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 people living with HIV (PLWH) 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 PLWH and support services for PLWH 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 PLWH or a PLWH'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).
Services to be Provided:	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 PLWH. • 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.
Service Unit Definition(s):	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.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Eligibility for Services:	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
Agency Requirements:	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. Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.

	Staff will refer Medicaid/Medicare eligible PLWH to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible PLWH 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 PLWH. 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 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

Modified Monitoring Process

Effective March 13, 2020 TRG enacted emergency response procedures due to COVID-19 pandemic. All monitoring was deferred/suspended in 2020 per DSHS and HRSA guidance.

In 2020, DSHS launched a burden reduction plan to reduce administrative burden by 50% for AA's and Subrecipients.

- This model requires subrecipient monitoring every other year (even years only).
- Per DSHS guidance, TRG is not required to complete monitoring in odd years
- In 2020, subrecipients that didn't have the ability to complete a remote review, were exempted from the 2020 Standards of Care chart review monitoring due to the COVID-19 State of Emergency.

2022 Monitoring

This year all subrecipients will be monitored, remotely if possible and in-person if necessary.

The monitoring period will cover calendar year 2021

Special chart review process is being evaluated for the RW Planning Council process during the "odd" years DSHS is not requiring monitoring (requires DSHS approval)

Hospice

NOT REVIEWED IN 2020

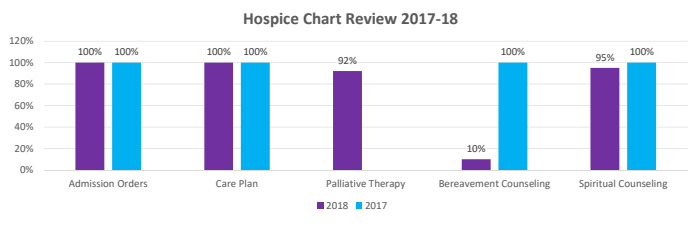
Description of Service

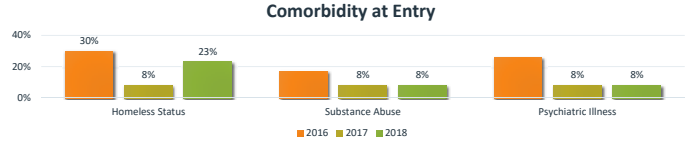
Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist.

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.

Chart Review Highlights- 2018 (not reviewed in 2019)





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.

NHPCO Facts and Figures

2021 EDITION

Published October 2021

NHPCO
National Hospice and Palliative Care Organization

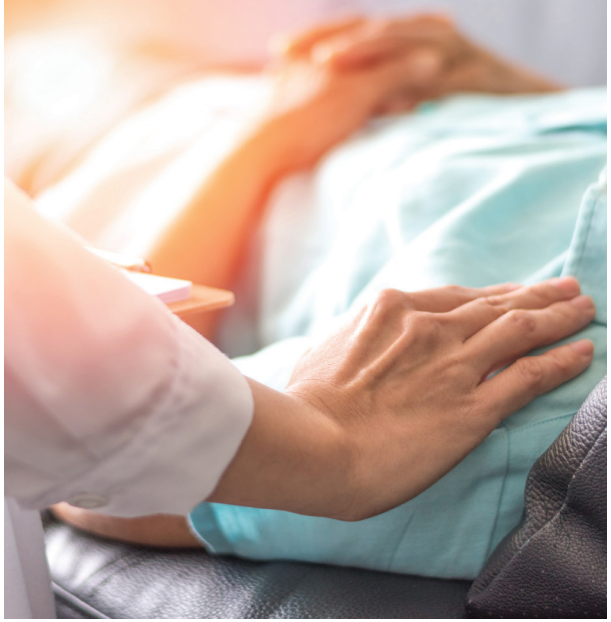


Table of Contents

Please see the Data Sources Section at the end of this report for details on the data sources used within this publication.

Section 1: Introduction

About this Report

NHPCO Facts and Figures 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 those patients who received care in 2019 provided by hospices certified by the Centers for Medicare and Medicaid Services (CMS) and reimbursed under the Medicare Hospice Benefit.

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.

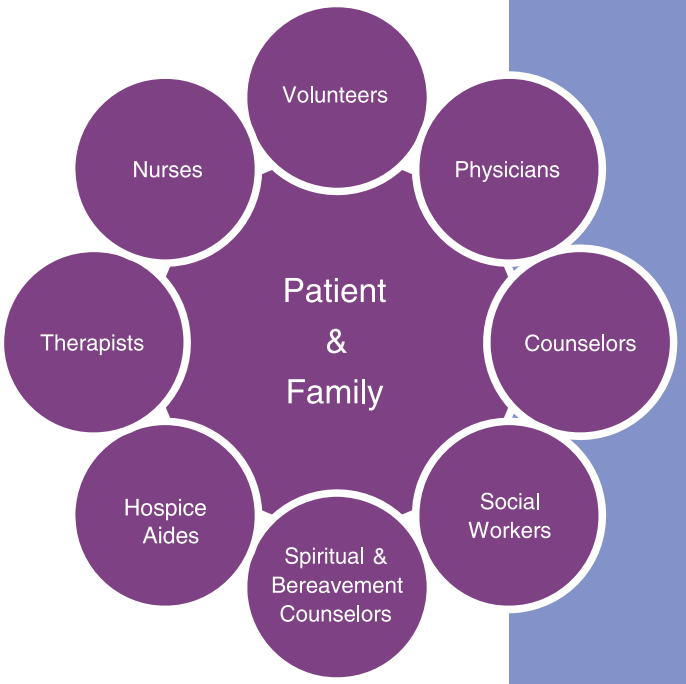
Hospice focuses on caring, not curing. In most cases, care is provided in the patient's private residence, but may also be provided in freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities. Hospice services are available to patients with any terminal illness. Hospices promote inclusiveness in the community by ensuring that all people regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease, or other characteristics have access to the hospice's programs and services.

Introduction (continued)

How is hospice care delivered?

Typically, a family member serves as the primary caregiver for the patient 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 when the caregiver needs respite time;
- Delivers special services like speech language pathology 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 illness. 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, Continuous Home Care, Inpatient Respite Care, and General Inpatient 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 who continue 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 visits, written materials about grieving, phone or video calls, 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, in addition to supporting patients and their families.

See page 24 for details on methodology and data sources, including cited references within the report.

