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2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of end-of-life care provided by licensed hospice care providers to clients in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and having a life expectancy of 6 months or less residing in the Houston HIV Service Delivery (HSDA).

2022-2023 Service Category Definition - DSHS State Services

<table>
<tr><td>Services to be Provided:</td><td>Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Allowable Ryan White/State Services funded services are:
• Room
• Board
• Nursing care
• Mental health counseling, to include bereavement counseling
• Physician services
• Palliative therapeutics

Services NOT allowed under this category:
• HIV medications under hospice care unless paid for by the client.
• Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents.
• Funeral, burial, cremation, or related expenses.
• Nutritional services,
• Durable medical equipment and medical supplies.
• Case management services.
• Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient’s death and can be offered in a skilled nursing facility or nursing home, Ryan White funding CANNOT pay for these services per legislation.</td></tr>
<tr><td>Service Unit Definition(s):</td><td>A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.</td></tr>
<tr><td>Financial Eligibility:</td><td>Income at or below 300% Federal Poverty Guidelines.</td></tr>
<tr><td>Client Eligibility:</td><td>Individuals with an AIDS diagnosis and certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course</td></tr>
<tr><td>Agency Requirements:</td><td>Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation or is certified as a Special Care Facility with Hospice designation.

Provider must inform Administrative Agency regarding issue of long-term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care.</td></tr>
</table>

2022-2023 Service Category Definition - DSHS State Services

	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services. Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
Staff Requirements:	All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart. Must comply with the **Houston HSDA Hospice Standards of Care**. The agency must comply with **the DSHS Hospice Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: ______ Approved With Changes:______	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: ______ Approved With Changes: ________	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

HOSPICE SERVICES
2019 CHART REVIEW REPORT

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HDSA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts one Subgrantee to provide hospice services in the Houston HSDA.

INTRODUCTION

Description of Service

Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.

Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.

Tool Development

The TRG Hospice Review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a population of 46 (CPCDMS) who accessed hospice services in the measurement year. The records of 39 clients were reviewed, representing 85% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Demographics- Hospice

2018 Annual

Total UDC: 46

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	1	2.17%
25 - 44 years	14	30.43%
45 - 64 years	28	60.87%
65 years or older	3	6.52%
Unknown	0	0.00%
	46	100.00%

Gender	Number of Clients	% of Total
"Other" and "Refused" are counted as "Unknown"		
Female	8	17.39%
Male	37	80.43%
Transgender FTM	0	0.00%
Transgender MTF	1	2.17%
Unknown	0	0.00%
	46	100.00%

Race/ Ethnicity	Number of Clients	% of Total
Includes Multi-Racial Clients		
White	19	41.30%
Black	27	58.70%
Hispanic	11*	23.91%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	46	100.00%

From 01/01/18 - 12/31/18

2019 Annual

Total UDC: 28

Age	Number of Clients	% of Total
Client's age as of the end of the reporting period		
Less than 2 years	0	0.00%
02 - 12 years	0	0.00%
13 - 24 years	0	0.00%
25 - 44 years	5	17.86%
45 - 64 years	18	64.29%
65 years or older	5	17.86%
Unknown	0	0.00%
	28	100.00%

Gender	Number of Clients	% of Total
"Other" and "Refused" are counted as "Unknown"		
Female	8	28.6%
Male	20	71.4%
Transgender FTM	0	0.00%
Transgender MTF	0	0.00%
Unknown	0	0.00%
	28	100.00%

Race/ Ethnicity	Number of Clients	% of Total
Includes Multi-Racial Clients		
White	15	41.30%
Black	13	58.70%
Hispanic	4*	23.91%
Asian	0	0.00%
Hawaiian/Pacific Islander	0	0.00%
Indian/Alaskan Native	0	0.00%
Unknown	0	0.00%
	28	100.00%

From 01/01/19 - 12/31/19

RESULTS OF REVIEW-2018

ADMISSION ORDERS AND ASSESSMENT

Percentage of client records that document attending physician certification of client's terminal illness.

	Yes	No	N/A
Client records that evidenced a Hospice Certificate Letter.	38	1	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**97%**	**3%**	-

Percentage of client records that have admission orders

	Yes	No	N/A
Client records that showed evidence of an admission order.	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

Percentage of client records that have all scheduled and PRN medications, including dosage and frequency

	Yes	No	N/A
Client records that evidenced all medication orders	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

CARE PLAN AND UPDATES DOCUMENTAITON

Percentage of client records that have a completed initial plan of care within 7 days of admission.

	Yes	No	N/A
Client records that evidence a completed initial plan of care within 7 days of admission	39	0	-
Clients in hospice services that were reviewed.	39	39	-
Rate	**100%**	**0%**	-

Percentage of client records that have a completed plan of care reviewed and/or updated at least monthly.

	Yes	No	N/A
Client records that evidenced a completed plan of care that was updated at least monthly.	12	0	27
Clients in hospice services that were reviewed.	12	39	39
Rate	**100%**	**0%**	**69%**

Percentage of client records that document palliative therapy as ordered by the referring provider

	Yes	No	N/A
Client records that showed evidence of palliative therapy as ordered.	33	3	3
Clients in hospice services that were reviewed.	36	36	39
Rate	**92%**	**8%**	**8%**

SERVICES

Percentage of client records that had bereavement counseling offered to family members upon admission to Hospice services

	Yes	No	N/A
Client records that showed evidence of bereavement counseling	3	27	9
Clients in oral health services that were reviewed.	30	30	39

Rate	**10%**	**90%**	**23%**

Percentage of client records that had dietary counseling

	Yes	No	N/A
Number of client records that evidenced dietary counseling	0	1	38
Clients in oral health services that were reviewed.	1	1	39
Rate	**0%**	**100%**	**97%**

Percentage of client records that had spiritual counseling

	Yes	No	N/A
Client records that evidenced spiritual counseling.	36	2	1
Clients in oral health services that were reviewed.	38	38	39
Rate	**95%**	**5%**	**3%**

Percentage of client records that had mental health counseling offered to family members upon admission

	Yes	No	N/A
Number of client records that evidence mental health counseling offered	0	0	39
Clients in oral health services that were reviewed.	39	39	39
Rate	**0%**	**0%**	**100%**

DISCHARGE

Percentage of client records that evidence all refusals of attending physician referrals by hospice providers with evidence indicating an allowable reason for the refusal

	Yes	No	N/A
Client records that evidenced appropriate refusal	6	0	33
Clients in hospice services that were reviewed.	6	39	39
Rate	**100%**	**0%**	**85%**

Percentage of client records that showed completed discharge documentation

	Yes	No	N/A
Client records that evidenced completed discharge documentation.	39	0	-
Clients in hospice services that were reviewed.	39	38	-
Rate	**100%**	**0%**	-

CONCLUSION

The review showed that Hospice Care continue to be delivered at a high standard. Seven of the thirteen Standard of Care data elements were scored at 100% compliance, including care plan, health assessment and discharge. Dietary and mental health counseling referrals to family members were below the threshold of 50% at 0% for each. These indicators are new to the review tool and will be documented in the future.

NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health.

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Hospice Care

Authors

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Last Update: March 21, 2021.

Definition/Introduction

Most Americans prefer to die at home or in a home-like setting, yet over 30% die in acute care hospitals.[1] Seriously ill patients often state preferences for receiving adequate pain and symptom management, avoiding inappropriate prolongation of dying, achieving a sense of control, and strengthening their relationships with their loved ones.[2] Similarly, caregivers want their loved ones to receive care that is concordant with their wishes and comfort. Hospice helps to achieve these goals for terminally ill patients.[3][4] Hospice is a model of high-quality, compassionate care for people suffering from a life-limiting illness. It provides expert medical care, pain and symptom management, and emotional and spiritual support tailored to the patient's needs and wishes. Hospice also provides emotional support to the patient's loved ones even into bereavement. This chapter will review hospice care in the US, its structure and delivery, and its growth and barriers to utilization.

The hospice movement began with the work of Dame Cicely Saunders, whose predominant concern was alleviating the suffering of dying patients. In 1967, Saunders opened St. Christopher's Hospice in South London and is now credited with developing the principles of hospice care that have become the core values reflected in hospice program policies worldwide.

The first hospice program established in the US was Connecticut Hospice in 1974, spearheaded by Florence Wald, RN, who modeled it on St. Christopher's Hospice. Both programs were in an inpatient setting.[5] US hospice programs follow a model that emphasizes care in the patient's home and supports patients to die at home. Since 1983 hospice services have become available through Medicare, Medicaid, and almost all US insurance plans (see Table 1).

Table 1: Eligibility Criteria for hospice care in the US under the Medicare hospice benefit

Hospice Care in America

The most recent decade has seen significant growth in the number of hospice programs and hospice utilization. In 2016, there were 4382 Medicare-certified hospices in operation.

An estimated 1.4 million people received hospice care in the US, with almost half being older than 84 years and 27.2% (the largest portion) having cancer as their terminal diagnosis. Over 50% of patients were cared for at home, with 42% cared for in a nursing home setting. On closer examination, there is tremendous geographic variation in the availability and use of hospice services. For example, the proportion of Medicare decedents enrolled in hospice at the time of death varied across states from a low of 23% (Puerto Rico) to a high of 58% (Utah). Hospice utilization also varies by race and ethnicity. Almost 50% of Whites who died in 2016 used hospice care compared to 31% to 37% of African American, Asian, or Native American descent. While longer Lengths of Stay (LOS) in hospice have been shown to be more beneficial to patient and family,[6] family satisfaction with hospice care is more closely associated with the quality of hospice care, meaning fewer unmet needs and fewer reported concerns.[7] The median LOS in hospice in 2016 was 24 days, while the average was 71 days. There is also a notable racial disparity in the timing of referral to

hospice, which impacts LOS. One study looking at a dataset of 43 869 home hospice enrollees found that African Americans are referred more frequently from a hospital location and have a greater chance of dying within seven days.[8]

Variations in hospice use can also have a basis on hospice and physician characteristics. One study found that 78 percent of hospices had at minimum one enrollment policy that might prove restrictive to access to care for patients with potentially high-cost medical care needs, such as chemotherapy or total parenteral nutrition. Smaller hospices, for-profit hospices, and hospices in some areas of the country consistently reported more limited enrollment policies.[9] This may be an important contributor to previously observed under-use of hospice by patients and families. Another contributor is physician characteristics. Patients cared for by physicians who frequently refer to hospice are more likely to be enrolled in hospice care earlier.[10]

To enable more timely referrals, educational interventions need to target physicians, and hospice programs need to expand patient access to potentially costlier palliative treatments that provide symptom relief. Ultimately, reform of the Medicare Hospice Benefit to include concurrent care or extend beyond a 6-month prognosis could also improve access to hospice in the United States.

Issues of Concern

The Medicare Hospice Benefit

Medicare was designed to provide comprehensive medical care for older Americans. Among its sections, Medicare Part A covers hospice services almost entirely—all services being provided without cost to the beneficiary, as long as the services are related to the terminal condition and have been approved by the hospice for payment. Given that this is a “carve-out” benefit, patients enrolled in hospice waive their traditional Medicare Parts A and D and elect the Medicare hospice benefit for care related to their terminal illness, including prescription medications. Historically, the Medicare hospice benefits only applied to medications related to the terminal diagnosis; for example, a hospice patient with congestive heart failure as their terminal diagnosis but with coexistent Diabetes and Hypertension would remain covered by traditional Medicare Parts A and D for the latter two comorbidities. Since 2015, under new guidance from Medicare, the hospice benefit now centers around a terminal prognosis rather than a diagnosis, given that prognosis is often worse in the setting of multiple comorbidities. For example, patients on hospice benefit from congestive heart failure who also suffer from chronic stage 4 kidney disease have a worse prognosis than patients with congestive heart failure but preserved kidney function.

