FAQs NORC Study – Value of Hospice in Medicare

HOMECARE & HOSPICE
National Association for Home Care & Hospice

NHPCO
National Hospice and Palliative Care Organization

Why did NAHC and NHPCO ask NORC to examine the value of hospice to the Medicare program?

- Despite a common understanding that the Medicare hospice benefit is a unique part of the health care system that provides compassionate care at the end-of-life to patients and families, and prior research showing it produces cost savings for many different payers, in recent years policy recommendations have been put forth to reduce payments to hospice programs in an effort to save the federal government money. Most concerningly, since 2020, the Medicare Payment Advisory Commission (MedPAC), has recommended that Congress cut the hospice aggregate payment cap for all hospices by 20%. This is an untargeted proposal that could make it harder for certain patients to access hospice. Concerned about the potential negative consequences of this and other proposals to cut hospice supports on the millions of Medicare beneficiaries who need specialized end-of-life care, NAHC and NHPCO commissioned NORC with quantifying the value of hospice.

What did the NORC study examine specifically?

- NORC conducted a comparative assessment of the fiscal value of hospice using Medicare administrative claims data representing the entire population of 2019 Medicare decedents. The study analyzed all medical services spending ("total cost of care") and utilization in the final 12 months of life for Medicare hospice users and non-hospice users.

Why is the NORC study important for the hospice community?

- The NORC study is a seminal analysis that definitively proves that utilization of the Medicare hospice benefit is associated with significant aggregate cost savings to the Medicare program. These savings resulted for hospice patients with many different kinds of terminal illnesses, and were also present in lengths of stay beyond 180 days, all the way up to 266+ days.
- Also, unlike previous research examining the value of hospice, the NORC study used full CMS administrative claims, encounters, and enrollment data files, which resulted in a study population of 2.3 million Medicare-enrollees who died during 2019. NORC researchers also used a novel methodology to ensure that the group of non-hospice users in the study resembled the hospice users as much as possible, an important but notoriously difficult task in hospice research. These statistical guardrails greatly enhance confidence that the results, showing billions in savings to Medicare, are indeed a direct result of hospice utilization, and not caused by other confounding factors related to the study population, including patients' functional limitations and level of frailty.

What are the most important take-away points from the NORC study to convey to policymakers?

- In the last year of life, the total costs of care for Medicare beneficiaries who used hospice was 3.1% lower than the adjusted spending of beneficiaries who did not use hospice, which translates to an estimated $3.5 billion less in Medicare costs for beneficiaries in their last year of life.
- Policies to support eligible patients' earlier enrollment in hospice and those that can increase their lengths of stay on the benefit would likely reduce Medicare spending even more.
- Hospice stays of six months or more add value to Medicare, including for those patients with terminal neurological conditions like Alzheimer's Disease or Parkinson's Disease.
- Hospice improves the quality of care and quality of life of patients with many different terminal diseases, while supporting the needs and well-being of their family members.

READ THE FULL STUDY HERE:
Value of Hospice in Medicare, NORC at the University of Chicago

Collectively, the study findings should convince Congress and CMS that cutting payments to hospice providers is bad policy. During this time when hospices are struggling with unprecedented workforce challenges, major reimbursement reductions will further strain a program that actually saves Medicare billions of dollars a year and is the only benefit dedicated to the holistic care of dying Americans and their families.

How did NORC calculate the savings estimate of $3.5 billion that hospice provides Medicare?

- Extrapolating the study findings to overall Medicare impacts, NORC estimates that hospice use in 2019 prevented $3.5 billion in Medicare spending that would have occurred had decedents not been enrolled in hospice. Overall, claims analysis shows 3.1% lower total cost of care in the last 12 months of life for hospice users relative to non-hospice user decedents.
  - This is among Traditional Medicare enrollees who met study inclusion criteria (over 465,000 or nearly 31% of the total Medicare hospice population). Given sample size and minimal data cleaning, these findings should be generalizable to the total Medicare hospice user population.
- Among hospice users, NORC found hospice-specific costs account for about 18.7% of last-year-of-life spending. The Medicare program spent an estimated $20.9 billion in 2019 on Part A hospice services. If that is 18.7% of total last year of life spending (as in the study population), NORC extrapolates that Medicare decedents who used hospice likely had a total spend around $112 billion, assuming spending patterns are similar in the unmeasured group and ignoring Medicare Advantage-specific payment concerns. Combining these estimates, NORC infers that Medicare would have spent an additional $3.5B (3.1%) in 2019 for these decedents had they not enrolled in hospice.