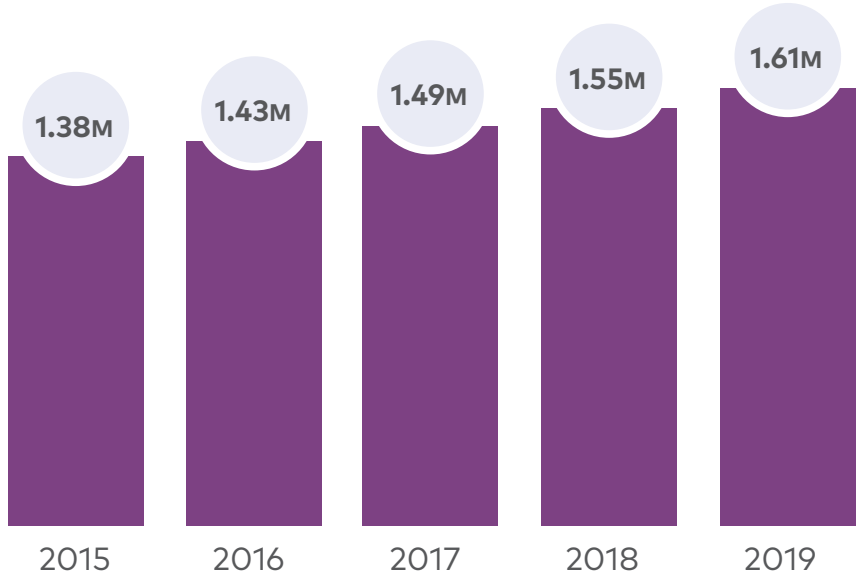
Section 2: Who Receives Hospice Care

How many Medicare beneficiaries received hospice care in 2019?

As seen in Figure 1, 1.61 million Medicare beneficiaries who died were enrolled in hospice care for one day or more in 2019. This is a 3.9 percent increase from 2018. This includes patients who:

- Died while enrolled in hospice
- Were enrolled in hospice in 2018 and continued to receive care in 2019
- Left hospice care alive during 2019 (live discharges)

Figure 1: Medicare Beneficiaries



**Includes all states, Washington, D.C., U.S. territories, and other*

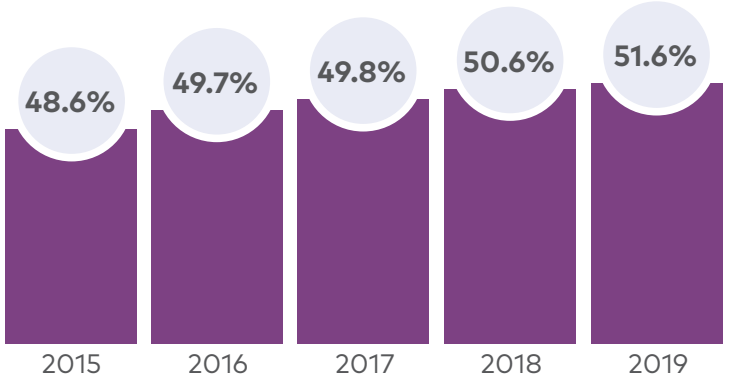
Source: MedPAC March Report to Congress, Table 11-3, Various years

Who Receives Hospice Care (continued)

What proportion of Medicare decedents were served by hospice in 2019?

Of all Medicare decedents in 2019, as seen in Figure 2, 51.6 percent received one day or more of hospice care and were enrolled in hospice at the time of death.

Figure 2: Percent of Medicare Decedents Receiving 1 or more Days of Hospice Care in 2019

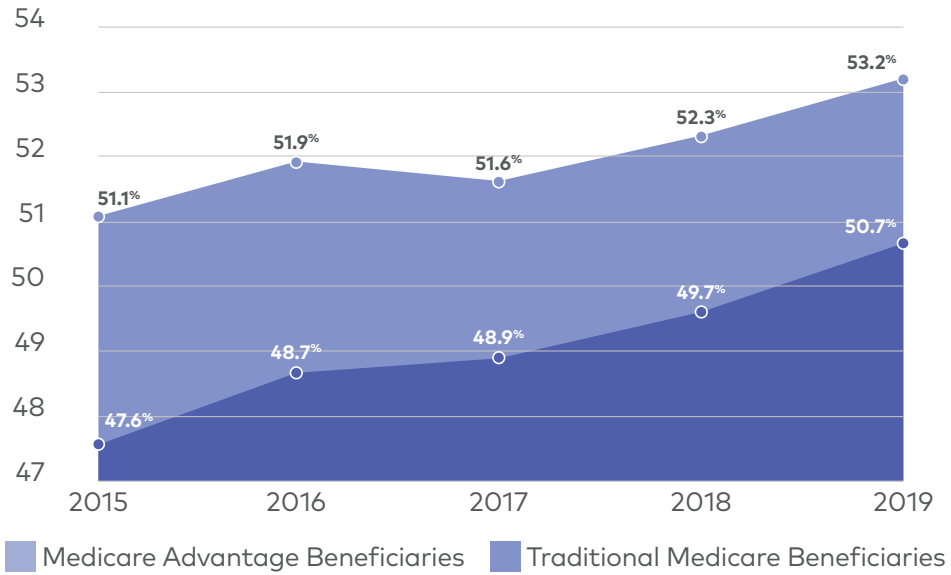


Source: MedPAC March 2021 Report to Congress, Table 11-2 and MedPAC March 2018 Report to Congress, Table 12-3

What % of Medicare Advantage Decedents Enrolled in Hospice between 2015 and 2019?

As demonstrated in Figure 3, utilization of the hospice benefit remains a bit higher among decedents enrolled in Medicare Advantage (MA) plans than among Traditional Medicare users, while the trendline for hospice usage continues to increase in both groups. MA decedents who utilized the hospice benefit rose from 51.1 percent in 2015 to 53.2 percent in 2019. During the same period, Traditional Medicare decedents utilizing the hospice benefit rose from 47.6 percent in 2015 to 50.7 percent in 2019.

Figure 3: Growth of Medicare Advantage Hospice Patients



Source: MedPAC March 2021 Report to Congress, Table 11-2 and MedPAC March 2018 Report to Congress, Table 12-3

Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2019?