Hospice Benefit Periods

All hospice services are rendered during benefit periods. Hospice care begins with two 90-day periods, followed by an unlimited number of 60-day periods. At the end of each benefit period and before the next one begins, the hospice team reevaluates the patient and recertifies that the patient has a terminal illness and that prognosis is less than 6 months. Each 60-day benefit period also requires a face-to-face visit from a hospice physician or nurse practitioner, who must provide clinical information to the certifying hospice physician in a timely manner. At any time during this process, a patient can change their mind about continuing hospice care.

Patients also may be discharged from hospice care for specific reasons, such as if they no longer have an expected prognosis of 6 months or if the patient moves away from the hospice’s service area. Patients are also free to re-enroll in the hospice benefit and need to be recertified for eligibility to resume hospice services. Whether patients revoke the hospice benefit or are discharged, traditional Medicare coverage becomes immediately available.

Since its inception, the Medicare hospice benefit has been a per diem capitated payment arrangement; hospices are paid a fixed dollar amount per day of patient care, based on the level of care. The rates of reimbursement are fixed annually and vary by geographic location.

Hospice Levels of Care

Four levels of care exist under the Medicare hospice benefit—two levels of care in the home and two inpatient levels. These are reimbursed differently by Medicare, with higher or more intense levels of care receiving higher reimbursement.

Routine Home Care

This level of care is administered in the patient's place of residence, which could be a private home, a personal care home, a nursing facility, or a prison. In most states, the benefit does not cover the cost of a patient's room and board in a nursing home. For a hospice program to obtain certification by Medicare, it is required to have 80% of its patients in their own homes. During home visits, the hospice team makes physical and environmental assessments and assesses the patient's and family's needs for additional services and assistance. Physical assessment involves reviewing the patient's symptoms, the need for adjustment of medications, level of dependence, and psychological and spiritual distress. Environmental assessments focus on patient safety (e.g., gait and balance, loose carpets, or inadequate lighting) as well as adaptations required to adjust to the patient's changing condition, such as having a hospital bed available for a patient who has become bedbound. Family assessment is crucial to detect caregiver burden and needs for additional support. When hospice care is rendered in the patient's home, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Hospice staff, usually nurses, are on-call 24 hours a day, seven days a week.

Continuous Home Care

This level of hospice care, which is more intense than routine home care, is given during brief periods of crisis management of acute symptoms with the intention of maintaining the patient in their home setting. To justify continuous home care, the patient needs direct skilled care for 8 hours a day, over 50% of which has to be delivered by the nurse. An example of skilled care would be intractable pain management with frequent assessment and administration of intravenous medications. A nursing home cannot provide this level of care.

General Inpatient Care (GIP)

Provision of this level of care is outside of the patient's usual home environment, in a Medicare-approved facility such as a free-standing inpatient hospice facility, a contracted nursing home, or hospital. This setting does not include custodial or residential. Indications that might determine a need for General Inpatient Care include managing uncontrolled pain, delirium, or other symptoms, especially ones that fall outside the purview of home care. Like continuous home care, a skilled need is necessary with GIP. Though GIP does not have a specified limit, patients are assessed daily by the hospice team regarding the necessity and eligibility of continuing that level of care. The expectation is for the patient to be stabilized and returned to their previous level of care/residence if possible.

Respite Care

This level is designed to provide relief to caregivers; it is allowable for no more than 5 consecutive days for every occurrence and is provided in a Medicare-approved facility such as an inpatient hospice facility or a nursing home. These patients don't require skilled care.

Clinical Significance

Benefits of Hospice Care

Hospice care offers numerous benefits, including greater patient and family control of medical care, familiar surroundings for patients, decreased isolation of patients, and better access to loved ones. Hospice care does not require patients to accept their terminal prognosis or have a do-not-resuscitate (DNR) order. Instead, hospice works with each patient and family member to provide support and education to help them come to terms with approaching death. At the crux of hospice care is the interprofessional hospice team.

Hospice Interprofessional Team

The core hospice team is comprised of the hospice nurse, social worker, and chaplain. Medicare requires the core team members to be employed by the hospice agency. The core hospice team provides every level of hospice care, with the nurse being at the forefront of coordinating all the care the patient receives. The hospice medical director is also required to be a part of the interprofessional team (IDT). Together these comprise a hospice IDT, which develops an individualized plan of care for each patient-family unit. The plan of care is designed to meet the patient's physical needs as well as the psychological, social, and even spiritual needs of the patient and family.

The interprofessional hospice team serves numerous roles. It manages the patient's pain and other symptoms, assists the patient and family members with the psychosocial, emotional, and spiritual aspects of dying; it provides medications and medical equipment, instructs the family on how to care for the patient, and provides grief support and counseling both to the patient, surviving family, and friends after the patient's death. Additionally, it makes short-term inpatient care available when pain or symptoms become unmanageable at home or when the caregiver needs respite time. When available, an IDT can provide specialized services like speech and physical therapy.

Role of the Physician

A physician can serve in one of three roles in hospice care; either the Hospice Medical Director (HMD), the attending physician, or the consultant physician. As the HMD, the physician assumes overall responsibility for the medical component of the care plans for all hospice patients, certifies and re-certifies a patient's terminal illness, reviews, and updates a patient's plan of care, participates in hospice's quality improvement initiatives and educates members of the IDT on evidence-based symptom management and communication techniques.

The HMD also collaborates closely with the patient's attending physician—the physician with the most significant role in determining and delivering the patient's medical care. In most cases, the patient's usual attending physician is a primary care physician but can also be a sub-specialist. The intent is for the attending physician to be the clinician who knows the patient best, likely from a previous provider-patient relationship. The patient/family must choose the hospice attending if they are able to identify one. The attending physician can then continue to serve in a similar collaborative capacity when the patient is admitted for hospice care.

A consultant physician must be contracted with the hospice and is typically a sub-specialist who provides a particular service related to a hospice patient's terminal condition (e.g., a single fraction palliative radiation treatment for a painful metastatic lesion administered by a consulting radiation oncologist). The Hospice can bill Medicare part A for these services and any medically indicated services provided by the HMD. These physician charges get reimbursed in addition to the per diem hospice rates paid by Medicare. The hospice per diem rate includes all of the administrative responsibilities of the Hospice Medical Director. The hospice attending physician typically bills Medicare directly for their services under Part B, using a hospice modifier to indicate if service was 'related' or 'unrelated' to the terminal hospice diagnosis.

Nursing, Allied Health, and Interprofessional Team Interventions

Hospice end-of-life care requires an interprofessional team that includes clinicians (e.g., family doctors, specialists as outlined above), specialty trained nursing staff, home and inpatient health aids, psychological and mental health professionals, pharmacists, and, if necessary, clergy. All these specialties and disciplines must coordinate their activities, utilize open communication, work with the patient's family and friends, and exercise the utmost compassion during this sensitive time. While no actions can change the final outcome, an interprofessional team can make the experience much less traumatic and more comfortable for patients and their families. [Level 5]

Continuing Education / Review Questions

- Access free multiple choice questions on this topic.
- Comment on this article.

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Figures

Table 1: Eligibility Criteria for hospice care in the US under the Medicare hospice benefit

Patient is eligible for Medicare part A	Patient >65 years or receiving Medicare disability payments
Patient has a terminal condition	At start of care, 2 physicians must sign a statement certifying that the patient's life expectancy is 6 months or less based on their best estimate of the patient's medical prognosis. One of the physicians is usually the hospice team physician or Hospice Medical Director (HMD)
Patient chooses hospice care	Patient signs a Medicare hospice benefit election form
Care is provided by a Medicare-Certified Hospice program	List of hospices and comparison of hospice agencies is available at cms.gov

Hospice Care Table. Contributed by Mamta Bhatnagar MD, MS

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ZaggoCare

Improving Patient Engagement

Pros and Cons of Hospice Care

by **Zaggocare** on August 5, 2019 in **Hospice and Palliative Care**

No one likes to discuss end-of-life care and death. But it's worth having the difficult conversations because patients should be as comfortable as possible, receiving the level of treatment they desire. What are the pros and cons of hospice care? Take the time to learn more so you can make an informed decision about your care or the care of a loved one.

For many, the word hospice brings up negative thoughts of very sick people spending their last days and weeks in a depressing hospice facility. However, that is outdated thinking that should not stop you from considering hospice services. Rather, hospice is designed to provide comfort care that can make the end of life easier to bear and more comfortable.

What is hospice care?

Hospice care is a philosophy of treatment focused on caring, not curing. The goal is to help patients get the best quality of life in the time remaining. Hospice staff care for any type of physical and emotional symptoms that cause pain, discomfort and distress. The care is specifically designed around the patient's needs and wishes. The patient's loved ones receive support as well.

Hospice care is frequently provided in the patient's home, but patients can receive hospice care in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities.

Importantly, patients in hospice can stop hospice service whenever they want.

The benefits of hospice care.

There are many benefits to the patient and family, including:

- Expert pain and symptom management, helping patients be as comfortable as possible.
- Emotional support for the patient and family.
- Following a patient's choices regarding their end-of-life care.
- Helping patients stay at home during their end-of-life.
- Help with practical tasks like bathing and feeding the patient. Additionally, hospice workers may help with household tasks and errands.
- Giving family caregivers a chance to take a break from caregiving tasks.

Additionally, studies have shown that hospice care can significantly lower hospitalization rates, ICU admissions, and the number of invasive procedures performed at the end of life. Finally, hospice care can significantly lower the total costs of care during the last year of life.

Hospice care for patients at home or in a long-term care facility.

- Hospices will arrange for the delivery of all the needed equipment and supplies, including a hospital bed, bedside commode, medications, etc.
- Hospice will send a variety of qualified staff to make the patient more comfortable. Staff can include a registered nurse, social worker, home health aides, and a chaplain.
- A trained hospice volunteer is usually available to provide non-medical support to patients and families, including running errands, staying with the patient to give family members a break, preparing light meals, and lending emotional support.
- Hospice care is available 24/7. If you need a nurse after normal business hours, most hospices have registered nurses who can respond to a call for help within minutes.

Who should receive hospice care?

In order to qualify for hospice care, two doctors must certify that the patient has a life-altering condition with a life expectancy of less than 6 months. However, it's important to understand that this expectation is a guess – there is no scientific way to know for certain how much time a person will live with a given set of medical conditions.

Many patients who could benefit from hospice don't receive it at all or enroll at the very end of their life, missing out on the benefits. Although end-of-life discussions are difficult, it's worth the time and effort to make sure the patient is as comfortable as possible until the end.

How do patients get hospice care?

If you think you or your loved one could benefit from hospice care, talk to your doctor. Doctors may not recommend hospice care unless patients/families specifically ask; it turns out that doctors are often uncomfortable talking about end of life issues. One survey found that 46% of doctors frequently or often felt unsure about what to say during end of life conversations, and only 29% had received formal training on how to have these difficult conversations. An additional roadblock can be determining when a patient can/should receive hospice care. Since Medicare and most private insurance companies only cover patients with less than 6 months, doctors may find it hard to determine if a patient qualifies, since all patients differ in their health trajectory.

Unfortunately, all of these stumbling blocks mean that many people who could benefit from weeks or months of hospice care are not getting the care until the last few days of their lives.

Is hospice care covered by insurance?

Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations cover hospice care,

paying all or most of the expense. But, you should check with your provider to learn the details of your coverage.

Because Medicare and Medicaid only cover hospice care in hospices they've approved, check eligibility before choosing a provider or facility.

What are the potential negatives of hospice care?

Hospice care is a rapidly growing industry with over 4,000 hospices in the US. Although some hospices provide safe, wonderful care, others provide dangerous, subpar care.

Problems with in-home hospice care.

A 2017 analysis by Kaiser Health News of 20,000 government inspection records found that "missed visits and neglect are common for patients dying at home". Families and caregivers filed over 3,200 complaints with state officials in the past five years. Subsequently, government inspectors found problems in 759 hospices; more than half were cited for missing visits or other services they had promised to provide.

