Hospice Governance Academy®

Hospice Industry Basics

The Medicare Hospice Benefit: Past, Present, and Future

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Summary

The Medicare Hospice Benefit was enacted into law in 1982, and has largely defined hospice care ever since. This article provides some history about hospice in America, as well as trends that are likely to shape it in the future.

The modern hospice movement can be traced to Dame Cicely Saunders who founded Christopher's Hospice in London in 1967. In her pioneering work, Dame Saunders introduced several novel concepts, among them: "Total Pain" which included emotional and spiritual pain, and a plan of care that includes "each person" involved in the patient's care.

In the U.S., hospice was an all-volunteer effort until the Medicare Hospice Benefit was enacted in 1982. Since then, the

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Key elements of the Medicare Hospice Benefit include:

- Interdisciplinary team (physician, nursing, social work, counseling (spiritual care and bereavement), aide and volunteer and PT/OT/ST as appropriate),
- Patients and families of choice considered the "unit of care",
- Required volunteer component,
- Bereavement care required for at least 13 months following death.
- Beneficiaries must elect the Hospice benefit, in doing so, giving up curative treatment.

The hospice medical director and the patient's attending physician must attest that the patient has a terminal illness and has a prognosis of 6 months or less if the disease and any co-morbidities run their course. The hospice is then responsible for providing all care related to the terminal illness and any other factors contributing to the prognosis. (The latter are referred to as Related, and services not associated with the terminal illness and prognosis are labelled Unrelated.)

Hospices must be able to provide the four levels of care defined by Medicare: 2 levels are provided in the patient's residence: Routine Home Care (RHC) and Continuous Home Care (CHC). The other two are provided in a temporary setting (Hospital, SNF or certified hospice care center): General Inpatient (GIP) and Inpatient Respite Care (IRC). CHC and GIP are intended for short-term management of pain and/or symptoms that are out of control. On average, about 98% of all hospice days are provided at the RHC level.

In 2019 there were about 4,800 hospices certified by Medicare. 71% of active Medicare Provider Numbers were assigned to hospice providers with for-profit tax status and 26% with not-for-profit status, remainder government-operated.

98% of hospice days of care are provided in the patient's residence. 95% of patients are over 65, with about 50% at 84 and up. Average length of stay (ALOS) is about 93 days nationally, while the median length of stay (MLOS) is only 18. This means that there some very long length of stay patients are offset by many more patients with a short length of stay.

An individualized plan of care must be developed within 5 days and reassessed at least every 15 days.

The percent of Medicare beneficiaries who die on hospice is often considered the penetration rate, and a key indicator of the utilization of hospice in a given market. Nationally, it averaged about 52% in 2019, with state averages ranging from about 25% to 58%, but the national averaged dipped to 48% in 2020, potentially due to the effects of the pandemic.

Most patients die on hospice, but a percentage are discharged live (for one of the following reasons: prolonged

prognosis, moving out of the hospice service area, transferring to another hospice, or revoking the benefit). The live discharge rate is receiving increased scrutiny as a high live discharge rate may be considered an indicator that the patient was not appropriate for hospice at admission.

Other areas of scrutiny as laid out in the Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER) are Long Length of Stay, care in ALFs and SNFs, absence of GIP and Continuous Home Care levels of care, and only a single diagnosis coded (typically a prognosis of 6 months or less involves multiple factors).

The Future

Several factors may be likely to change the dominance of traditional Medicare hospice benefit as the dominant form of end-of-life care.

One is the increasing prevalence of palliative care. Because there is not yet a defined set of reimbursement and regulations for palliative care, palliative care programs can be defined uniquely and creatively. Although issues of long-term financial sustainability exist for most palliative care program models, palliative care may capture patients upstream from the traditional transition to hospice. If not well-coordinated, palliative care may have the potential to delay transfers to hospice.

The other is the growing utilization of Medicare Advantage (MA) and increased flexibility being offered to MA plans. There is potential for MA plans to define services that blur palliative care and hospice, which again could become an alternative or a delay to traditional hospice care.

The Value-Based Insurance Design (VBID) Model pilot allows MA plans to provide a hospice benefit. To date, the number of MA beneficiaries in plans with hospice "carve-ins" is small, but expected to increase as experience with hospice under MA builds.

See these Spotlight Interviews for more detailed discussion of new payment models:

- *What Medicare Advantage and VBID Mean for Hospice*
- *What Hospice Boards Should Know About the Primary Care First Payment Model*