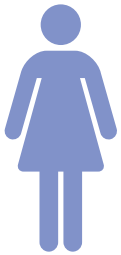
Figure 4: Patient Gender

In 2019, among beneficiaries who identified as female and died in 2019, 56.2% used hospice and 43.8% did not. Among beneficiaries who identified as male and died in 2019, 46.7% used hospice and 53.3% did not.

Among Medicare decedents who identified as female

56.2%

used hospice



Among Medicare decedents who identified as male

46.7%

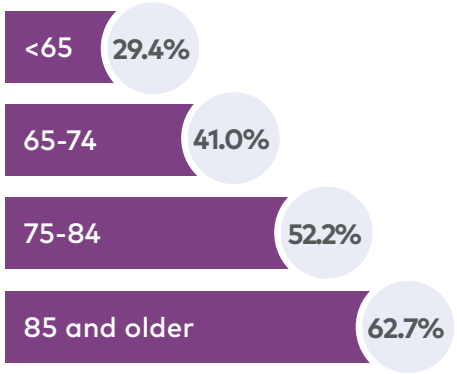
used hospice

Source: MedPAC March 2021 Report to Congress, Table 11-2.

Patient Age

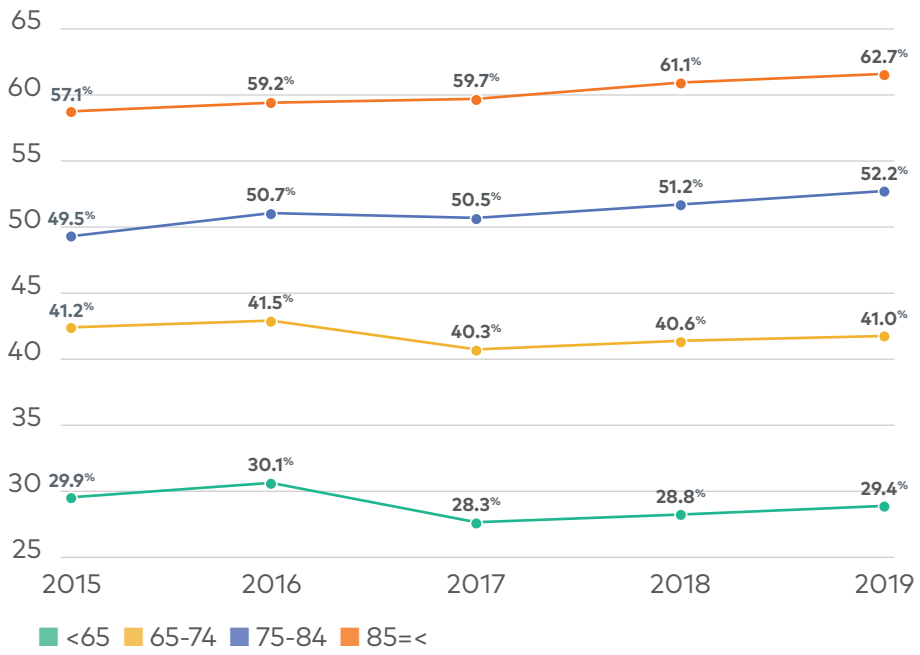
In 2019, as shown in Figure 5, nearly 63 percent of Medicare decedents age 85 years and older utilized the Medicare hospice benefit, while progressively smaller percentages of decedents in younger age groups received hospice care. Figure 6 shows that two of the four Medicare beneficiary age groups identified by MedPAC in its March 2021 Report to Congress saw increased usage of the Medicare hospice benefit over the five year period from 2015 to 2019.

Figure 5: % of Patients by Age group for 2019



Source: MedPAC March 2021 Report to Congress, Table 11-2.

Figure 6: % Change over 5 Years



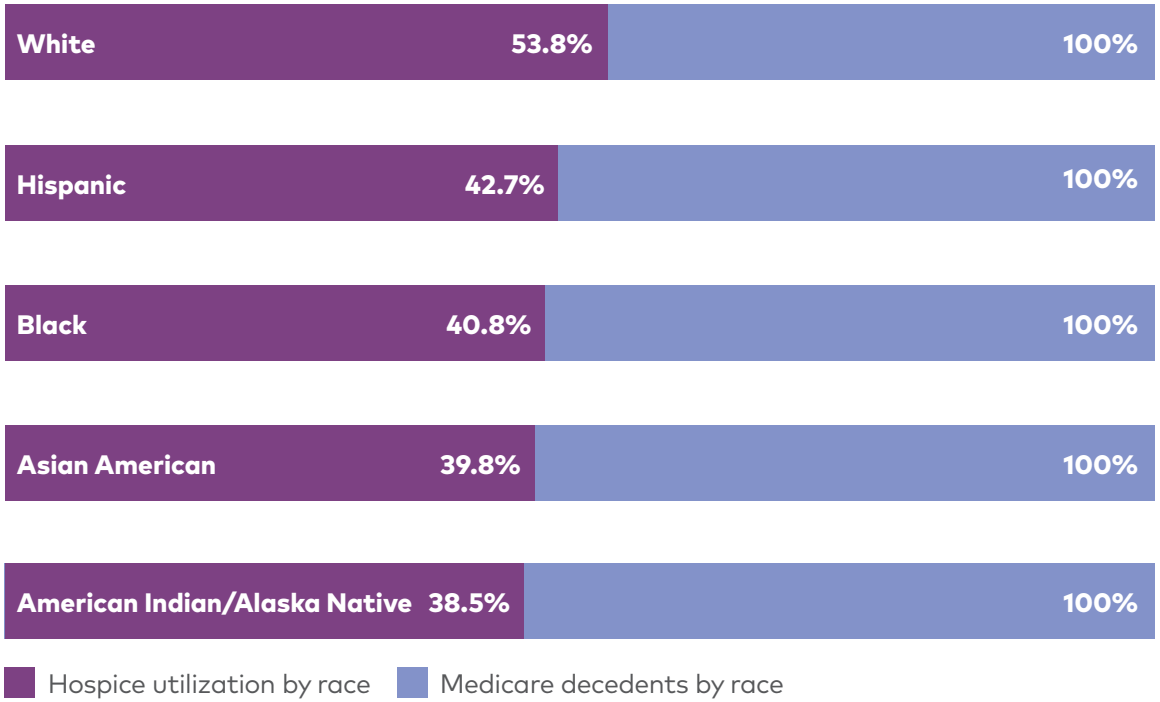
Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2019?

