



## What the Media Said about End-of-Life Care This Week

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#### MEDPAC ISSUES REPORT TO CONGRESS

**MedPAC issued its Report to Congress. Chapter 11, of the 14-chapter report, addresses hospice services.** The report reviews the Medicare Hospice Benefit and shares that, in 2020, “more than 1.7 million Medicare beneficiaries (including almost half of Medicare decedents) received hospice services from 5,058 providers, and Medicare hospice expenditures totaled \$22.4 billion.

**The report shares, “In 2020, the number of hospice providers increased by 4.5%, due to growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers.** The percentage of decedents of Medicare hospice declined—from 2019 to 2020—from 51.6% to 47.8%. This is due, says the report to the fact that “deaths increased more rapidly than hospice enrollments.” Patient days in hospice care did grow—from 92.5 days in 2019 to 97.0 days in 2020. Median length of stay remained at 18 days.

**“In 2019, Medicare payments to hospice providers exceeded marginal costs by roughly 17%.” This indicates “that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.”** Continuing growth of for-profit providers —up 7% in 2020—suggests that capital is available for this group of providers. But capital for nonprofit freestanding hospices may be more limited.

**Because of the pandemic, quality of care for 2020 is difficult to assess, and the report explains this more fully.**

**MedPAC made some recommendations to Congress. MedPAC recommends that hospice payments remain the same in 2023 as in 2022. The hospice aggregate cap, says MedPAC, “can be wage adjusted and reduced by 20 percent, which would focus payment reductions on providers with disproportionately long stays and high margins.** The report notes the lack of telehealth reporting on hospice claims. Hospices were not allowed to offer these reports, and **MedPAC recommends that CMS should require that telehealth visits by hospices be reported on claims.** Each of these recommendations are made and a rationale for the recommendations are included in the report.

The remainder of the chapter offers an overview of the history of the hospice benefit, an assessment of the capacity of hospices to serve patients, a summary of various kinds of hospices from 2010-2020, a summary of urban and rural providers of hospice, number of Medicare decedents served by hospice from 2010-2020, and other statistics and data. There is also information about cultural diversity and disparities, and numerous trends and patterns.

**The chapter closes with a discussion of nonhospice spending for hospice enrollees and offers a brief summary of the concern.** “Among beneficiaries using hospice in 2018, almost half (47 percent) received at least one Part A or Part B service or Part D drug during their hospice stay that was paid for outside the hospice benefit by Medicare FFS (fee for service), a prescription drug plan, or an MA (Medicare Advantage) prescription drug plan.” The report shares more data about the nonhospice spending that is of concern. **The report suggest ways that the concern might be addressed, including carving hospice into the MA benefit, bundling care with FFS providers, and penalizing hospices who have “nonhospice spending above a specified threshold.”**

**The complete report is online at the link below.** (MedPAC, March 2022, [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf))

## IS THE HOME REALLY THE BEST PLACE TO DIE?

**Americans tend to think that dying at home, with family caregivers, is a good death.** A majority of Americans say dying at home is their wish. But reality “frequently diverges from this scenario.” Caregivers face difficult paths, and often find themselves unable to meet all the needs of the dying patient. **Palliative care experts, says an article in *New England Journal of Medicine (NEJM)*, are questioning this conventional wisdom that dying at home is preferred.**

**“Where Americans Die—Is There Really ‘No Place Like Home’” is an article in *NEJM*. The article explores the various locations where people die, the costs of dying in various locations, regulations that impact where we die, and how we work to be sure that patients receive the best care possible for their specific situation.** The oft-held wish to die at home comes from “culturally shaped preferences,” says the article, “financial incentives and publicly reported quality measures [that] influence stakeholders.” This singular focus does not consider individualized needs.

**Home deaths often lower end of life healthcare costs.** Expenses at hospitals are higher and, by dying at home, unpaid family caregivers save money for healthcare providers. Hospitals are incentivized to discharge patients, and sending them home is the “quickest and easiest discharge destination.” Hospitals are also penalized if patients return to the hospital too soon or die too soon after hospitalization. “This penalty is a strong incentive to avoid hospitalizing patients for what may be a ‘terminal admission’ because it could increase the hospital’s death rate.” The article explores the range of incentives and disincentives that impact patient location near life’s end.

**Hospices, as well as hospitals, face cost issues.** The article says that hospices “tend to lose money under the general inpatient care provision, but earn profits for providing routine home care.” This is because, says the article, hospices can have lower nursing-to-patient ratios, can offer fewer home health aide services, and rely on family caregivers.