Widespread issues exist at hospice facilities.

In July 2019, the Office of Inspector General (OIG), of the US Dept of Health and Human Services, released reports that illustrates widespread deficiencies at hospice facilities throughout the US. Sadly, the OIG found that 87% of 4,563 US hospices violated at least 1 of Medicare's safety requirement over a 5-year period. Additionally, for the same 5 years, the OIG found a tripling in the number of hospices which had severe complaints filed against them.

The issues identified can lead to poor care and can jeopardize patient safety.

What is the cause of problems?

According to the OIG report, the most common deficiencies involve:

- Poor care planning
- Mismanagement of aide services
- Inadequate assessments of patients

Additionally, hospices had other problems that also posed risks to patients, including:

- Improperly vetting of staff
- Inadequate quality control

How bad can these problems get?

Bad. Very bad.

The OIG report provides examples of harm caused by serious lapses in care found in 2016 at hospice facilities. Here are a few examples:

- One hospice failed to treat a patient's wounds, which then became gangrenous. As a result, the patient needed an amputation of the lower left leg.
- Inspectors found maggots around the insertion site of a patient's feeding tube.
- One patient didn't receive his needed respiratory therapy, leading to difficulty breathing and increased fatigue.
- Although there were signs of injuries on the patient's pelvic area and other body parts, a hospice failed to recognize signs of a possible sexual assault.

How to choose a hospice?

Because the risk of problems is high, do your research before choosing a provider or facility:

- First of all, ask your doctor, friends and family for referrals. A personal recommendation is likely the best way to make a choice.
- Call your state hospice organization (find contact information for your state at Medicare.gov/contacts).
- Visit Medicare.gov/HospiceCompare to learn about services provided and quality of care. However, it's important to realize that for legal reasons, these reports do not contain data on deficiencies gathered by private accrediting organizations. Therefore, some important quality data is missing.
- If you plan on in-patient care at a hospice facility, a family member/trusted adult should visit in person. How do the staff interact with and treat the patients? Do the patients look well cared for? Are the facilities clean?
- Use the helpful worksheet provided by the National Hospice and Palliative Care Organization to help you evaluate the hospices available in your area.

Want to learn more?

Visit these sites to learn more:

- Centers for Medicare and Medicaid Services booklet on hospice
- Compassion and Choices
- Hospice Foundation of America
- National Hospice and Palliative Care Organization
- The Conversation Project

My final thoughts on the pros and cons of hospice care…

Although the OIG and other investigations found serious, concerning issues, hospice remains a helpful service for patients at the end of life and their families. Personally, when my teenage son Zach was near the end of his life, the services we received from hospice (and palliative care) were very helpful and appreciated. So, if you, or a loved, one is near the end of life, I suggest you consider hospice care. But do your homework before choosing a provider!

Healthy Lifestyle

End of life

Hospice care might be an option if you or a loved one has a terminal illness. Understand how hospice care works and how to select a program.

By Mayo Clinic Staff

If you or a relative has a terminal illness and you've exhausted all treatment options, you might consider hospice care. Find out how hospice care works and how it can provide comfort and support.

Hospice care is for people who are nearing the end of life. The services are provided by a team of health care professionals who maximize comfort for a person who is terminally ill by reducing pain and addressing physical, psychological, social and spiritual needs. To help families, hospice care also provides counseling, respite care and practical support.

Unlike other medical care, the focus of hospice care isn't to cure the underlying disease. The goal is to support the highest quality of life possible for whatever time remains.

Hospice care is for a terminally ill person who's expected to have six months or less to live. But hospice care can be provided for as long as the person's doctor and hospice care team certify that the condition remains life-limiting.

Many people who receive hospice care have cancer, while others have heart disease, dementia, kidney failure or chronic obstructive pulmonary disease.

Enrolling in hospice care early helps you live better and live longer. Hospice care decreases the burden on family, decreases the family's likelihood of having a complicated grief and prepares family members for their loved one's death. Hospice also allows a patient to be cared for at a facility for a period of time, not because the patient needs it, but because the family caregiver needs a break. This is known as respite care.

Most hospice care is provided at home — with a family member typically serving as the primary caregiver. However, hospice care is also available at hospitals, nursing homes, assisted living facilities and dedicated hospice facilities.

No matter where hospice care is provided, sometimes it's necessary to be admitted to a hospital. For instance, if a symptom can't be managed by the hospice care team in a home setting, a hospital stay might be needed.

If you're not receiving hospice care at a dedicated facility, hospice staff will make regular visits to your home or other setting. Hospice staff is on call 24 hours a day, seven days a week.

A hospice care team typically includes:

- **Doctors.** A primary care doctor and a hospice doctor or medical director will oversee care. Each patient gets to choose a primary doctor. This can be your prior doctor or a hospice doctor.
- **Nurses.** Nurses will come to your or your relative's home or other setting to provide care. They are also responsible for coordination of the hospice care team.
- **Home health aides.** Home health aides can provide extra support for routine care, such as dressing, bathing and eating.
- **Spiritual counselors.** Chaplains, priests, lay ministers or other spiritual counselors can provide spiritual care and guidance for the entire family.
- **Social workers.** Social workers provide counseling and support. They can also provide referrals to other support systems.
- **Pharmacists.** Pharmacists provide medication oversight and suggestions regarding the most effective ways to relieve symptoms.
- **Volunteers.** Trained volunteers offer a variety of services, including providing company or respite for caregivers and helping with transportation or other practical needs.
- **Other professionals.** Speech, physical and occupational therapists can provide therapy, if needed.
- **Bereavement counselors.** Trained bereavement counselors offer support and guidance after the death of a loved one in hospice.

Medicare, Medicaid, the Department of Veterans Affairs and private insurance typically pay for hospice care. While each hospice program has its own policy regarding payment for care, services are often offered based on need rather than the ability to pay. Ask about payment options before choosing a hospice program.

To find out about hospice programs, talk to doctors, nurses, social workers or counselors, or contact your local or state office on aging. Consider asking friends or neighbors for advice. The National Hospice and Palliative Care Organization also offers an online provider directory.

To evaluate a hospice program, consider asking:

- Is the hospice program Medicare-certified? Is the program reviewed and licensed by the

state or certified in some other way? Is the hospice program accredited by The Joint Commission?

- Who makes up the hospice care team, and how are they trained or screened? Is the hospice medical director board certified in hospice and palliative care medicine?
- Is the hospice program not-for-profit or for profit?
- Does the hospice program have a dedicated pharmacist to help adjust medications?
- Is residential hospice available?
- What services are offered to a person who is terminally ill? How are pain and other symptoms managed?
- How are hospice care services provided after hours?
- How long does it take to get accepted into the hospice care program?
- What services are offered to the family? What respite services are available for the caregiver or caregivers? What bereavement services are available?
- Are volunteer services available?
- If circumstances change, can services be provided in different settings? Does the hospice have contracts with local nursing homes?
- Are hospice costs covered by insurance or other sources, such as Medicare?

Remember, hospice stresses care over cure. The goal is to provide comfort during the final months and days of life.

Show References

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NHPCO Facts and Figures

2020 EDITION

Published August 20, 2020

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Introduction

About this Report

NHPCO Facts and Figures: Hospice Care in America provides an annual overview of hospice care delivery. This overview provides specific information on:

- Hospice patient characteristics
- Location and level of care
- Medicare hospice spending
- Hospice provider characteristics
- Volunteer and bereavement services

Currently, most hospice patients have their costs covered by Medicare, through the Medicare Hospice Benefit. The findings in this report reflect only those patients who received care through 2018, provided by the Medicare Hospice Benefit by the hospices certified by the Centers for Medicare and Medicaid Services (CMS) to care for them.

What is hospice care?

Considered the model for quality compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's family as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice facilities, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients with any terminal illness or of any age, religion, or race.

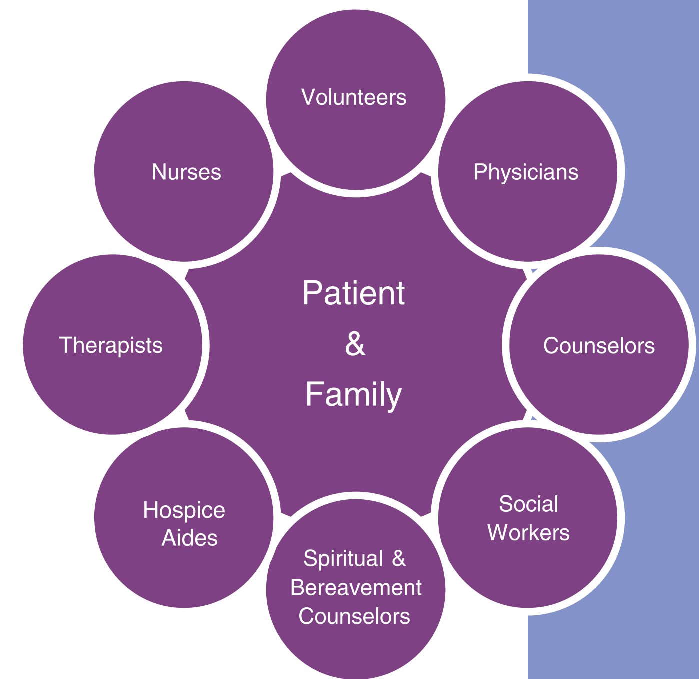
Consideration for discussion around differences in numbers reported by other authorities like MedPAC: This report presents metrics that may differ from other reporting sources eventhough the data sources are from CMS. This is a result in differing approaches and/or rules being applied such as use of fiscal vs calendar years, ICD Codes, and other historical lookback models. Please be aware of this when using the data for analysis and comparison between analytic vendors.

Introduction (continued)

How is hospice care delivered?

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. This interdisciplinary team, as illustrated in Figure 1, usually consists of the patient's personal physician, hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and speech, physical, and occupational therapists, if needed.



What services are provided?

The interdisciplinary hospice team:

- Manages the patient's pain and other symptoms;
- Assists the patient and family members with the emotional, psychosocial, and spiritual aspects of dying;
- Provides medications and medical equipment;
- Instructs the family on how to care for the patient;
- Provides grief support and counseling;
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time;
- Delivers special services like speech and physical therapy when needed;
- Provides grief support and counseling to surviving family and friends.

Location of Care

The majority of hospice care is provided in the place the patient calls home. In addition to private residences, this includes nursing homes and residential facilities. Hospice care may also be provided in freestanding hospice facilities and hospitals (see Levels of Care).

Introduction (continued)

Levels of Care

Hospice patients may require differing intensities of care during the course of their disease. While hospice patients may be admitted at any level of care, changes in their status may require a change in their level of care.

The Medicare Hospice Benefit affords patients four levels of care to meet their clinical needs: Routine Home Care, General Inpatient Care, Continuous Home Care, and Inpatient Respite Care. Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the interdisciplinary team, medication, medical equipment and supplies.

- **Routine Hospice Care (RHC)** is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care at their residence.
- **Continuous Home Care (CHC)** is care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
- **Inpatient Respite Care (IRC)** is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long-term care facility that has sufficient 24 hour nursing personnel present.
- **General Inpatient Care (GIP)** is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has a registered nursing available 24 hours a day to provide direct patient care.

Introduction (continued)

Volunteer Services

The U.S. hospice movement was founded by volunteers and continues to play an important and valuable role in hospice care and operations. Moreover, hospice is unique in that it is the only provider with Medicare Conditions of Participation (CoPs) requiring volunteers to provide at least 5% of total patient care hours.

Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services that support patient care and clinical services ("clinical support")
- Engaging in a variety of activities such as fundraising, outreach and education, and serving on a board of directors (general support).

Bereavement Services

Counseling or grief support for the patient and loved ones is an essential part of hospice care. After the patient's death, bereavement support is offered to families for at least one year. These services can take a variety of forms, including telephone calls, visits, written materials about grieving, and support groups. Individual counseling may be offered by the hospice or the hospice may make a referral to a community resource.