Patient Race

In 2019, almost 54 percent of White Medicare decedent beneficiaries used the Medicare hospice benefit (53.8 percent). Nearly 43 percent (42.7) of Hispanic Medicare beneficiaries and almost 41 percent (40.8) of Black Medicare beneficiaries enrolled in hospice in 2019. More than 38 percent of Asian American and American Indian/Alaska Native Medicare decedents used hospice in 2019.

Figure 7: % of Medicare decedents by race who used hospice



Source: MedPAC March 2021 Report to Congress, Table 11-2

Note: *In previous years, the NHPCO Facts and Figures has presented data on the share of Medicare beneficiaries who used hospice by race. In an effort to focus on equity, we are now presenting data from the 2019 MedPAC March report to Congress, Table 11-2, focused on the percentage of Medicare decedents by race who used hospice.*

Who Receives Hospice Care (continued)

What are the characteristics of Medicare beneficiaries who received hospice care in 2019?

Principal Diagnosis

The principal hospice diagnosis is the diagnosis that has been determined to be the most contributory to the patient's terminal prognosis. Specific diagnoses have been collapsed into major disease groupings in Figures 8 and 9 to the right. 2019 showed that more Medicare hospice patients had a principal diagnosis of Alzheimer's/Dementia/Parkinson's than any other disease.

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

Figure 8: Percentage of Medicare Decedents Using Hospice by Top 15 Principal Diagnoses

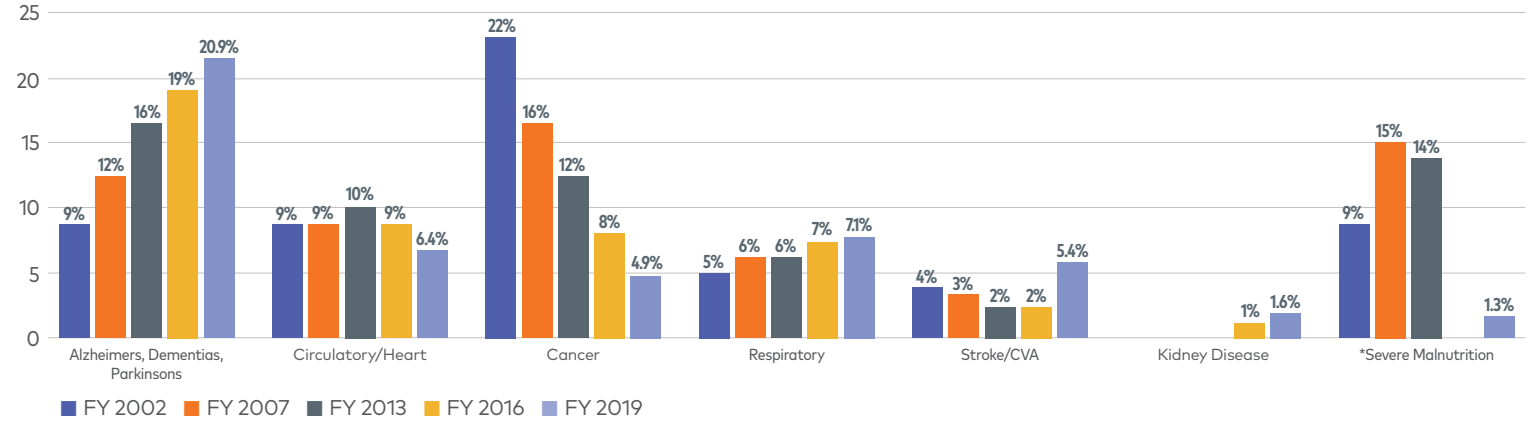
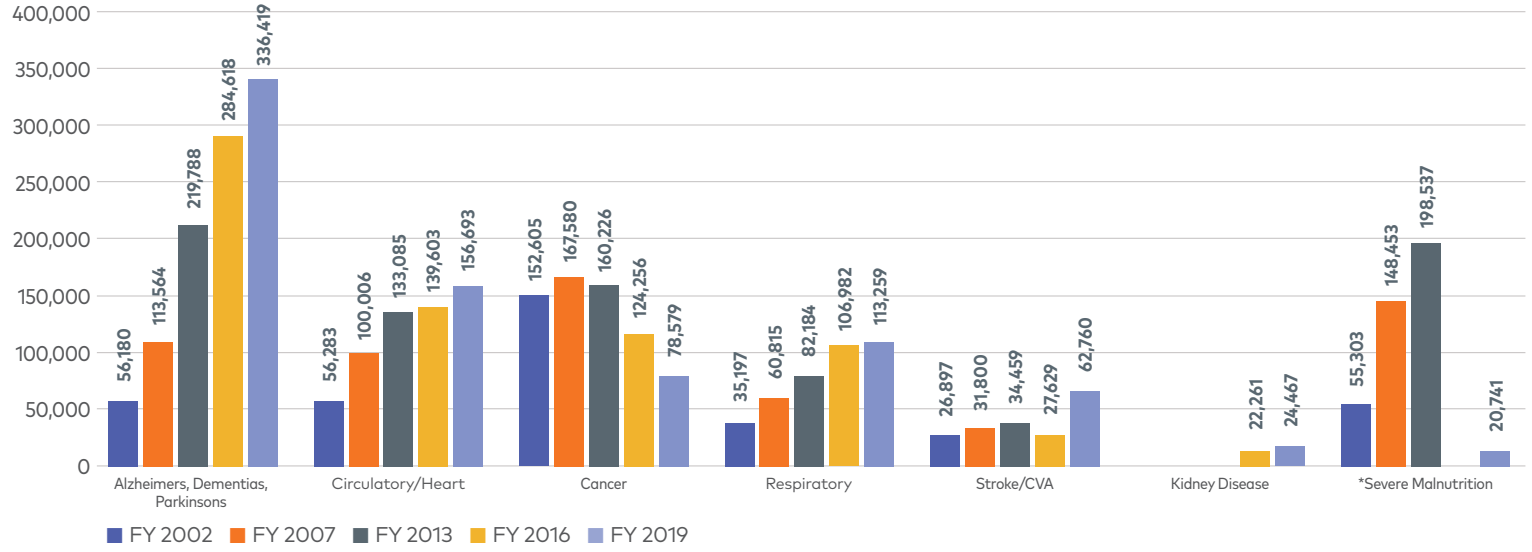


Figure 9: Number of Medicare Decedents Using Hospice by Top 15 Diagnoses



** In 2002, 2007 and 2013, severe malnutrition includes debility unspecified and adult failure to thrive. Those diagnoses were disallowed and no longer used in later years.*

Source: CMS-1675-P, FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements and CMS-1754-P Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

Section 3: How Much Care Is Received?