**So, ask the authors, what need to change in order “to provide high quality end-of-life care in whatever setting best aligns with patients’ individual goals and needs?”** The authors offer three actions that can support this. First, policymakers could make changes, especially for underserved populations and racial and ethnic minorities. Expanding support for family caregivers is needed. A minimum number of home health aides could be required, with aides becoming core services. Additionally, Medicare could increase access to continuous home care, and provide more services to these patients who are very near life’s end.

**“Policymakers are also called on to remove barriers that prevent high-quality end-of-life care in inpatient settings.”** “One strategy could involve increasing access to general inpatient hospice care in nonacute care settings, including freestanding hospice facilities and hospice units within SNFs or hospitals. This can be supported by loosening eligibility criteria and increasing payments.” In both of these calls for change, the article notes lessons that can be learned from the Veterans health Administration.

**The authors also call for “research to support goal- and need-concordant end-of-life care.”** Shared decision-making tools are needed, as well as tools for assessment of patient and family needs. **“Finally, a cultural shift that reduces stigma surrounding nonhome death will be needed to ensure the success of these policy changes.”**

**The authors close by noting that these changes will not be cost-neutral.** Costs need to move from “individual families and toward the government and other payers, with the goal of providing equitable access to high-quality end-of-life care.” Some patients and families will decide that they want to die at home, others will prefer a hospital, inpatient hospice, or nursing facility. (*NEJM*, 3/12, <https://www.nejm.org/doi/full/10.1056/NEJMp2112297>)

## HOSPICE NOTES

\* **“What Impact Do End-of-Life Experiences Have on Grief?”** appears in *Psychology Today*. The article says deathbed visions and dreams are common, though, in the past, they have been dismissed as “delusions and hallucinations.” The article calls for exploration of these experiences and says they “can have a positive impact on all involved and not just at the deathbed.” The experiences at life’s end can help loved ones “accept the reality of the

loss.” **The article calls for death education for hospice staff and volunteers so that they can help people process these experiences.** (*Psychology Today*, 3/16, <https://www.psychologytoday.com/us/blog/understanding-grief/202203/what-impact-do-end-life-experiences-have-grief>)

\* **Husch Blackwell LLP offers a podcast that examines the “Office of Inspector General’s OIG) new data report announcing [that] identifies billions being billed to Medicare Part A and B for hospice patient.”** The podcast is online at the link below. There is a link on this page that also leads to their earlier, 2/22, podcast title “The OIG’s Impending Review of Nationwide Hospice Eligibility Demands a Robust Response from Hospices.” (JDSUPRA, 3/16, <https://www.jdsupra.com/legalnews/hospice-audit-series-beyond-part-d-oig-42839/>)

\* **A hospice owner in California, Gurgen Israyelan, pleaded guilty of fraud in securing government funds for relief during the pandemic.** In fact, St. Christopher Hospice Inc. in North Hollywood ceased operations about September 2019. “Israyelyan pleaded guilty to three counts of theft of government property,” and will be sentenced on June 13. (Department of Justice, 3/18, <https://www.justice.gov/opa/pr/california-man-pleads-guilty-misappropriating-covid-19-relief-funds>)

\* **“AI, machine learning can drive better hospice utilization” appears in *Healthcare Finance*.** The article shares about a message delivered by David Klebonis, chief operation officer of Palm Beach Accountable Care Organization (PBACO). Addressing the problems with accurate prognosis for hospice patients, Klebonis shared about the work using custom built AI. (*Healthcare Finance*, 3/16, <https://www.healthcarefinancenews.com/news/ai-machine-learning-can-drive-better-hospice-utilization>)

## PALLIATIVE CARE NOTE

\* ***Scientific American* features an article titled “Psychedelics in Palliative Care.”** Author Mellody Hays is an anesthesiologist with a focus on palliative care and psychedelic medicine. She offers a brief overview of palliative care and espouses its benefits. Psychedelics can improve anxiety, depression, Alzheimer’s, and other illnesses, and ongoing research is happening. Though physiologically safe, these medications are potent and need to be used judiciously. The article elaborates on these concerns. “The transformation, hope and engagement in purpose that patients who undergo psychedelic treatment experience as a part of their palliative care contributes to their wellness,” says Hays. “This may also help end the branding problem of palliative care.” (*Scientific American*, 3/20, <https://blogs.scientificamerican.com/observations/psychedelics-in-palliative-care/>)

## END-OF-LIFE NOTES

\* **In “What My Grandmother Knew About Dying,” physician Rachel Bedard shares about the death of her grandmother, Harriet.** “As a physician,” says Bedard, “I trained in the delicate art of preparing people for death. Losing Harriet made me see the work differently.”