Some hospices also provide bereavement services to the community at large.

See page 26 for details on methodology and data sources including cited references within the report.

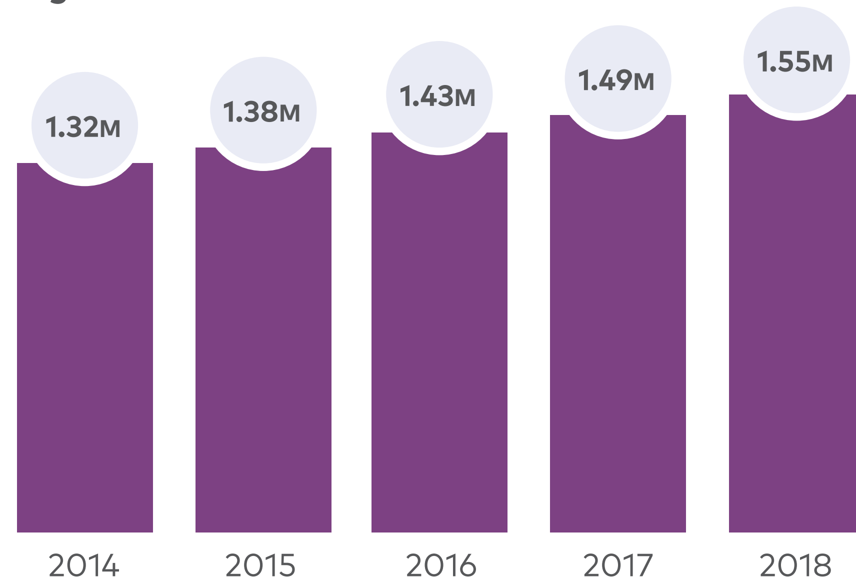
Who Receives Hospice Care

How many Medicare beneficiaries received hospice care in 2018?

1.55 million Medicare beneficiaries, a 4% increase from prior year, were enrolled in hospice care for one day or more in 2018*. This includes patients who:

- Died while enrolled in hospice
- Were enrolled in hospice in 2017 and continued to receive care in 2018
- Left hospice care alive during 2018 (live discharges)

*includes all states, Washington, D.C., U.S. territories, and Other.

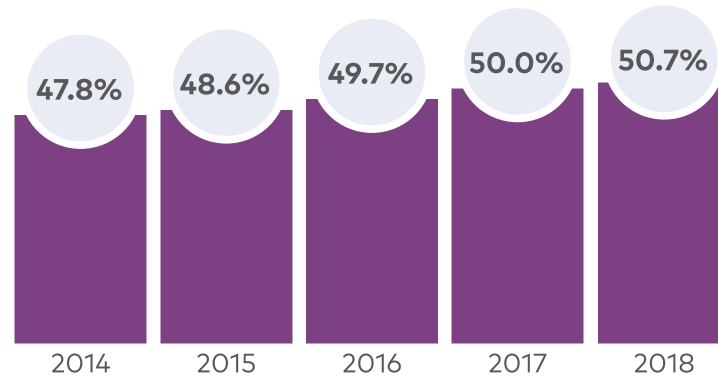


Who Receives Hospice Care (continued)

What proportion of Medicare decedents were served by hospice in 2018?

Of all Medicare decedents in 2018, 50.7% received one day or more of hospice care and were enrolled in hospice at the time of death.

Figure 2: Medicare Decedents Receiving 1 or more Days of Hospice Care

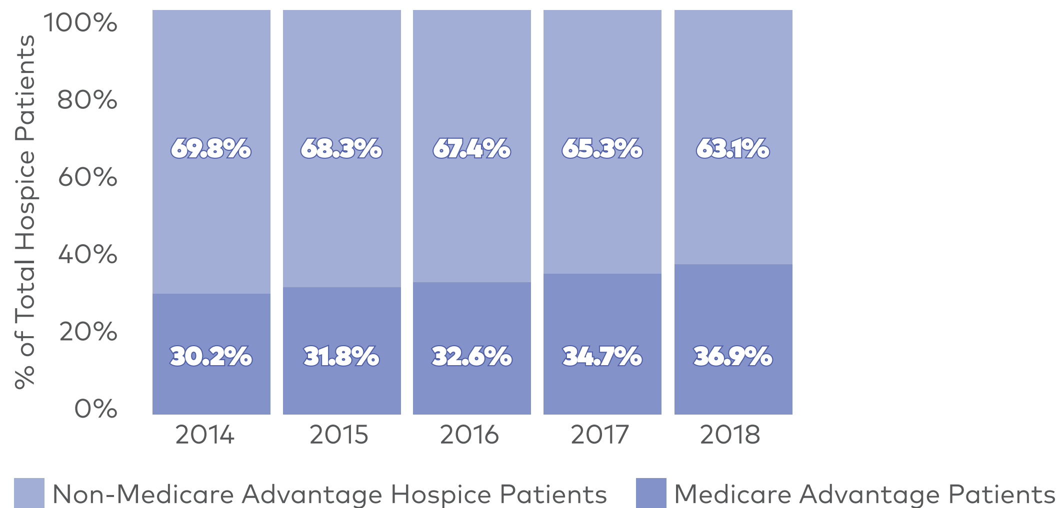


Source: MedPAC March Report to Congress, Table 12-3, Various years

What % of Hospice Patients Enrolled in Medicare Advantage within the Year?

The number of individuals who enrolled in a Medicare Advantage plan within the same year that they utilized the hospice benefit rose from from 30.2% of Medicare hospice patients in 2014 to 36.9% in 2018. The increase in hospice beneficiaries with MA enrollment is consistent with the overall increase in MA enrollment over this period.

Figure 3: Growth of Medicare Advantage Hospice Patients

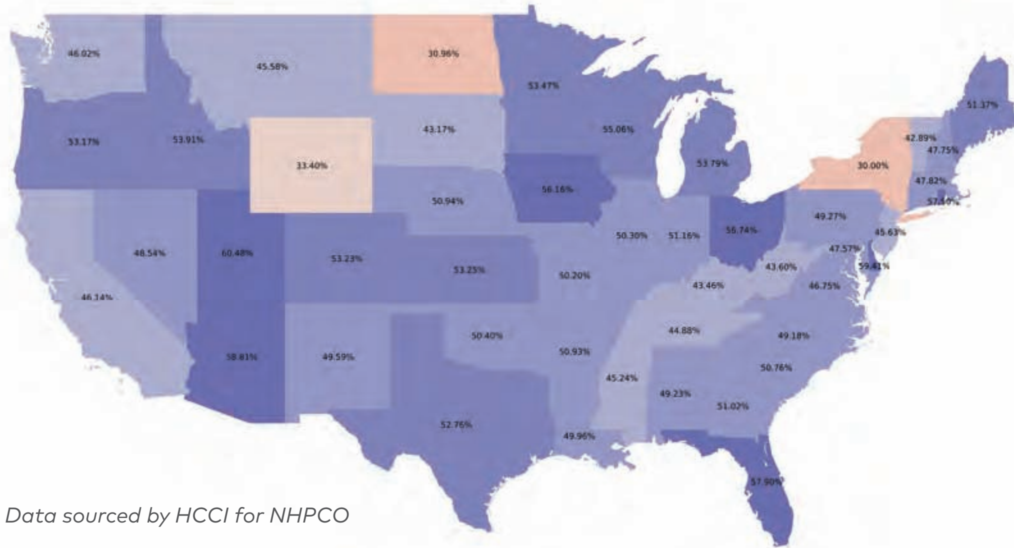


CMS Data sourced by HCCI for NHPCO

Who Receives Hospice Care (continued)

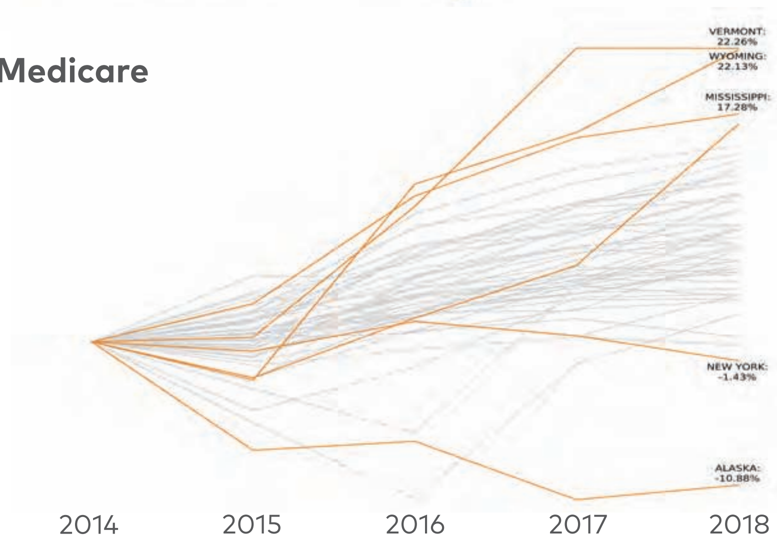
As illustrated on this page, the proportion of Medicare decedents enrolled in hospice at the time of death varied from a low of 14.3% (other) to a high of 60.5% (UT). Vermont and Wyoming had the greatest % increase since 2014 at 22.26% and 22.13% respectively. Alaska was the lowest with -10.88%.

Figure 4: % of Medicare Decedents Served by Hospice by state *(Aligns with Figure 5)*



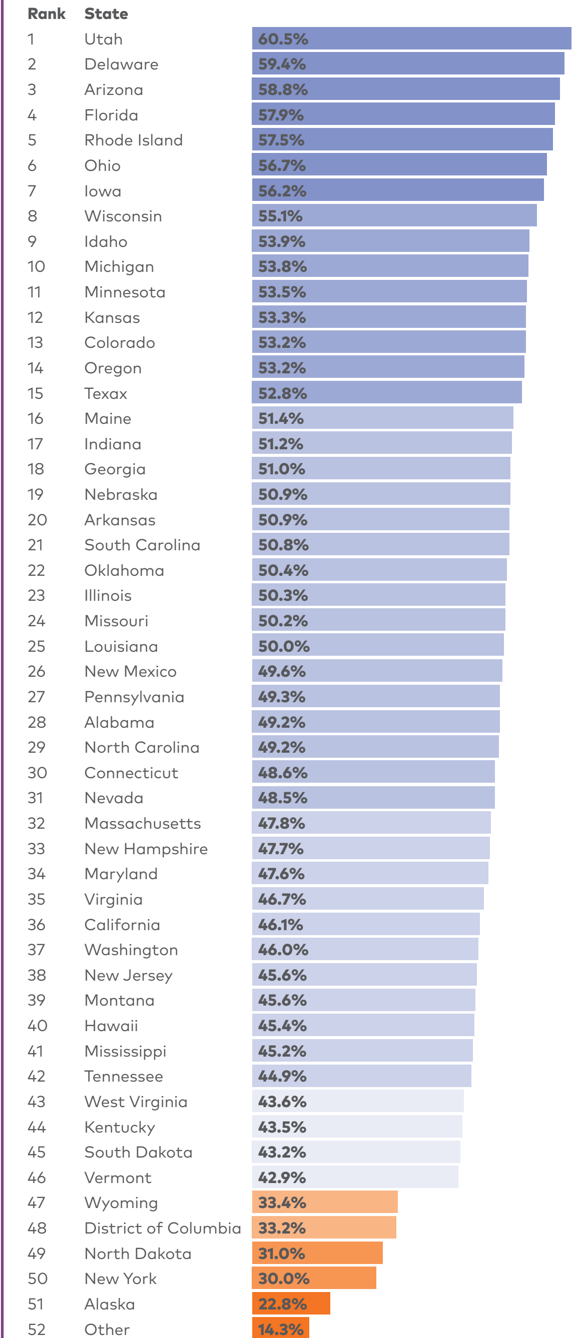
Source: CMS Data sourced by HCCI for NHPCO