What is the theory behind how hospice saves Medicare so much money?

- Utilization of the Medicare hospice benefit drives savings primarily by substituting for and preventing the use of costly "disease-focused" treatments and procedures aimed at curing the underlying serious illness. This includes avoidance of very expensive hospitalizations and emergency department visits, which are not only major drivers of Medicare costs but are often burdensome and ultimately unhelpful for patients at the end of life and their families.

What data sources did NORC use for the study?

- To calculate health care utilization and spending and define study subgroups of interest, NORC analyzed full CMS Medicare administrative claims, encounters, and enrollment files from 2019.

Are there any limitations to the study analysis?

- One limitation of the study is that the analysis does not include all hospice beneficiaries who were live-discharged from the benefit. Beneficiaries whose death date was at least seven days after discharge from their final hospice stay were considered to be "live hospice discharges" for this particular analysis, and were excluded from NORC's calculations. These beneficiaries were excluded so as to produce a study group whose hospice experience best reflected the benefit's intended outcome (if beneficiaries are discharged from hospice, expiration should likely occur soon thereafter).

  In recent years, extremely high rates of live discharge from hospice have been a focus for policymakers, given concerns that some hospices may use the discharge process as an attempt to avoid going over the aggregate cap spending amount and that abrupt and uncoordinated discharges can disrupt the coordination of patient and family care.
- Another limitation of the study is that it only looked at spending in the last year of life. While the results indicate that even very long stays within this 12-month "look-back" period drive savings for Medicare, it is possible that spending patterns could look different in the final 18 or 24 months of life. That said, a full 90% of beneficiaries that use hospice are on service for 264 days or less.
- Finally, the fact that the study uses 2019 data could be considered a limitation. However, 2019 is the most recent year for which there is high-quality, publicly available data that is unimpacted by the anomalous health care utilization and spending environment created by the COVID-19 pandemic.

There has been a lot of focus from MedPAC and others about long lengths of stay on hospice, especially for patients with Alzheimer's Disease and other neurological conditions – does the NORC study tell us anything specifically about these issues?

- Yes. NORC found that hospice stays of six months or more add value to Medicare, including for those patients with terminal neurological conditions like Alzheimer's Disease or Parkinson's Disease. For those who spent at least 6 months in hospice in the last year of their lives, spending was 11% lower than the adjusted spending of beneficiaries who did not use hospice. When sorted by disease group, spending ranged from being 4 % lower for neurodegenerative disease to 25% lower for chronic kidney disease/end stage renal disease (CKD/ESRD). Furthermore, when hospice stays extend beyond 266 days, and hospice spending accounts for almost 90% of the total Medicare bill, total costs of care for hospice users are approximately $8,000 less than that of non-hospice users.

Does the NORC study show that hospice saves Medicare money no matter how short or long a patient is enrolled in the benefit?

- No. NORC found that in the last year of life, hospice users that had lengths of stay under 10 days actually cost the Medicare program more money than comparable non-hospice users. This result reflects that fact that for very short stays like this, hospice simply does not have enough time to defer those expensive costs of care that otherwise occur in the last 12-months of a beneficiary's life (and outside of hospice care). When considering that over 25% of all hospice users are on service for a week or less, this finding that short stays are associated with increased overall spending speaks to how beneficial it would be, for both Medicare's finances and to patients and families, to get eligible beneficiaries onto hospice earlier and for longer periods of time than is currently the case (current median length of stay on hospice is only 17 days).