Length of Stay

The average Length of Stay (LOS) for Medicare patients enrolled in hospice in 2019 was 92.6 days. The median length of stay (MLOS) was 18 days.

Table 1: Average and Median Length of Stay

Year	Total Days (in millions)	Average Length of Stay	Median Length of Stay	Number of Patients (in millions)
2015	95.9	86.7	17 days	1.38
2016	101.2	87.8	18 days	1.42
2017	106.3	89.3	18 days	1.49
2018	113.5	90.3	18 days	1.55
2019	121.8	92.6	18 days	1.61

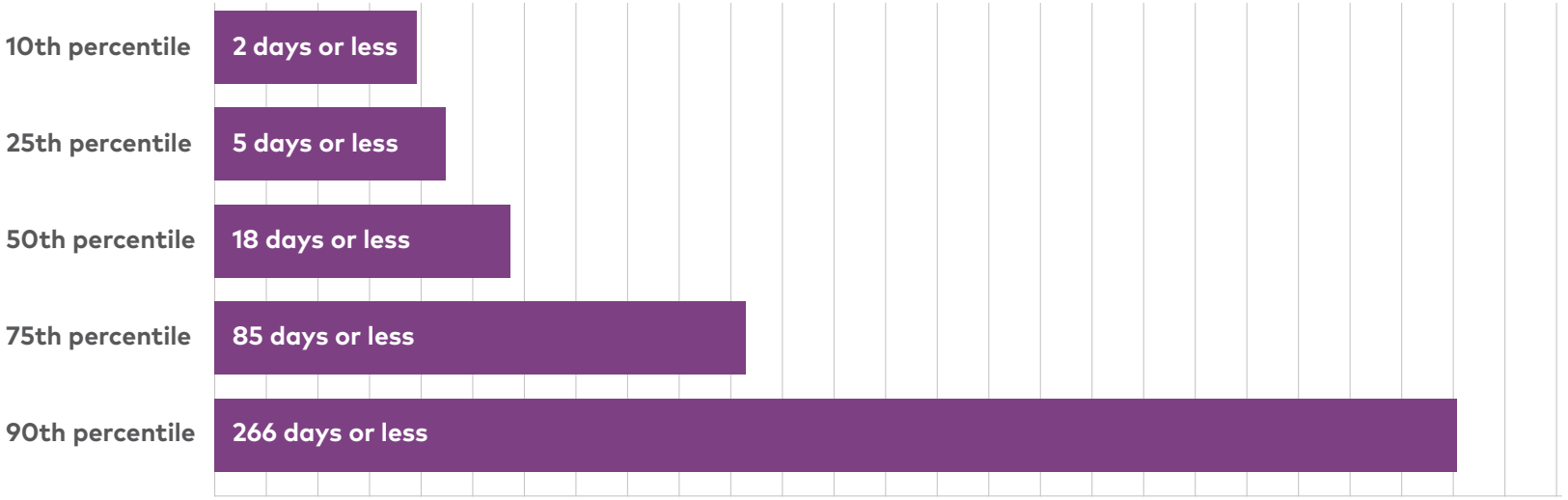
Source: MedPAC March 2021 Report to Congress, Table 11-3 and the MedPAC March 2018 Report to Congress, Table 12-4

How Much Care Is Received (continued)

Days of Care by Length of Stay in 2019

- 10% of patients were enrolled in hospice for 2 days or less.
- 25% of patients were enrolled in hospice for 5 days or less.
- 50% of patients were enrolled for 18 days or less.
- 75% of patients were enrolled for 85 days or less.
- At the 90th percentile, 10% of patients were enrolled for more than 266 days.

Figure 10: Days of Care



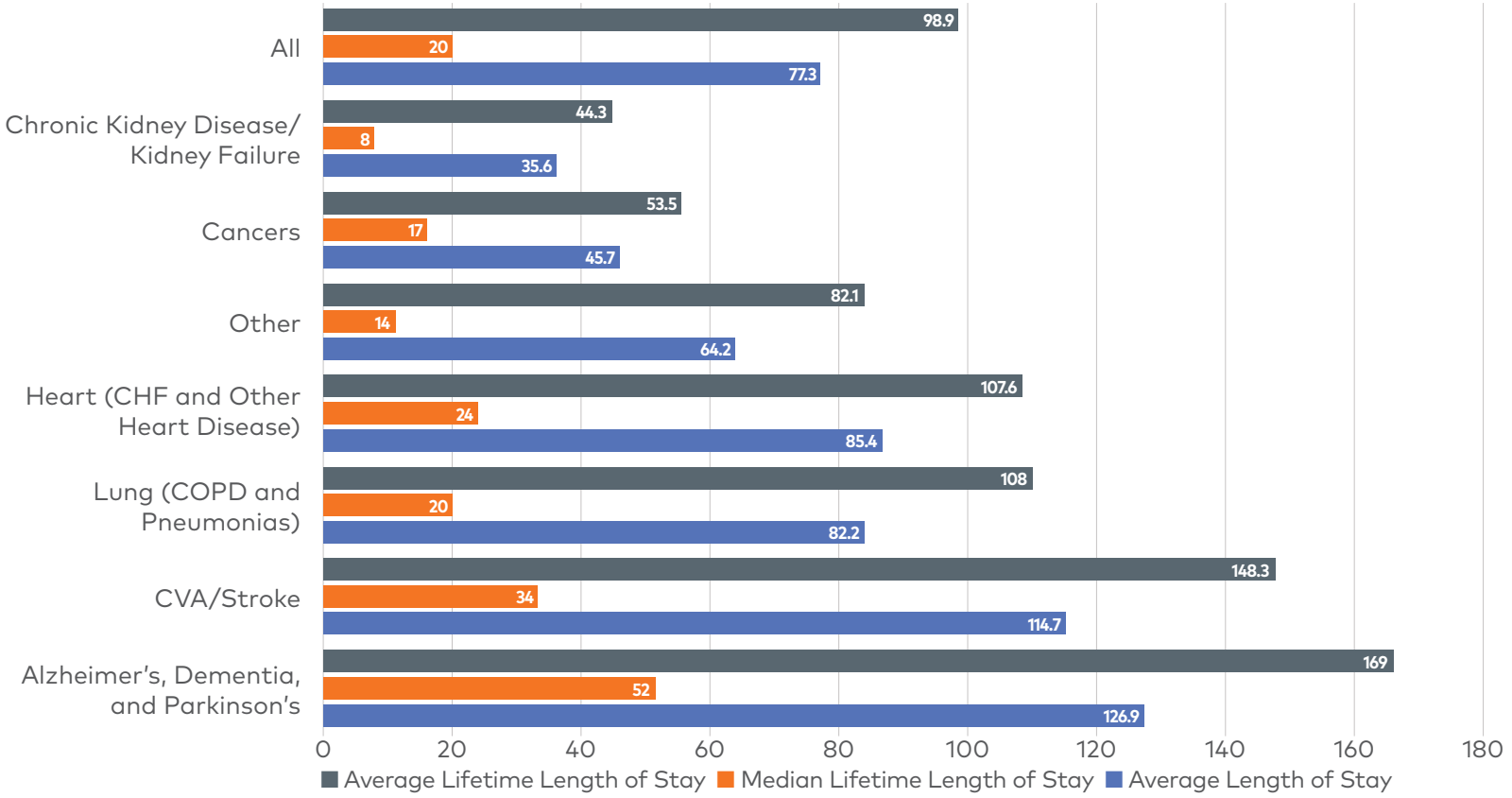
Source: MedPAC March 2021 Report to Congress, Figure 11-1.