Figure 6: 5 Year Change in Medicare Decedents by State



Source: CMS Data sourced by HCCI for NHPCO

Figure 5: Medicare Decedent Enrollment % for 2018



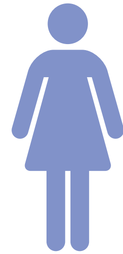
Rank	State	%
1	Utah	60.5%
2	Delaware	59.4%
3	Arizona	58.8%
4	Florida	57.9%
5	Rhode Island	57.5%
6	Ohio	56.7%
7	Iowa	56.2%
8	Wisconsin	55.1%
9	Idaho	53.9%
10	Michigan	53.8%
11	Minnesota	53.5%
12	Kansas	53.3%
13	Colorado	53.2%
14	Oregon	53.2%
15	Texax	52.8%
16	Maine	51.4%
17	Indiana	51.2%
18	Georgia	51.0%
19	Nebraska	50.9%
20	Arkansas	50.9%
21	South Carolina	50.8%
22	Oklahoma	50.4%
23	Illinois	50.3%
24	Missouri	50.2%
25	Louisiana	50.0%
26	New Mexico	49.6%
27	Pennsylvania	49.3%
28	Alabama	49.2%
29	North Carolina	49.2%
30	Connecticut	48.6%
31	Nevada	48.5%
32	Massachusetts	47.8%
33	New Hampshire	47.7%
34	Maryland	47.6%
35	Virginia	46.7%
36	California	46.1%
37	Washington	46.0%
38	New Jersey	45.6%
39	Montana	45.6%
40	Hawaii	45.4%
41	Mississippi	45.2%
42	Tennessee	44.9%
43	West Virginia	43.6%
44	Kentucky	43.5%
45	South Dakota	43.2%
46	Vermont	42.9%
47	Wyoming	33.4%
48	District of Columbia	33.2%
49	North Dakota	31.0%
50	New York	30.0%
51	Alaska	22.8%
52	Other	14.3%

Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2018?

Patient Gender
In 2018, more than half of hospice Medicare beneficiaries were female.

55.1% were **female**

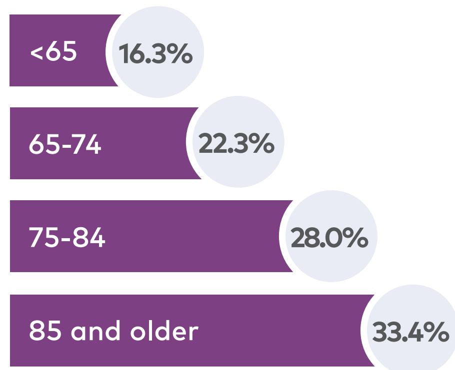


46.1% were **male**

Source: MedPAC March 2020 Report to Congress, Table 12-3

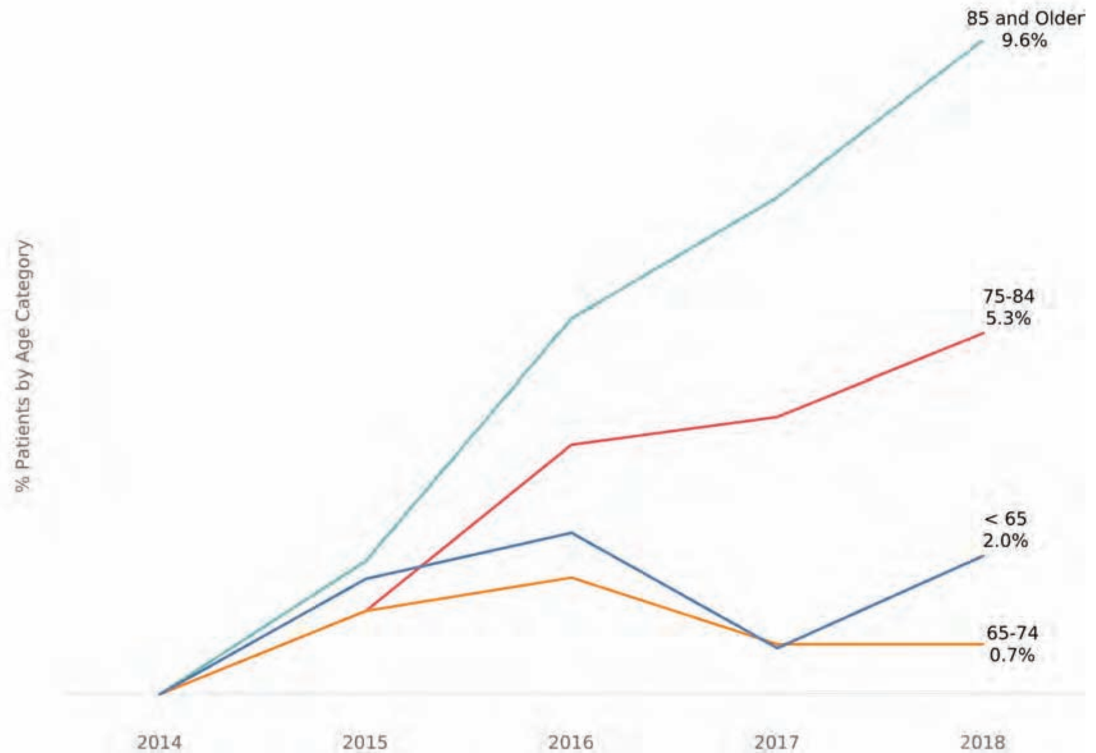
Patient Age
In 2018, about 61.4% of Medicare hospice patients were 75 years of age or older. The 85 and older age category has increased the most since 2014 at 9.6%.

Figure 7: % of Patients by Age for 2018



Source: MedPAC March 2020 Report to Congress, MedPac analysis of the denominator file and the Medicare Beneficiary Database (Applies to both Figure 7 & 8)

Figure 8: % Change over 5 Years

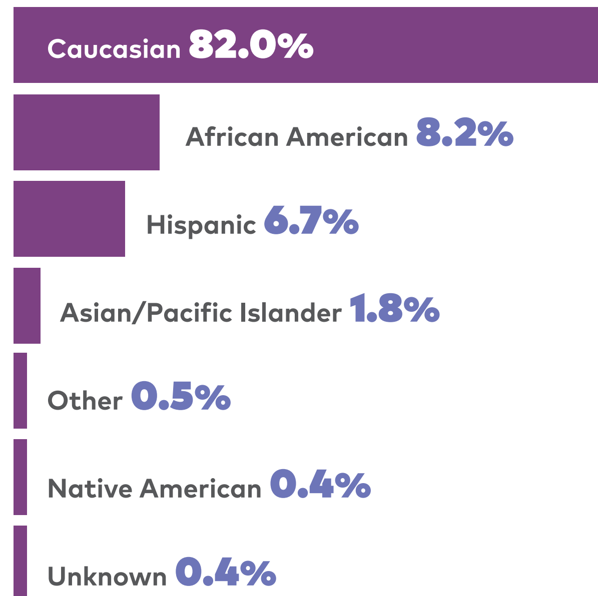


Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2018?

Patient Race

In 2018 a substantial majority of Medicare hospice patients were Caucasian. However, since 2014, patients identified as Asian/Pacific Islander and Hispanic have increased by 45% and 33% respectively.



Source: CMS Data sourced by HCCI for NHPCO

Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2018?

Principal Diagnosis

The principal hospice diagnosis is the diagnosis that has been determined to be the most contributory to the patient's terminal prognosis. 2018 continued to show that more Medicare hospice patients had a principal diagnosis of cancer than any other disease.

Principal diagnosis categories of Stroke, Other, Respiratory, and Circulatory/Heart have grown the most since 2014.

Figure 10: % of Hospice Decedents by Principal Diagnosis for 2017 & 2018

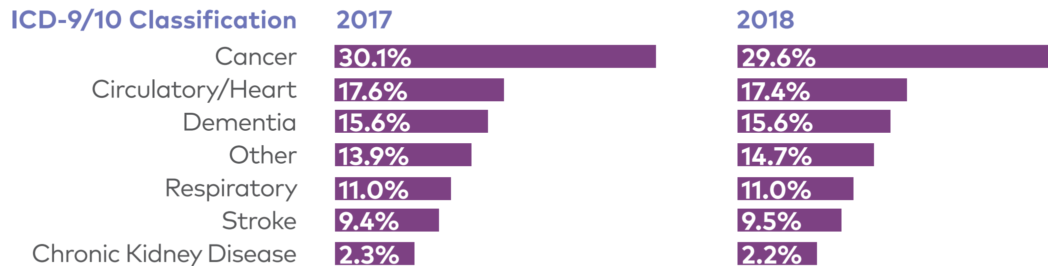
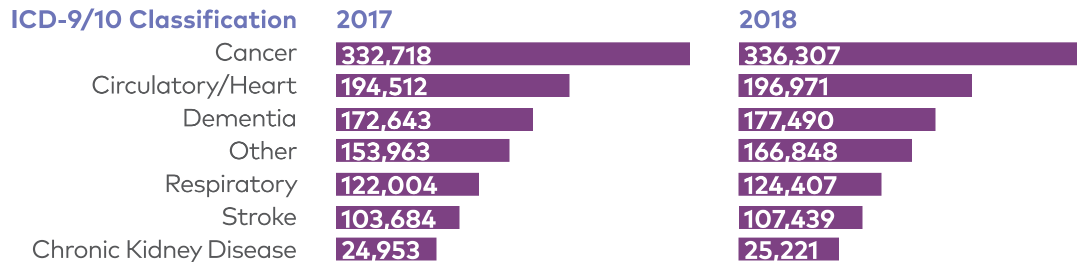


Figure 11: No. of Hospice Decedents by Principal Diagnosis for 2017 & 2018



Source: CMS Data sourced by HCCI for NHPCO

How Much Care Is Received?

Lifetime Length of Stay

The average Lifetime Length of Stay (LLOS) for Medicare patients enrolled in hospice in 2018 was 89.6 days. The median length of service (MLOS) was 18 days.

Table 1: Average Lifetime Length of Stay

Year	Patients	Total Days	Avg. Days of Care
2014	1.32M	91.9M	88.2
2015	1.38M	95.9M	86.7
2016	1.43M	101.2M	87.0
2017	1.49M	106.3M	88.1
2018	1.55M	113.5M	89.6

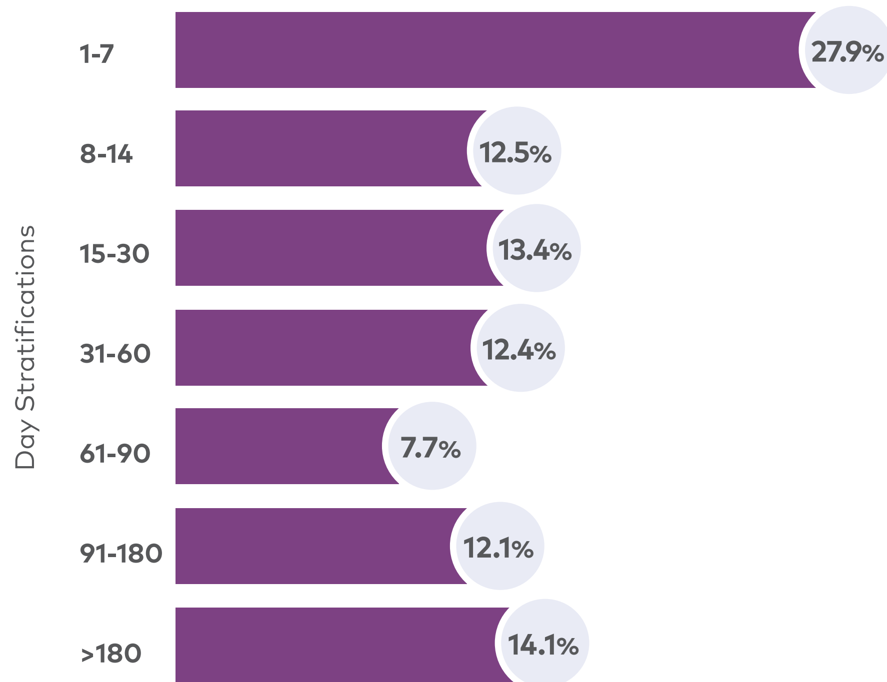
Source: MedPAC March Report to Congress, Various years

Days of Care

In 2018 hospice patients received a total of 114.0 million days of care paid for by Medicare.

