I. OPPOSE EXPANSION OF COPAYMENTS FOR MEDICARE HOSPICE SERVICES

The Medicare hospice benefit was created to provide compassionate and supportive care to Medicare beneficiaries in the last months of their lives. Two physicians must certify that the patient has a terminal diagnosis with a life expectancy of six months or less. The hospice is paid a set rate per day based upon the level of care provided, and an interdisciplinary team is responsible for coordinating and providing all care related to the terminal and related conditions.

A number of Medicare reform proposals would combine Parts A and B and impose a single deductible and uniform copayment on services; these proposals vary in their treatment of hospice services, with some including and others excluding hospice from application of copayments and the deductible.

The hospice benefit is separate and distinct from other services under Medicare – patients must waive their right to receive services for the terminal diagnosis and related conditions from any provider other than the hospice and the patient’s attending physician. Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit:

- Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness and related conditions. Given that many “curative” interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.

- While Medicare covers a significant portion of the cost of hospice care, the patient may be responsible for copayments on drugs and facility-based respite care.

- In addition to medical and supportive services, many hospices also provide (at no cost to the patient or to Medicare) complementary therapies like massage, music, art, and pet therapies that enhance comfort and quality of life.

- Hospices also are required, by law, to provide bereavement services to family members for 12 months after the patient’s death at no cost to Medicare.
Historically, copayments have been imposed on services to reduce overutilization. While use of hospice services has grown, many beneficiaries are referred to hospice too late to reap the full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations – who are the least likely to be able to afford additional cost-sharing burdens.

II. PROTECT THE FINANCIAL INTEGRITY OF HOSPICE PROGRAMS
Medicare-participating hospices have been subjected to a number of reimbursement reductions in recent years, including:

- In FY2010, the Centers for Medicare and Medicaid Services (CMS) began phasing out by regulatory issuance the Budget Neutrality Adjustment Factor (BNAF) to the hospice wage index over seven years. It is estimated that the phase-out, when completed, will reduce hospice payments by 4 percent.
- In addition to the BNAF phase out, the FY2013 payment cycle reflects additional reductions mandated by the Affordable Care Act (ACA), including a 0.7 percentage point productivity cut and a 0.3 percentage point market basket reduction. Rather than a scheduled 3 percent inflation update, hospice providers received only a 0.9 percent update for FY2013 to cover increased costs of care and administration.
- The March 2013 sequester mandated by the Budget Control Act will reduce 2013 hospice payments to 1.1 percentage points BELOW the level of payment in FY2012.
- The Medicare Payment Advisory Commission (MedPAC) has projected that Medicare hospice financial margins for 2013 (without consideration of costs related to volunteer and bereavement services or to the impact of the 2 percent sequester) will average about 6.3 percent; however, financial margins vary widely in the hospice sector, and many hospices operate at serious financial risk and must rely on donations to keep their doors open.

Congress should restore the market basket and productivity reductions mandated by the ACA, cancel the 2 percent across-the-board sequester, and reject any further cuts to the hospice market basket update. Congress should oppose any reductions in the annual updates until such time as all payment reforms required by the ACA are instituted and then only after the issues are fully examined.
III. SUPPORT THE HOSPICE EVALUATION AND LEGITIMATE PAYMENT (HELP) ACT

During the 112th Congress, Sen. Ron Wyden (D-OR) and Rep. Tom Reed (R-NY) introduced companion legislation that would make important refinements to existing Medicare hospice policy by:

- **Ensuring an Appropriate Transition to the New Hospice Payment System** — Under current law, payment reforms will be implemented in hospices nationwide on or after Oct. 1, 2013. The Centers for Medicare & Medicaid Services (CMS) is not required to test these payment reforms to determine what the “real world” impact will be on beneficiary access to quality care and on the financial viability of hospice programs. The HELP Act would address this concern by requiring a 15-site demonstration of the new payment system prior to nationwide implementation.

- **Refining the Hospice Face-to-Face Encounter Requirements** — In Jan. 2011, CMS implemented a requirement that hospice patients entering their third or later benefit period (180 days) have a face-to-face encounter with a hospice physician or nurse practitioner (NP) prior to the start of the benefit period. While CMS allows an additional two days to complete the face-to-face under documented exceptional circumstances (such as when a patient is a new readmission to hospice after a break in service or when CMS data systems are unavailable or lack full information on the patient’s benefit period status), hospices continue to have difficulty meeting the time frames for the face-to-face. HELP would make modest changes by allowing seven days for completion of the face-to-face requirement when exceptional circumstances occur; the legislation also permits hospices to use other clinicians, such as physician assistants, to perform the encounter. These changes will be of particular benefit to small, rural providers and in areas where physicians and NPs are in short supply.

- **Requiring Surveys of Hospice Programs Every Three Years** — Despite the need for regular surveys of hospice programs to ensure they meet Medicare’s many and frequently changing regulatory requirements, most hospices are surveyed only every six or seven years. HELP would require that hospice programs be surveyed at least once every three years, which will help to ensure that hospice providers are adhering to survey and certification requirements.

Sen. Wyden and Rep. Reed plan to reintroduce the HELP Act in the near future.

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