The article, in *New Yorker*, shares Bedard’s work as a geriatrician and palliative care physician. She understands the importance of talking about the care we hope to receive near the end of life, and she shares some vignettes about her patients. In her family, however, no one has done this sharing—and she has been unsuccessful in facilitating this. Bedard shares about the life of her grandmother, and her journey toward death. Her experience with working with her own family on addressing Harriet’s care led her to say, “I forgot all my practiced communication techniques when speaking to my own family members, tripped up by my intimacy with the patient and with them.” Nevertheless, all agreed to bring Harriet home to die—and the family had the resources to do so. In Harriet’s denial, says Bedard, she “didn’t intend to die at all, and yet she did so in a way that perfectly reflected her spirit and charisma.” (*New Yorker*, 3/6, <https://www.newyorker.com/culture/personal-history/what-my-grandmother-knew-about-dying>)

\* **End Well has posted “How We Can Have a Beautiful Death” on the group’s YouTube channel. Physician and author Sunita Puri offers the talk.** (YouTube, [https://www.youtube.com/watch?v=lpuHJwG4\\_zs&ab\\_channel=EndWell](https://www.youtube.com/watch?v=lpuHJwG4_zs&ab_channel=EndWell))

\* **“How I learned to talk about death and dying” appears in *Washington Post*.** Author Steven Petrow shares his

own experiences—with his mother as she died; decades later with his own experiences with cancer; and, again, with a longtime friend. He shares his own lessons-learned through these “long goodbyes.” (*Washington Post*, 3/12, <https://www.washingtonpost.com/health/2022/03/12/death-dying-conversations/>)

## GRIEF AND ADVANCE CARE PLANNING NOTES

\* **“Feeling Pressure to Grow from Grief” is posted at the website titled What’s Your Grief? The article examines subtle and not-so-subtle pressures that encourage is to “bypass the reality of loss.”** Grief, says the article, calls for being, grieving and mourning. While there is no right or wrong way to grieve, the article calls for allowing the time and space to actually grieve. ((What’s Your Grief?, 3/10,<https://whatsyourgrief.com/feeling-pressure-to-grow-from-grief/>)

\* **End of Life University offers “The Grieving Brain: The Science of Love and Loss with Mary-Frances O’Connor PhD.”** The podcast explores “the changes that occur in the brain during the grief process and how we can go about restoring a meaningful life.” The podcast is online at the link below. (End of Life University, 3/14, <https://eolupodcast.com/2022/03/14/ep-342-the-grieving-brain-the-science-of-love-and-loss-with-mary-frances-oconnor-phd/>)

\* **Hospice and palliative care physician Cathi Whaley posted “Complicated grief: the hidden pandemic in health care workers.”** The post, online at *KevinMD*, explores the loss, grief and disbelief experienced by many healthcare workers during the pandemic. “Grief,” says Whaley, “is an invisible wound that requires support for processing.” “Unprocessed grief results in prolonged suffering,” Whaley ask if this processing of grief can diminish and relieve burnout. William Cowper, she says, said “grief is itself a medicine.” (*KevinMD*, 3/15, <https://www.kevinmd.com/2022/03/complicated-grief-the-hidden-pandemic-in-health-care-workers.html>)

\* **“Prolonged grief disorder” has been added to the Diagnostic and Statistical Manual of Mental Disorders.** Those suffering this disorder are described as “pining and ruminating a year after a loss, and unable to return to previous activities.” This designation comes after a decade of argument within the mental health community. Critics argued “against categorizing grief as a mental disorder, saying that the designation risks pathologizing a fundamental aspect of human experience.” There is also concern that “drug companies will try to persuade the public that they need medical treatment to emerge from mourning.” Proponents say the designation opens the way for people who have been isolated in their losses to receive mental health care. The designation means that clinicians can now bill insurers for services offered to this population. (*New York Times*, 3/18, <https://www.nytimes.com/2022/03/18/health/prolonged-grief-disorder.html>)

## OTHER NOTE

\* **Connecticut’s HB 5396 would establish psychedelic treatment centers, Pending FDA approval “under its expanded access program for investigation new drugs.” The bill was approved by the Joint Public Health Committee and moves now to floor consideration.** Testimonials were described as powerful. A video of the committee meeting, and the article about the bill is online at the link below. In the first few minutes of the video, the chair of the group reads a summary of the bill. (*Marijuana Moment*, 3/18, <https://www.marijuanamoment.net/connecticut-lawmakers-approve-bill-to-fund-psilocybin-and-mdma-therapy/>)

*Hospice Analytics is the national sponsor of Hospice News Network for 2022. Hospice Analytics is an information-sharing research organization whose mission is to improve hospice utilization and access to quality end-of- life care. For additional information, please call Dr. Cordt Kassner, CEO, at 719-209-1237 or see [www.HospiceAnalytics.com](http://www.HospiceAnalytics.com).*

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