A greater proportion of Medicare patients (27.9%) were enrolled in hospice a total of seven days or fewer compared to all other length of service categories. Forty percent of hospice beneficiaries in 2018 were served 14 days or less.

Figure 12: % of Patients by Days of Care for 2018*



**These values are computed using only days of care that occurred in 2018. Days of care occurring in other years are not included. Days of care have been combined for patients who had multiple episodes of care in 2018.*

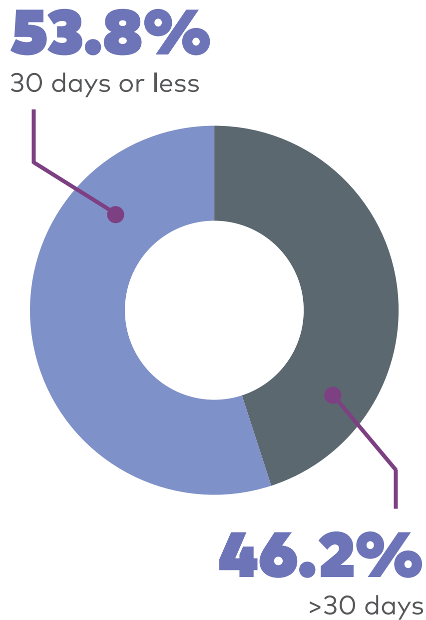
Source: CMS Data sourced by HCCI for NHPCO

How Much Care Is Received (continued)

Days of Care

In 2018 over half (53.8%) of patients were enrolled in hospice for 30 or fewer days.

Figure 13: % of Patients by Days of Care for 2018

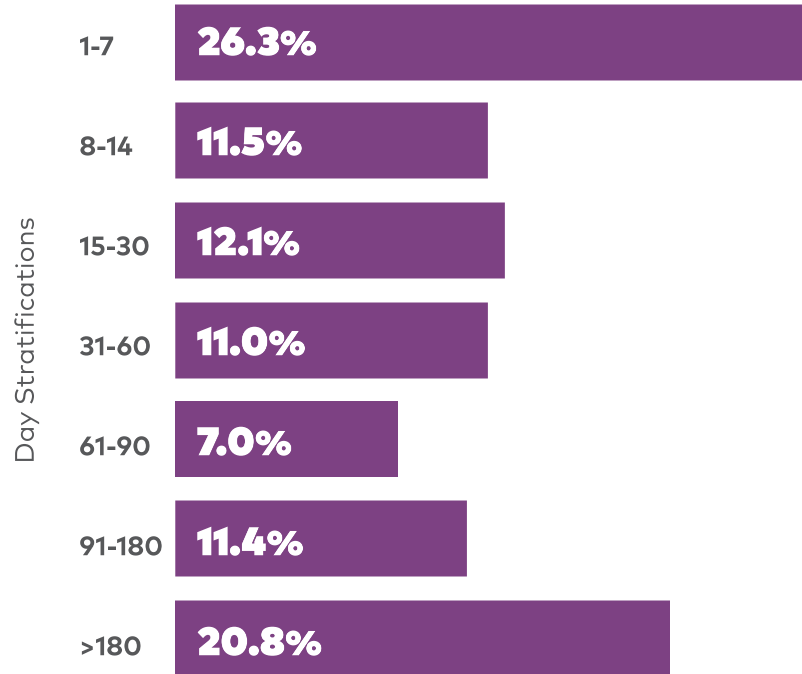


Source: CMS Data sourced by HCCI for NHPCO

Days of Care

Days of care over multiple years by percentage of patients*

Figure 14: Days of Care Between 2016-2018 by % of Patients



**These values are computed using all days of care that occurred between 2016 through 2018 highlighting extended care beyond 180 days that covered multiple years vs just 2018.*

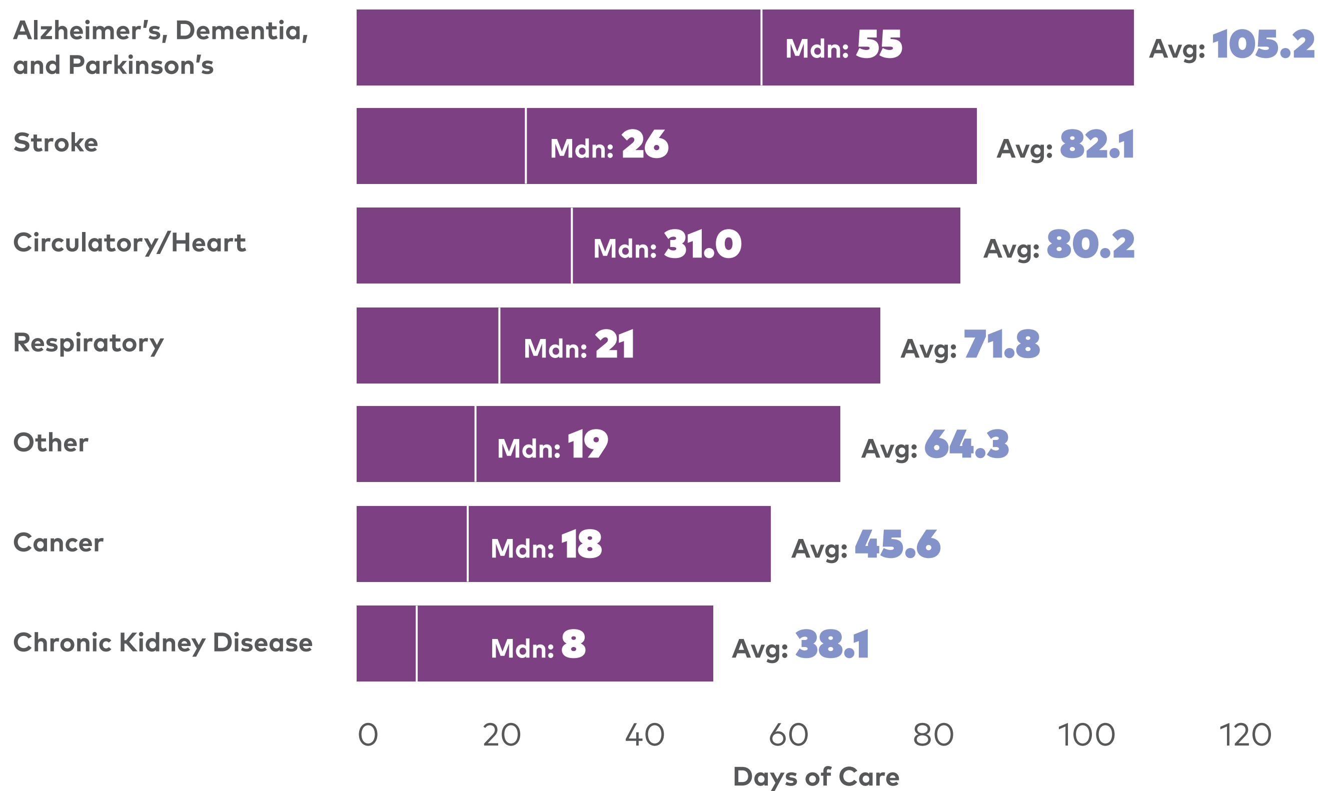
Source: CMS Data sourced by HCCI for NHPCO

How Much Care Is Received? (continued)

Days of Care

Patients with a principal diagnosis of dementia had the largest number of days of care on average in 2018.

Figure 15: Days of Care by Principal Diagnosis for 2018



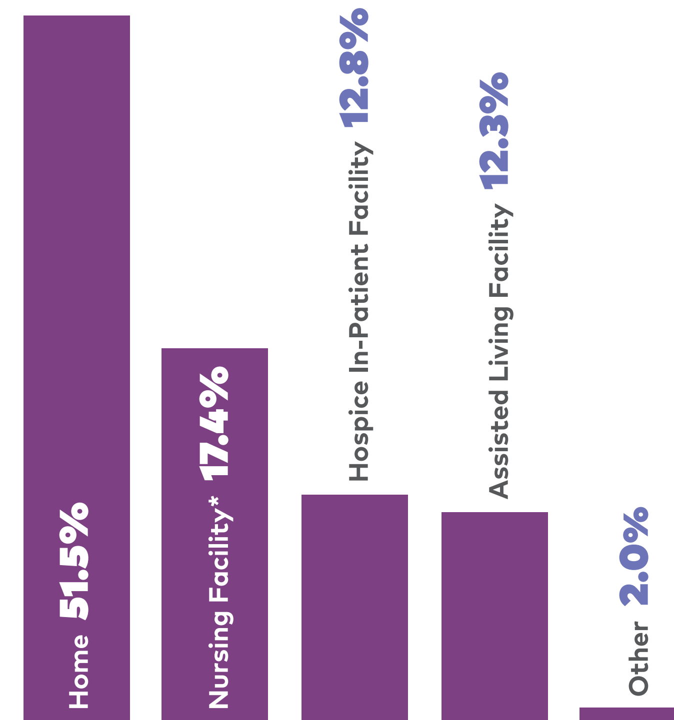
**These values are computed using only days of care that occurred in 2018. Days of care have been combined for patients who had multiple episodes of care in 2018. Days of care occurring in other years are not included.*

Source: CMS Data sourced by HCCI for NHPCO

How Much Care Is Received? (continued)

Deaths

In 2018, 1.1 million Medicare beneficiaries died while enrolled in hospice care. 51.5 % of deaths occurred in the home, and more than a third between nursing facilities, hospice in-patient facilities, and assisted living facilities. However, assisted living facilities have grown the most over 5 years by over 40%.



Source: CMS Data sourced by HCCI for NHPCO

How Much Care Is Received? (continued)

Discharges and Transfers

In 2018, there were 1.3M discharges. Live discharges comprised 17% of all Medicare hospice discharges with patient and hospice initiated discharges being about equal.

Table 2: Discharge by Type for 2018

Deaths	Decedents	83%
Patient Initiated-Live Discharges	Revocations	6.6%
	Transfers	2.2%
Hospice Initiated-Live Discharges	No Longer Terminally Ill	6.3%
	Moved Out of the Service Area	1.6%
	Discharges for Cause	0.3%

**Calculations are based on total number of discharges which includes patients who were discharged more than one time in 2018.*

Source: CMS Data sourced by HCCI for NHPCO

Level of Care

In 2018, the vast majority of days of care were at the Routine Homecare (RHC) level.

Table 3: Level of Care by % of Days of Care

LOC Metrics	2014	2015	2016	2017	2018
RHC Days	97.7%	97.9%	98.0%	98.0%	98.2%
CHC Days	0.3%	0.3%	0.3%	0.2%	0.2%
IRC Days	0.3%	0.3%	0.3%	0.3%	0.3%
GIP Days	1.7%	1.6%	1.6%	1.3%	1.2%

Source: MedPAC March Report to Congress, Various years

How Much Care Is Received? (continued)

Location of Care

In 2018, most of days of care were provided at a private residence followed by assisted living facilities and nursing facilities.