How Much Care Is Received? (continued)

Days of Care

Figure 11 depicts the average lifetime, average and median lifetime length of stay for major hospice disease categories. Average and median lifetime lengths of stay are defined by CMS as "the sum of all days of hospice care across all hospice elections." In 2019, as seen in Figure 11, patients with Alzheimer's, dementias and Parkinson's used the Medicare Hospice benefit for the greatest average, lifetime average, and median length of stay in days. This contrasts with chronic kidney disease/kidney failure and cancer patients, who utilized the Medicare hospice benefit for a much lower average and median number of days in 2019.

Figure 11: Days of Care by Principal Diagnosis for 2019



Source: FY 2022 Hospice Wage Index and Quality Reporting Proposed Rule, Table 6

Note: *Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.*

How Much Care Is Received? (continued)

Live Discharges and Transfers

In 2019, out of all Medicare hospice discharges, 17.4 percent of all Medicare beneficiaries using hospice were discharged alive, with patient-initiated and hospice-initiated discharges being about equal.

Table 2: Discharge by Type and Reported Reason, 2017-2019

Reason for Discharge	2017	2018	2019
All discharges	16.7%	17.0%	17.4%
Patient-Initiated Live Discharges			
Revocation	6.4	6.6	6.5
Transferred to another hospice	2.1	2.2	2.3
Hospice-Initiated Live Discharges			
No longer terminally ill	6.5	6.3	6.5
Moved out of service area	1.4	1.6	1.7
Discharged for cause	0.3	0.3	0.3

**Calculations are based on total number of discharges which includes patients who were discharged more than one time in 2019.*

Source: MedPAC March 2021 Report to Congress, Table 11-11.

How Much Care Is Received? (continued)

Location of Care

In 2019, most of days of care were provided at a private residence followed by nursing facilities and assisted living facilities.

Average days by location of care as shown in Figure 12 were 95 days at a private residence, 109 days in nursing facilities, and 161 days in assisted living facilities. Median length of stay by location of care, shown in Figure 13, were 27 days at a private residence, 22 days in nursing facilities and 56 days in assisted living facilities.

Table 3: Location of Care by Average and Median Days of Care for 2019

	Average	Median
Private Residence	95	27
Nursing Facility	109	22
Assisted Living Facility	161	56

Figure 12: Average Days by Location of Care

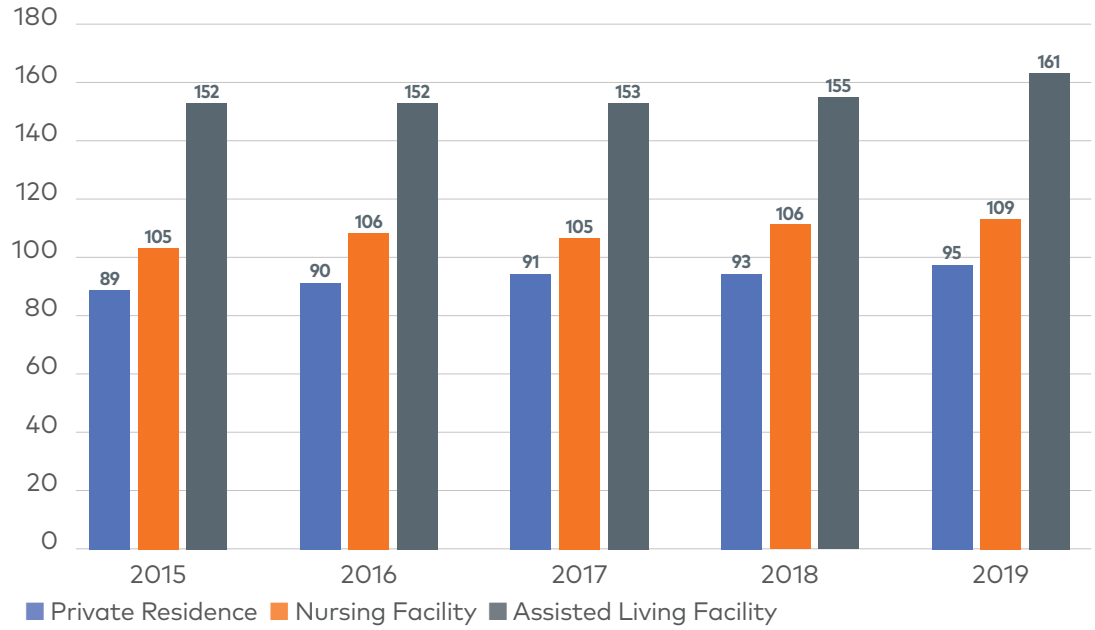
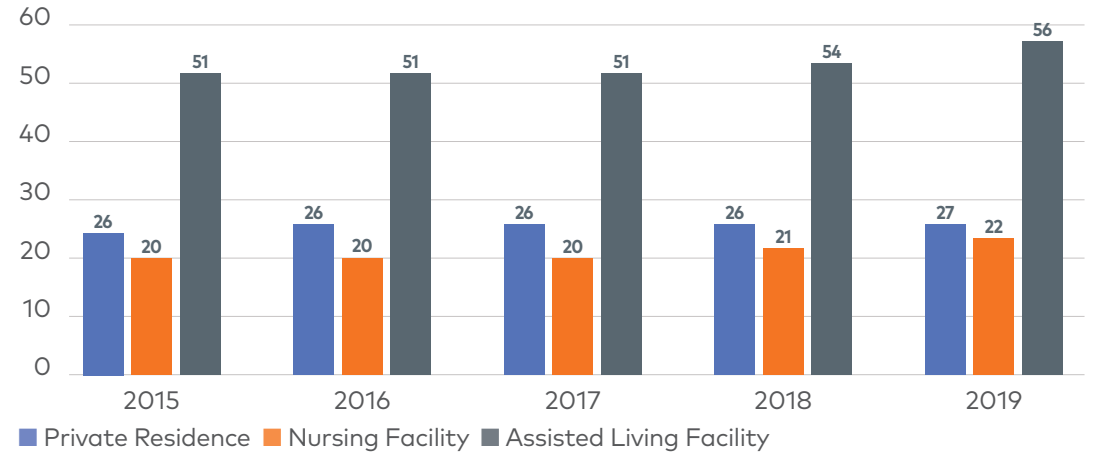


