically reviewed by the Medicare Administrative Contractor for hospices at which stays exceeding 180 days make up 40% or more of their total cases.

In 2013, NHPCO released nine recommendations for Congress to consider to strengthen the Medicare Hospice Benefit. Many of the recommendations add transparency and accountability to the referral process and clarity to the relationships between hospice and nursing homes.13

In addition, a 2013 report by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services found that 17% of state-surveyed hospices had not been surveyed for recertification in the prior six years, and in 12 states, 25% or more of hospices had not been surveyed during the same time period.14 The HELP Hospice Act (H.R. 2302/S. 1053), supported by NHPCO, includes a provision that would increase and standardize hospice survey frequency to every three years, complementing the recommendations made by the OIG, and proactively ensuring compliant, high-quality hospice care for patients and families across the country.

While conversations concerning the 11.5% of patients with long lengths of stay in hospice continue, it is critical to remember the even larger percentage of hospice patients and families that are not able to experience the full benefits of hospice due to very short stays. NHPCO and the Hospice Action Network fully support the analysis of the drivers of very long lengths of stay and promote measures to maintain the integrity of hospice programs. Yet the changing demographics and diagnoses of hospice patients must be included in these assessments.

The hospice community finds the prevalence of so many short stays in hospice, particularly those fewer than seven days, even more troubling. The Medicare Hospice Benefit was established to provide high-quality care to individuals facing the end of life; the full benefits of hospice cannot be received in a few short days. Further research and dialogue need to occur to ensure that hospice-eligible patients are able to receive the right care at the right time.
Congress Has Spoken on Hospice Length of Stay

The Medicare Hospice Benefit was originally limited to 210 days (two 90-day periods and one 30-day period). A fourth benefit period, of unlimited duration, was first added in the Medicare Catastrophic Coverage Act of 1988, until the law was repealed. The fourth benefit was reinstated in the Omnibus Budget Reconciliation Act of 1990.

However, the law allowed only for four benefit periods, to be elected in sequence. If a patient revoked or was discharged from the benefit during the fourth benefit period, the patient could never be eligible for hospice again. Therefore, even if a patient no longer met eligibility criteria during the fourth benefit period, hospices were reluctant to discharge them. The Balanced Budget Act of 1997 changed the benefit periods to the current system: one 90-day period followed by an unlimited number of 60-day periods, as long as the patient is certified as terminally ill.

Suggested Readings


2 2012, NHPCO National Data Set and/or NHPCO Member Database.
3 2012, NHPCO National Data Set and/or NHPCO Member Database.
8 This cap was originally conceived to be an amount that reflected the cost to the Medicare program for patients with cancer in the last six months of life. However, the average annual payment cap was ultimately set at an amount that was not based on this calculation (GAC 2004).
10 Yu W. End of Life Care: Medical Treatments and Costs by Age, Race, and Region. HSR&D study IIR 02-189. URI: http://www.hsrd.research.va.gov/research/abstracts/IIR_02-189.htm.
13 A copy of the recommendations is available at http://hospiceactionnetwork.org/linked_documents/get_informed/policy_resources/Program_Integrity_Brief_2013.pdf.