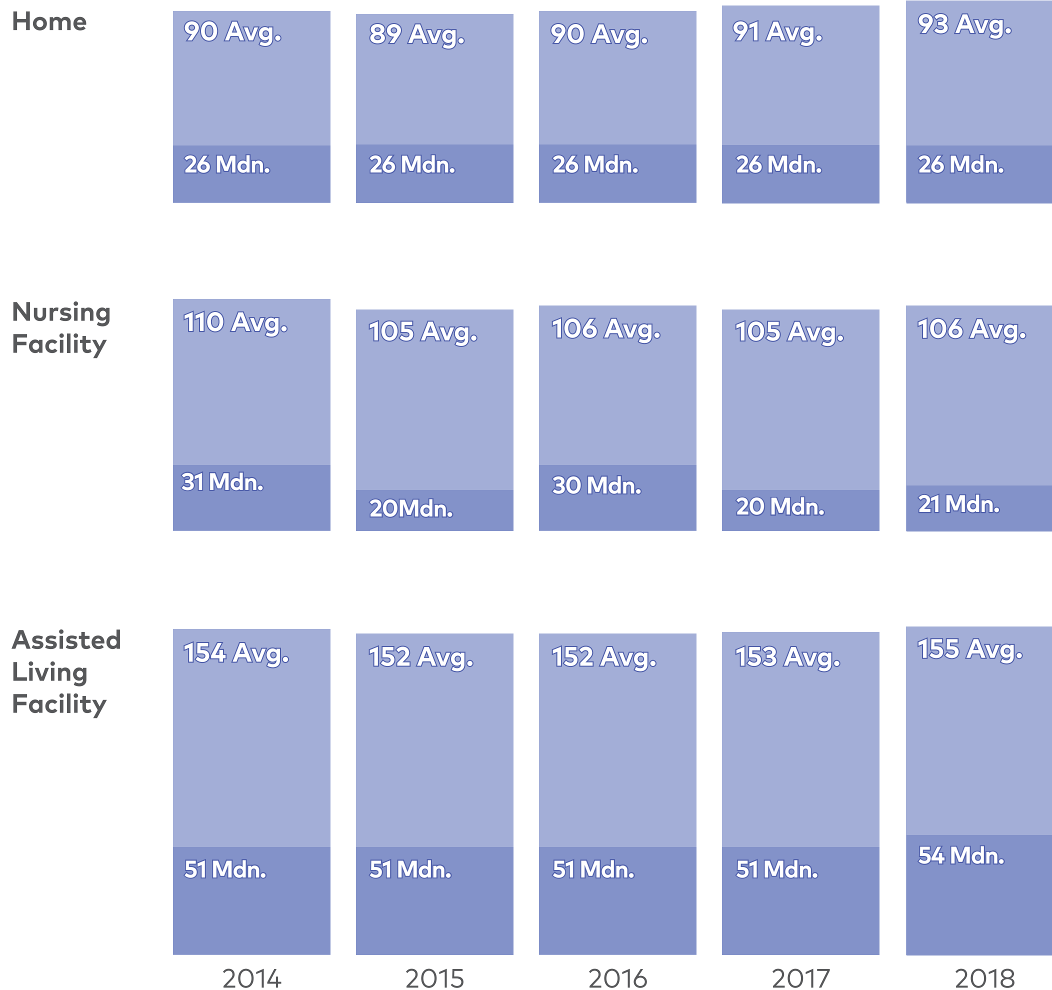
Average days by location of care as shown in figure 22 were 93 days at Home, 106 days in Nursing Facilities, and 155 days with Assisted Living Facilities. Avg Days at Home grew by 3.3 % since 2014 while Nursing Facilities declined by 3.6% over the same period.

Table 4: Location of Care by % of Days of Care for 2018

Location	% of Days
Home	55.6%
Assisted Living Facility	19.74%
Nursing Facility*	17.27%
Other	6.6%
Hospice In-Patient Facility	0.8%

** Includes skilled nursing facilities, nursing facilities, and RHC days in a hospice inpatient facility.*

Source: CMS Data sourced by HCCI for NHPCO

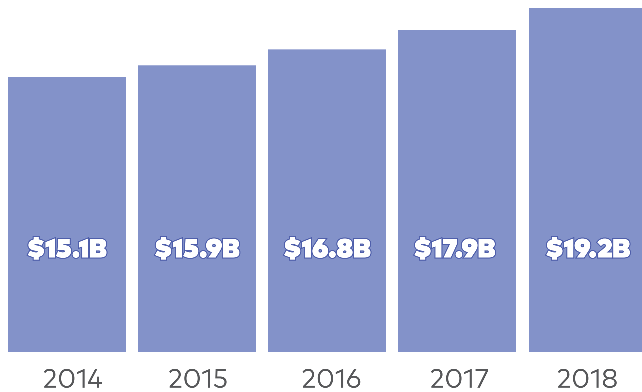


Source: MedPAC March 2020 Report to Congress, Table 12-5

How Does Medicare Pay for Hospice?

Medicare paid hospice providers a total of $19.2 billion dollars for care provided in 2018, representing an increase of 7.2% over the previous year.

Figure 18: Medicare Spending



Source: MedPAC March Report to Congress, Various Years

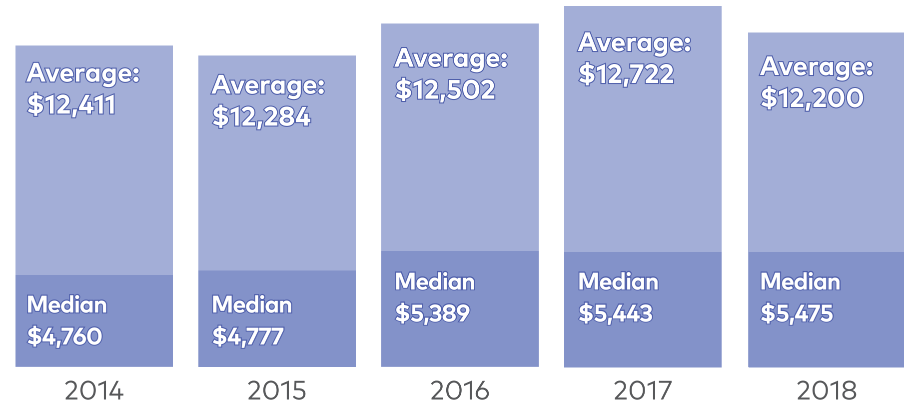
Spending by Days of Care

In 2018, only 27.9% of Medicare spending for hospice care was for patients who had received 180 or fewer days of care.* (See Table 5)

Spending Per Patient

The average spending per Medicare hospice patient was $12,200.

Figure 19: Average Medicare Spending Per Patient



Source: CMS Data sourced by HCCI for NHPCO

Table 5: Medicare Payments by Days of Care Stratified from 2012-2018

Day Stratifications	2014	2015	2016	2017	2018
1-7	3.12%	3.04%	3.1%	1.85%	1.90%
8-14	2.80%	2.68%	2.73%	1.66%	1.69%
15-30	4.18%	4.02%	4.20%	2.79%	2.79%
31-60	5.95%	5.80%	6.19%	4.61%	4.61%
61-90	5.38%	5.31%	5.54%	4.67%	4.67%
91-180	12.78%	12.58%	12.46%	11.06%	12.23%
>180	65.79%	66.58%	65.79%	73.75%	72.10%

** Includes days of care that spanned between the years of 2012 through 2017.*

Source: CMS Data sourced by HCCI for NHPCO

How Does Medicare Pay for Hospice? (continued)

Spending by Diagnosis

In 2018, patients with a principal diagnosis of dementia continued to lead Medicare hospice spending at 25.3%. Stroke, circulatory/heart, and respiratory related medicare spending grew the most since 2014.

Table 6: % of Medicare Spending by Principal Diagnosis

CCS	2018
Dementia	25.3%
Circulatory/Heart	20.2%
Cancer	17.7%
Other	13.3%
Respiratory	10.9%
Stroke	11.5%
Chronic Kidney Disease	1.1%

Source: CMS Data sourced by HCCI for NHPCO

Spending by Level of Care

In 2018, the vast majority of Medicare spending for hospice care was for care at the routine home care level. This has grown 17.8% since 2014.

Table 7: Spending by Level of Care

Level of Care	2018
Routine Home Care	89.81%
General Inpatient Care	6.44%
Inpatient Respite Care	1.95%
Continuous Home Care	1.79%

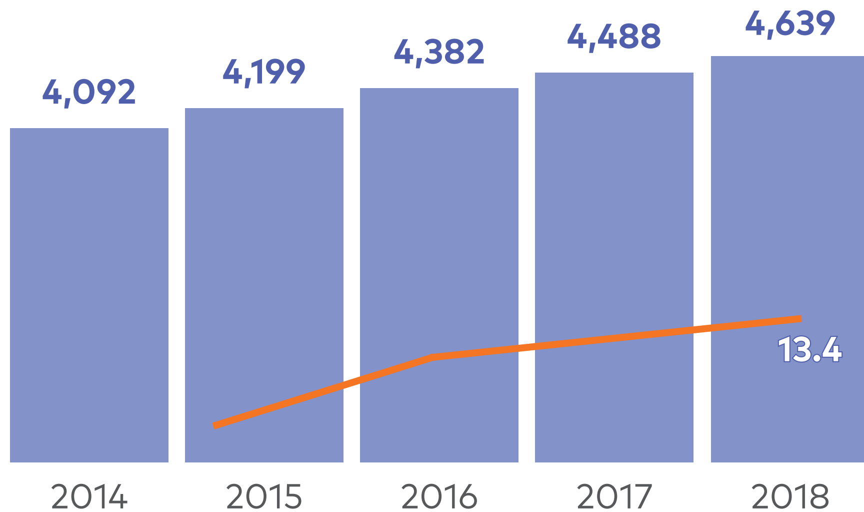
Source: CMS Data sourced by HCCI for NHPCO

Who Provides Care?

How many hospices were in operation in 2018?

Over the course of 2018, there were 4,639 Medicare certified hospices in operation based on claims data. This represents an increase of 13.4% since 2014.

Figure 20: Number of Operating Hospices



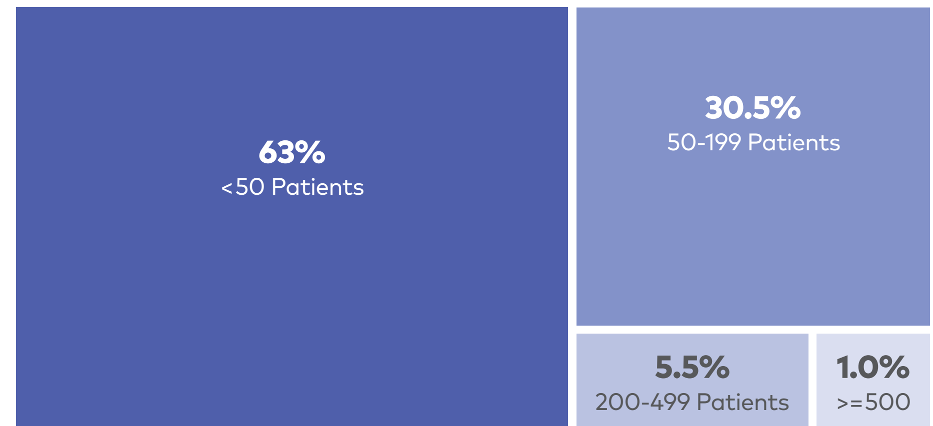
Source: MedPAC March Report to Congress, Various Years

Hospice Size

One indicator of hospice size is the average daily census (ADC) or more specifically the number of patients cared for by a hospice on average each day.

In 2018, the mean ADC for all hospices was 66.9 with a median of 31.8 patients. 63% of all hospices had an ADC of less than 50 patients.