Figure 13: Median Days by Location of Care

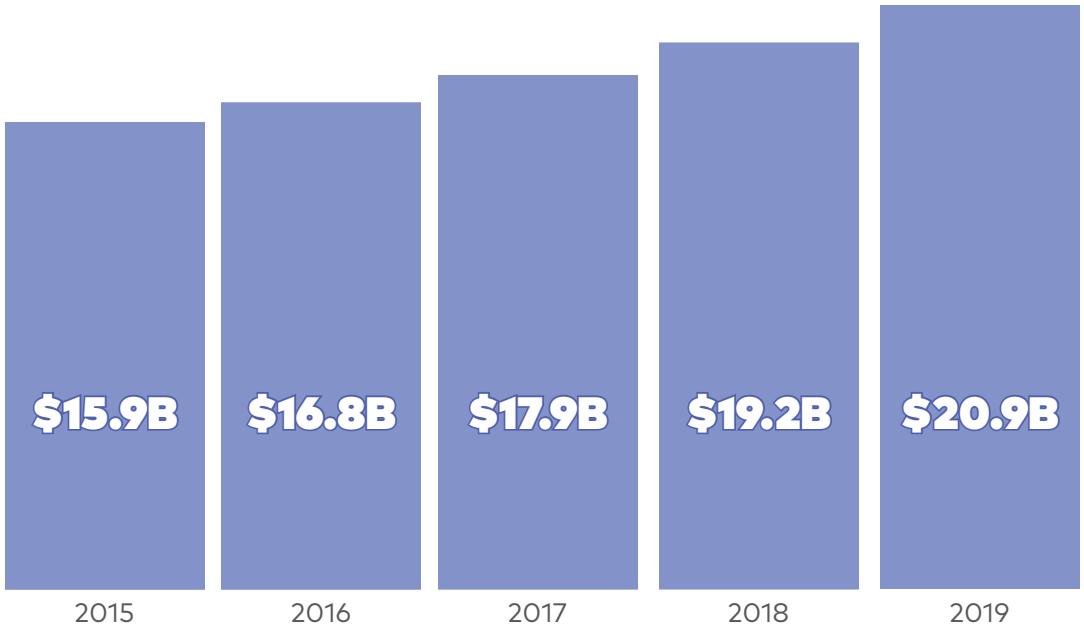


Source: MedPAC March 2021 Report to Congress, Table 11-4

Section 4: How Does Medicare Pay for Hospice?

Medicare paid hospice providers a total of $20.9 billion dollars for care provided in 2019, representing an increase of 8.5% over the previous year.

Figure 14: Medicare Spending



Source: MedPAC March 2021 Report to Congress, Table 11-3 and MedPAC March 2018 Report to Congress, Table 12-4.

How Does Medicare Pay for Hospice? (continued)

Spending by Level of Care

In 2019, the vast majority of Medicare spending for hospice care was for care at the routine home care (RHC) level.

Table 4: Percent of Days by Spending

Level of Care (LOC)	2019
Routine Home Care (RHC)	93.8%
General Inpatient Care (GIP)	4.9%
Inpatient Respite Care (IRC)	0.3%
Continuous Home Care (CHC)	0.9%

Source: FY 22 Hospice Wage Index, Proposed Rule, Table 5

Table 5: Percent of Days by Level of Care

Level of Care (LOC)	2015	2016	2017	2018	2019
Routine Home Care (RHC)	97.9%	98.0%	98.0%	98.2%	98.3%
Continuous Home Care (CHC)	0.3%	0.3%	0.2%	0.2%	0.2%
Inpatient Respite Care (IRC)	0.3%	0.3%	0.3%	0.3%	0.3%
General Inpatient Care (GIP)	1.6%	1.6%	1.3%	1.2%	1.2%

