The Value of Hospice and Palliative Care Services

Since its inception in 1983, the Medicare Hospice Benefit has steadily increased the number of Medicare beneficiaries served. Between 2000 and 2012, total hospice enrollment increased from 534,000 to 1.27 million beneficiaries (Abt Associates, 2013). In addition, the number of non-cancer diagnoses, the increased prevalence of chronic diseases and other co-morbidities and the increased integration of health information technology to coordinate care among providers including a patient’s primary care physician have each contributed to significant changes and improvements in the delivery of Medicare hospice services. The FY 2015 Hospice Payment Rate Update notes that the percentage of Medicare deaths for patients under a hospice election increased from 20 percent in 2000 to 44 percent in 2012. Fifty percent of Medicare Advantage dependents compared to 45.6 percent of traditional, fee-for-service Medicare beneficiaries used hospice in 2012 (MedPAC, 2014). These changes highlight the need to update and reform the Medicare hospice benefit and payment model to better serve and support Medicare beneficiaries at end-of-life.

Hospice Services Support Physicians, Patients and Family Caregivers

Hospice care in the United States remains an underutilized benefit. Hospice and palliative care providers have the capacity and ability to provide support and care services for many more Americans and to improve quality, care and patient satisfaction at the end of life. Unfortunately, current federal regulatory challenges and payment policies dramatically restrict the number of patients who receive hospice care and dramatically shorten the period of hospice care provided at the end of life. In fact, in many cases, patients are not referred to hospice until the final days of life.

Visiting Nurse Associations of America's (VNAA) members are not-for-profit home health and hospice agencies who, by mission and design, serve all beneficiaries without regards to their insurance coverage or ability to pay. VNAA supports efforts to redesign hospice and palliative care services for terminally ill patients and believes significant opportunity exists to improve patient referrals to, and enrollment in, hospice programs. In part, this may be accomplished through the implementation of provider incentives and new models of care delivery. VNAA is also a steering committee member of the Coalition to Transform Advance Care (C-TAC) and actively supports C-TAC’s work to advance a new vision and model for advanced illness care in the final years of life.

Specifically, VNAA advances the following principles for consideration of hospice system redesign:

- Expand and promote advanced care models to support Medicare beneficiaries in the last years of life through improved care coordination in the home and community, including earlier entry to palliative care and hospice programs;
- Encourage physicians to discuss advanced care planning and the role of palliative and hospice care with patients and families;
• Strengthen patient choice at the time of hospice election;
• Include concurrent curative treatment for beneficiaries receiving hospice and palliative care services;
• Categorize palliative care within the hospice benefit, rather than under the home health benefit;
• Target program integrity review and enforcement on providers with high numbers of inpatient days, high rates of recertification, and high numbers of live discharges;
• Ensure appropriate reimbursement for hospice and palliative care services to ensure continued accessibility to such services for all eligible patients.

Other Hospice Considerations

VNAA also urges policymakers to ask CMS to compare spending at end-of-life, perhaps for the last six months of life, for those beneficiaries who do not elect hospice versus those beneficiaries that do. VNAA urges CMS to include all non-hospice costs in the tally of expenses for patients not electing hospice regardless of whether costs are within a curative care delivery model or any movement toward a palliative care model. Such analysis will help CMS identify opportunities to improve and modernize the Medicare hospice benefit and the patient and family caregiver experience.

Finally, ensuring access to hospice care is a critical component of activities to update the Medicare hospice benefit. VNAA recommends that CMS carefully study access to hospice and palliative care services among Medicare beneficiaries. One measure of access is low percentage utilization areas. A review of these areas, as well as insights from the Hospice Experience of Care Survey from the National Hospice and Palliative Care Organization could help CMS identify challenges to access and propose opportunities to improve and increase utilization. CMS should also study the referral rates to hospice services among hospitals with and without palliative care programs to better understand the impact of such programs on referral rates to hospice at end-of-life.