Figure 21: Hospice Average Daily Census for 2018



Source: CMS Data sourced by HCCI for NHPCO

Table 8: ADC Support Stats

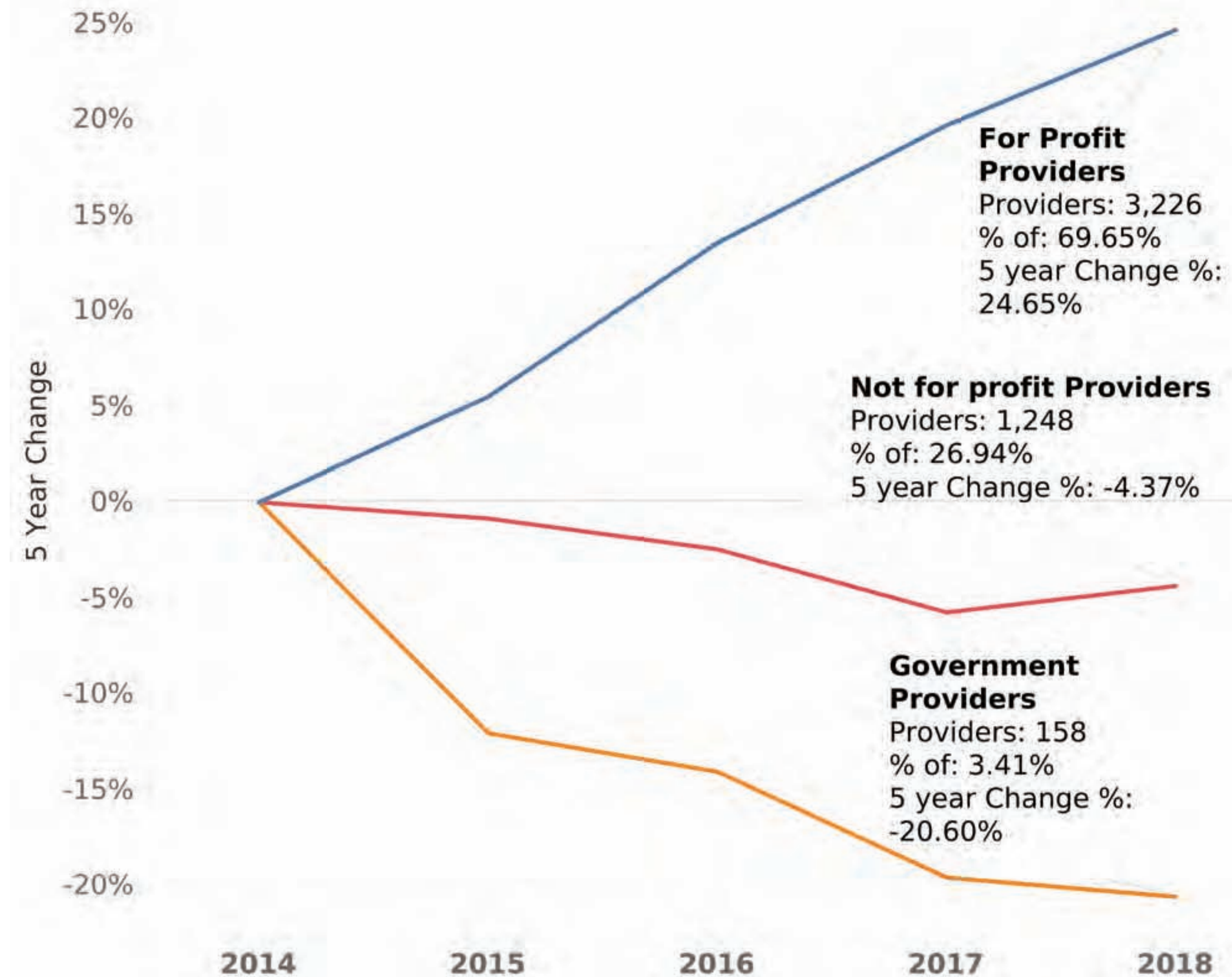
Year	Mean Census	Median Census	10th Percentile Census	25th Percentile Census	75th Percentile Census	90th Percentile Census
2014	66.9	33.5	4.1	12.8	75.3	150.3
2015	66.3	33.2	4.0	13.2	74.5	146.5
2016	67.3	33.1	3.1	12.1	75.9	153.5
2017	68.9	33.2	3.6	12.2	78.3	157.6
2018	66.9	31.8	4.0	12.5	75.5	154.2

Source: CMS Data sourced by HCCI for NHPCO

Who Provides Care? (continued)

Tax Status

As shown in figure 22, 69.7% of active Medicare provider numbers were assigned to hospice providers with for-profit tax status and 26.9% with not-for-profit status. For-profit hospice providers grew by 24.7 % since 2014 while non-profit hospice providers retracted 4.4%. Government-owned hospice providers comprised only 3.4% and has also declined by more than 20% since 2014.



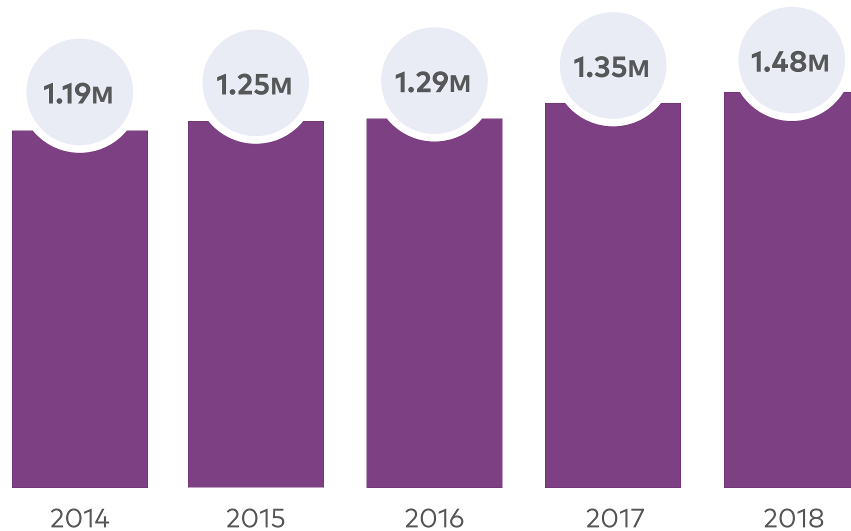
Source: MedPAC March Report to Congress, Various Years

Who Provides Care? (continued)

Patient Volume First Admissions

In 2018 hospice providers performed a total 1.48 million unduplicated admissions* of Medicare hospice patients representing a 23.9% increase since 2014.

Figure 23: First Admissions



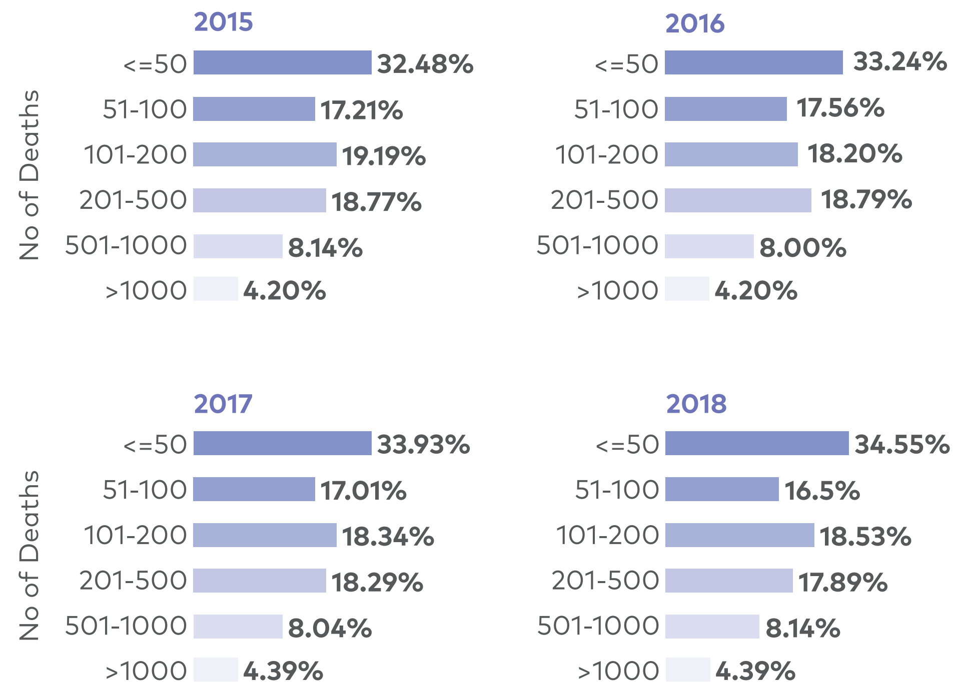
**Unduplicated admissions include patients who were part of the census at the end of 2017, carried over into 2018, discharged in 2017 and readmitted within the year.*

Source: CMS Data sourced by HCCI for NHPCO

Volume of Deaths

In 2018, the highest number of hospice providers served 50 or fewer patients who died while enrolled in hospice care.

Figure 24: % of Hospice Providers by Decedent Count



Source: CMS Data sourced by HCCI for NHPCO

Who Provides Care? (continued)

Provider Medicare Certification

More than 55% of all providers have been certified for 10 or more years, highlighting the maturity of the industry. The biggest growth of provider certification since 2014 has been on newer providers certified for 2-5 years, highlighting new entrants within the industry.

Table 9: Provider Certification

Years Certified	2014	2015	2016	2017	2018
<2 Years	11.1%	10.3%	10.3%	10.1%	10.1%
2-5 Years	13.3%	15.5%	16.9%	17.9%	17.6%
5-10 Years	21.8%	18.8%	17.2%	16.3%	17.1%
10+ Years	53.8%	55.4%	55.6%	55.7%	55.1%

Source: CMS Data sourced by HCCI for NHPCO

Data Sources

The data sources primarily used for this report are from the MedPAC March Report to Congress (various years), MedPAC Data Book, and various CMS claims related data sourced by the Health Care Cost Institute (HCCI) paid for by NHPCO. See cited sources through out the report for each table and figure. For data references provided by MedPAC, the March Report to Congress from various years or the FY2020 MedPAC Data Book are used. They can be found at www.medpac.gov. For data references provided by HCCI, various sources and the following methodology was used. The CMS Research Identifiable Files (RIF) Medicare Fee-for-Service (FFS) claims data including 100% of Medicare Part A from 2012-2018. The CMS 2018 Provider of Service (POS) file is used to provide further information on facilities certified to provide care to Medicare beneficiaries. The Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software (CCS) was used to classify patients into diagnosis categories based on their primary ICD-9 or ICD-10 diagnosis. The FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements is the source for the tax status statistics.

Methodology Note

For all HCCI related references, all claims are analyzed within the calendar year with the date assigned based on the claim through date, the last date on the billing statement for services covered to a beneficiary. The methods used to aggregate hospice claims were based on those outlined in the Centers for Medicare and Medicaid Services' Medicare Hospice Utilization &Payment Public Use File: A Methodological Overview. Results may differ from other reports such as Medpac's publications that look within a fiscal year or across multiple years for patients that have lengths of stay that cross many years. Unless otherwise specified, the denominator is all hospice beneficiaries who had any services covered within the calendar year, regardless of the discharge status code for the last service rendered. This differs from other analyses that may restrict to patients who were discharged (live discharges and/or decedents).

CMS Research Identifiable Files (RIF) Data Set

The Medicare FFS RIFs used for this report contain all Medicare Part A claims related to payment made directly towards hospice services. All beneficiaries with at least one hospice claim paid through Medicare are included in this file (2.5% of all Medicare beneficiaries in 2018). Selected variables within the files are encrypted, blanked, or ranged. The RIF Medicare claims used for Facts and Figures include the following data files:

- Hospice File: Hospice Fee-for-Service claims submitted by Medicare certified hospice providers (see documentation for detailed information on hospice files)
- Member Beneficiary Summary File (MBSF): Medicare beneficiary enrollment information via Medicare Parts A, B, C, and D (see documentation for detailed information on MBSF)

CMS 2018 Provider of Service (POS) Data Set

The POS file contains information of health care providers who are certified to provide care to Medicare beneficiaries.

Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software (CCS)

The CCS tool was used to group patients into diagnosis groups based off ICD-9 or ICD-10 diagnosis.

Questions May Be Directed To:

National Hospice and Palliative Care Organization Attention:
Research Phone: 703.837.1500
Email: communications@nhpco.org

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