Does the NORC study break down spending and utilization based on hospice tax status?

- The study did not separate analyses based on tax status, instead focusing on a more powerful analysis of Medicare hospice benefit utilization and spending across all providers and provider types – large/small, for-profit/not-for-profit, rural/urban, etc. The findings that hospice use in the last year of life saves Medicare money in the aggregate, without qualifications about tax status or size of the hospice, is the key takeaway from the study.
- More generally, the tax status of a hospice alone does not tell you much about the quality of care that hospice provides. The vast majority of hospice providers, regardless of tax status, ethically fulfill their mission of caring for dying patients and their families, and are not in the business to bend the rules merely to maximize profit. A recent JAMA study comparing for-profit and not-for-profit hospices concluded that "choice of a hospice should not assume that profit status is a proxy for quality, but should be guided by the reported care experiences and other quality indicators for a particular hospice."
- The average score of for-profit hospices on CMS' new Hospice Care Index (HCI) composite quality measure is 8.7 out of 10
- The growth in recent years of the number of hospices has also coincided with an increase in the number and proportion of people using the Medicare hospice benefit:
- In 2000:
  - Hospice use:
    - 460,000 people used the Medicare hospice benefit, representing 23% of Medicare decedents.
- In 2020:
  - Hospice use:
    - 1.3 million people used the Medicare hospice benefit, representing 47.8% of Medicare decedents
- This expansion in access and use represents major progress - many more individuals and families are able to experience the comprehensive and compassionate care hospice provides.

Since the NORC study indicates that getting patients onto service sooner could both save Medicare more money and improve beneficiaries' quality of life, what kinds of policy changes would help achieve this goal of more timely access to hospice for eligible patients?

- **Congress and CMS should** be exploring ways to increase awareness and understanding amongst consumers and clinicians of what hospice is and is not, how it can benefit patients and families at the end-of-life, when someone's clinical and functional conditions would make them an appropriate candidate for hospice, and how and when other health care providers and entities should refer patients to hospice in a timely manner. CMS should carry out an educational campaign for all Medicare providers on these issues. They should also explore creating quality measures that build-in accountability for upstream provider types to discuss hospice with eligible patients and refer them to hospice in a timely manner.

- Researchers and hospice providers have long known that one of the major barriers to earlier hospice enrollment is patient and family resistance to foregoing disease-focused treatments (the so-called "terrible choice" in hospice). As a response to this dilemma, in 2015 CMS launched the Medicare Care Choices (MCCM) demonstration model, which tested a new option for beneficiaries to receive supportive care services from hospices, while continuing to receive services provided by other Medicare providers, including care for their terminal condition. The 2022 evaluation report of the demo found that this novel test of "concurrent care" reduced Medicare expenditures by 14% ($7,254 per MCCM enrollee). Importantly, 70% of the savings accrued through increased and earlier use of the Medicare hospice benefit. At the same time, MCCM enrollees had 26% fewer inpatient hospital admissions, spent 38% fewer days admitted to an inpatient intensive care unit (ICU), and spent more days at home than a matched comparison group. **Congress and CMS should** work together to scale the MCCM model of care or test a "next generation" MCCM demonstration that includes larger samples sizes, allows beneficiaries with more diagnoses of serious illnesses to participate, and removes certain restrictive model criteria that limited how many hospices were able to participate.

- In recent years, advances in treatments have expanded the types of services that can be utilized to control pain and other symptoms for terminally ill patients. These services include renal dialysis, blood transfusions, and chemotherapy and radiation. The costs of these treatments can be significant, and many hospices are not able to admit otherwise eligible patients receiving these services because of their very high cost and the fact that they may not be widely accepted as part of a hospice's palliative care philosophy. Sadly, this often results in patients who want to utilize these kinds of treatments forgoing enrollment in hospice. **Congress and CMS should** pursue a thorough examination of the full array of treatment approaches currently in use in palliative care, study the extent to which these treatments are being used in hospice, and explore reimbursement mechanisms in the hospice payment system to ensure that these treatments can be more broadly utilized.