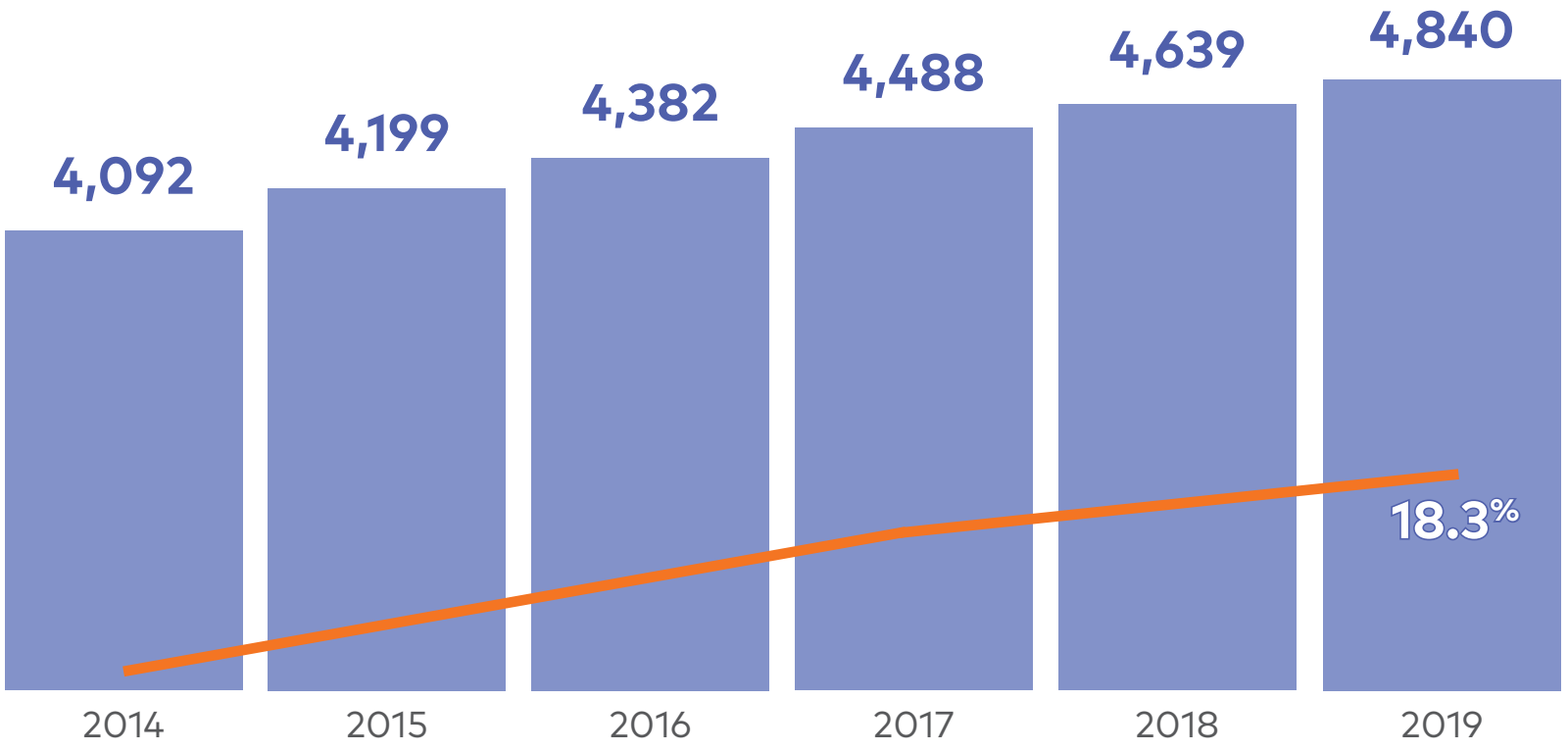
Source: MedPAC March Report to Congress, various years and FY 2022 Hospice Wage Index and Quality Reporting Proposed Rule, April 2021

Section 5: Who Provides Care?

How many hospices were in operation in 2019?

Over the course of 2019, there were 4,840 Medicare certified hospices in operation based on claims data. This represents an increase of 18.3% since 2014.

Figure 15: Number of Operating Hospices



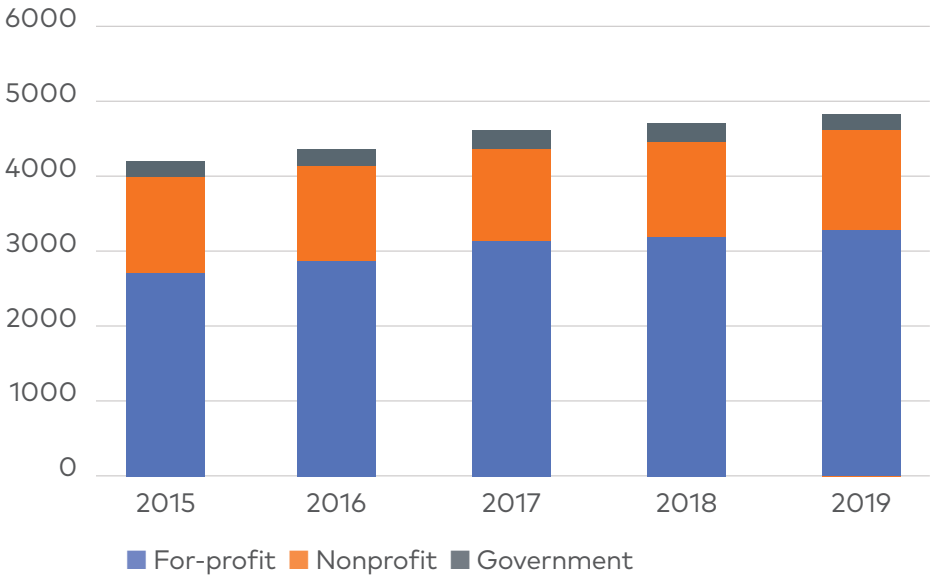
MedPAC March 2021 Report to Congress, Table 11-1. and MedPAC March 2018 Report to Congress, Table 12-3.

Who Provides Care? (continued)

Tax Status

As shown in Figure 19, the growth in hospice ownership is being driven by the growth in for-profit ownership. As reported by MedPAC in the March 2021 Report to Congress, between 2018 and 2019, the number of for-profit hospices increased by 6.3 percent, while the number of nonprofit hospices increased by 0.2 percent, and government owned hospices declined by 5.7 percent. As of 2019, about 71 percent of hospices were for profit, 26 percent were nonprofit, and 3 percent were government owned.

Figure 16: Providers by Type



Source: MedPAC March Report to Congress, Various Years

Data Sources

The data sources primarily used for this report are from the Medicare Payment Advisory Commission (MedPAC) March Report to Congress (various years) and the FY 2022 Hospice Wage Index and Quality Reporting Proposed Rule, published in the Federal Register on April 14, 2021. 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 are used. They can be found at www.medpac.gov.

For data references provided by the Centers for Medicare and Medicaid Services (CMS), the FY 2022 Hospice Wage Index and Quality Reporting Proposed Rule, (CMS-1754-P) was published in the Federal Register at www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf on April 14, 2021.

Questions May Be Directed To:

National Hospice and Palliative Care Organization Attention
Email: Communications@nhpco.org
Subject line: Facts and Figures

Phone: 703.837.1500
Web: www.nhpco.org
Email: Communications@nhpco.org

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NHPCO
National Hospice and Palliative Care Organization

NHPCO
1731 King Street
Alexandria, VA 22314

tel. 703.837.1500 | **nhpco.org**

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