



August 30, 2011

Via Electronic Mail

The Honorable Patty Murray
The Honorable Jeb Hensarling

Co-Chairs
Joint Select Committee on Deficit Reduction

The Honorable Xavier Becerra
The Honorable Dave Camp
The Honorable James E. Clyburn
The Honorable Fred Upton
The Honorable Chris Van Hollen
The Honorable Max Baucus
The Honorable Jon Kyl
The Honorable John Kerry
The Honorable Rob Portman
The Honorable Pat Toomey

Members
Joint Select Committee on Deficit Reduction

Dear Co-Chairs and Members:

On behalf of hospice and palliative care providers as well as the more than 1.5 million patients and families served by hospice each year, the National Hospice and Palliative Care Organization (NHPCO) respectfully asks you to be mindful of the challenges facing the hospice community as you deliberate on further deficit reductions to Medicare providers.

NHPCO understands the significant long-term fiscal challenges facing our nation and supports the overarching goals of Congressional leaders and policymakers aimed at getting our country back on a sustainable path toward economic stability and prosperity. We certainly recognize the serious, long-term structural imbalances that threaten entitlement programs. We are, however, deeply concerned about the impact of any further reductions in Medicare and Medicaid hospice reimbursement on the ability of hospice providers to offer compassionate, high quality, fiscally responsible, end-of-life care to patients and families in the future.

With average margins of only 2.8 percent and declining (MedPAC, 2010), the hospice community is already absorbing a more than 14 percent reduction in reimbursement rates due to a regulatory change to the calculation of the Medicare hospice wage index through the elimination of the Budget Neutrality Adjustment Factor (BNAF) and the implementation, under the new Affordable Care Act (ACA), of a “productivity adjustment” and, for fiscal years 2013



through 2019, an additional reduction in the annual market basket hospice payment updates. Our providers are also bearing the additional cost and/or challenges associated with other important new ACA requirements, including the hospice face-to-face encounter and 100 percent review of certain patients, intended to provide more transparency and accountability to the Medicare hospice benefit. In addition, hospice is bracing for the uncertainty of further changes under the first comprehensive hospice payment reform to take place since the benefit was created almost 30 years ago, which also is a requirement under the ACA. **Given all of this, we simply cannot survive *any* additional financial challenges at this critical time.**

As you know, the hospice model is a comprehensive, all-inclusive benefit based on an interdisciplinary team-oriented approach that puts the patient's needs and wishes at the center of all aspects of care. Since the hospice benefit was added to the Medicare program in 1983, an ever increasing number of beneficiaries have availed themselves of the expert medical care, pain management and wide range of support services that hospice provides. Today, 89.4 percent of hospice patients are Medicare and Medicaid beneficiaries thus making hospice programs particularly dependent on federal reimbursement levels, with little, if any, ability to "cost shift".

Over the past decade, more Medicare beneficiaries have availed themselves of the hospice benefit. The number of patients receiving care has grown from 700,000 in 2000, to more than 1.5 million people now. Current Medicare spending on hospice has increased to nearly \$12 billion.

Yet, despite the significant increase in the number of beneficiaries and providers since 2000, hospice costs still comprise only 2 percent of total Medicare expenditures.

In 2000, the majority of those served by hospice had some form of cancer, where the expected trajectory of the illness -- and the associated costs -- was relatively more predictable. Today, the demographic of hospice patients is more like that of Medicare decedents as a whole, and hospice serves a diverse range of patients in need of end of life care. Less than 40 percent of hospice patients have cancer. Hospice providers are serving more patients with complex illnesses -- such as those with late-stage dementia -- who have uncertain trajectories making prognosis and care much more complex and difficult.

And perhaps most importantly, in 2000, for every person that received hospice care, there were two other dying Americans who would have benefitted from this compassionate, high quality care, but did not get it. Indeed, around this time, HHS took active steps to encourage an *increase* in hospice referrals. In 2000, HCFA (the predecessor to CMS) Administrator Nancy-Ann Min DeParle announced a voluntary pre-authorization program to preempt concerns about denial of claims for patients with more complicated prognoses, and thereby promoting earlier enrollment to hospice for more beneficiaries who want and are eligible for hospice care.



Then in 2002, under CMS Administrator Thomas Scully, the agency published articles in several physician-focused journals to demonstrate that they were “requesting that members of the physician community, as well as other health care professionals, think more about hospice as they care for terminally ill patients” (Scully, 2002).

In addition to our commitment to quality care to all patients and families in need of end-of-life care, hospice providers are dedicated to ensuring that they are cost-efficient and conscientious stewards of finite Medicare and Medicaid resources. Hospices administer a range of provider services, medications, medical supplies and equipment as well as providing respite care, counseling and family bereavement, under an all-inclusive bundled per diem rate averaging \$142.91 in 2010. A Robert Wood Johnson Foundation study conducted by Duke University found that hospice saves Medicare, on average, more than \$2,300 per patient compared to alternative sources of care for this population. At the same time, patient and family satisfaction with hospice services remains extraordinarily high. According to surveys¹, more than 98% of families served by a hospice program would recommend those services for another loved one at the end of life.

In proposing any Medicare and Medicaid savings, we urge you to avoid provisions that would do irreparable harm to the hospice community’s ability to care for our most vulnerable citizens, the extremely frail and terminally ill, and potentially cost the Medicare and Medicaid program even more money. Please reject proposals that will damage our safety net and will ultimately break our social compact with those most in need.

Additionally, to ensure that the hospice community is able to continue to serve patients and families choosing high-quality, compassionate end-of-life care, while achieving savings to the Medicare and Medicaid programs, NHPCO urges the Joint Select Committee on Deficit Reduction to include the provisions of the Hospice Evaluation and Legitimate Payment (HELP) Act, S. 722, in its recommendations to Congress.

We appreciate the considerable challenges that lie ahead in this area. We look forward to working with you to find responsible ways to address these important issues without sacrificing quality care or threatening access to valuable and needed services.

Sincerely,

J. Donald Schumacher, PsyD
President/CEO

¹ The Family Evaluation of Hospice Care (FEHC) is a post-death survey designed to yield actionable information that reflects the quality of hospice care delivery from the perspective of family caregivers.