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Carla M. Braveman, *Chair* Big Bend Hospice

October 18, 2011
The Honorable Patty Murray
Co-Chair, Joint Select Committee on Deficit Reduction

The Honorable Jeb Hensarling
Co-Chair, Joint Select Committee on Deficit Reduction

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

Members, Joint Select Committee on Deficit Reduction

Dear Co-Chairs and Members:

I am writing today as Chair of the Hospice Association of America. We represent the more than 3500 Medicare-certified hospices and tens of thousands of hospice caregivers and volunteers who serve millions of patients and family members each year. On their behalf I am urging that you do all within your power to ensure that access to these vital end-of-life services be preserved as you move forward in discussions on deficit reduction.

In recent weeks proposals have been put forth to cut outlays under Medicare and Medicaid, either to address deficit concerns or other health policy priorities. We have grave concerns that while well-intended, some of these proposals will reduce access to hospice care and others will create a serious disincentive for patients to elect hospice services. Following are some of our specific concerns:

Uniform Part A and B Deductible/Uniform Medicare Copayments. Since the hospice

program's inception, services have been made available to patients who are medically determined to be in the last six months of life. Patients must elect hospice and agree to forgo curative care. There is no applicable deductible, and limited copayments (related to respite care and drugs). Despite these limited financial obligations, it is a widely-held belief that there are too few (rather than too many) Medicare decedents (approximately 40 percent) who elect hospice services; the remainder, instead, receive much more invasive care at the end of life at a tremendous cost to the Medicare program. Additionally, there are still many patients electing hospice too late to reap the full benefits that hospice services can offer at the end of life – for the last 10 years the median length of stay has remained at 17 days. Numerous studies -- including one conducted by Duke University – have found that hospice services provided within the last two to three months of life not only provide tremendous comfort and relief to patients and their families but also reap significant savings to the Medicare program. Imposition of a deductible or additional beneficiary coinsurance on the hospice program will further deter patients from opting for hospice services, at great emotional and financial costs to our country.

Limit FY2012 Hospice Update to 1 Percent. The Medicare Payment Advisory Commission (MedPAC) recommended in March that hospice payment increases for fiscal year 2012 be limited to 1 percent. This would translate to a 1.5 percent reduction over the rates that are already being paid to hospice providers (effective Oct. 1, 2011). While this may appear (in isolation) to be a nominal reduction, it is important that you keep in mind that the Medicare hospice benefit is undergoing considerable change at this time. For the first time since hospice services became available under Medicare in 1983, the Centers for Medicare & Medicaid Services is developing payment refinements to ensure that Medicare hospice payments are appropriately targeted to the services being delivered. The average provider financial margin, based on MedPAC analysis, are modest – projected at approximately 4 percent in 2011 – and do not take into account all of the costs incurred by hospices in delivering services to Medicare beneficiaries (for example, the cost of required bereavement services and running a volunteer program are not reimbursed). Additionally, regulatory reductions that will ultimately cut payments by 4 percent annually are currently being phased in over seven years. Similarly, hospice payments are scheduled for additional legislatively-mandated reductions beginning in October 2012. Imposing additional, retroactive cuts that hospice providers have not been able to plan for will create tremendous financial strain, particularly on small providers and those in rural areas. As a result, the accessibility and availability of hospice services may be further diminished.

Reductions for Payment for Hospice Patients Residing in Nursing Facilities. In response to a study conducted by the Office of the Inspector General (OIG), MedPAC recently suggested that payments for hospice patients residing in nursing facilities should be reduced, based on the belief that hospices gain higher profit from patients living in nursing facilities over those served in their homes. While MedPAC has modified its proposal to reduce the financial impact and “target” the cut to hospice providers with higher patient loads in nursing facilities, we still have grave concerns about the impact of the proposal. All nursing home residents do not have access to hospice services

(depending on whether the facility in which they reside has a contract with a hospice or not). We fear that access to hospice services may be further diminished if hospices are discouraged from entering into agreements with nursing facilities as the result of the MedPAC policy. Our analysis indicates that many hospices provide the same level of services to nursing facility patients as they do to patients in private residences; unless the cut can be targeted further – to hospices with enough patients in a single facility to result in true economies of scale – imposition of such a reduction will discourage hospices from providing care to patients living in nursing facilities and reduce the rights of nursing facility residents to the hospice benefit. Many nursing home patients who die without hospice care die in hospitals at a significantly higher cost to the Medicare system.

Medicaid Hospice Services. Medicaid hospice services, which are currently covered in 48 states, are at serious risk. Hospice care for adults is classified as an “optional” benefit. With states struggling to make fiscal ends meet, there will be great temptation for states to eliminate hospice coverage for needy adults. This temptation will only be exacerbated by cuts or caps on the Medicaid program, or by movement to block granting of the Medicaid program.

Hospice care, delivered at the right time, not only saves valuable Medicare and Medicaid dollars – it changes lives. Unfortunately, it is still the case that too many recipients come onto care too late to reap the full benefit that hospice has to offer. At this important point in its evolution in the United States, we urge that you do everything within your power to preserve access to hospice services under Medicare and Medicaid. We stand ready to assist you in these efforts in any way possible. Please do not hesitate to call upon us.

Sincerely,

A handwritten signature in cursive script that reads "Carla Braveman".

Carla Braveman