

# REFORMING THE MEDICARE HOSPICE BENEFIT

**THE CASE FOR MODERNIZATION**

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**SUMMER 2022**

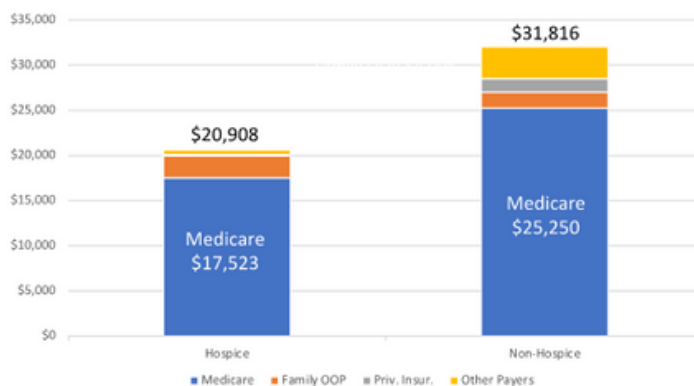
# THE ORIGINS OF HOSPICE

Since Medicare first began providing coverage for hospice in 1983, use of the hospice benefit has grown substantially, treatment of advanced illness has evolved, and the healthcare marketplace in which end-of-life care is provided has transformed. The Medicare hospice benefit, across this nearly forty-year span, has remained largely unchanged.

The modern hospice movement, which first appeared in the U.S. in the 1970's, offered a holistic alternative approach to end-of-life care. The original providers who offered the benefit formed organically from legions of volunteers building a foundation for community-based, mission-driven care. It focused on pain and symptom management and spiritual and bereavement support for patients who preferred to forego intensive, and often futile, medical treatment at the end-of-life. Its palliative and supportive services, originally provided primarily in hospice facilities and later in the home, offered patients and their families greater comfort and quality of life, and an alternative to intrusive and expensive medical treatment in an Intensive Care Unit (ICU).

The Medicare hospice benefit has been part of a successful movement in transforming American attitudes about serious illness and death. The benefit serves as a critically important tool in providing support for patients and their families through a difficult transition in their preferred care settings. Moreover, hospice has delivered savings for the Medicare program as more patients have chosen a low-intensity and lower-cost alternative to expensive hospital-based, end-of-life care.

Health Care Spending at End-of-Life - Hospice v. Non-Hospice  
Per Capita Spending in Last 3 Months of Life for Individuals Enrolled in Hospice – 2002-2018



Melissa Aldridge, et al. Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018. JAMA Health Forum. 2022;3(2)



# THE STRUCTURE OF THE HOSPICE BENEFIT

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Overall, the U.S. has been shifting long-term care of those with advanced illnesses from institutional to home- and community-based settings, raising concerns about sustaining - and financing - the continuum of care and functional supports throughout the progression of illness.

Medicare provides discontinuous coverage for its beneficiaries over the course of a serious illness. Once a beneficiary is discharged from a hospital and exhausts limited post-acute coverage in a skilled nursing or rehabilitation facility or at home, Medicare coverage ceases until the illness is deemed terminal (a prognosis of six months or less to live should the illness run its "regular" course) and hospice is elected. At that point, for a beneficiary who chooses to forgo further curative treatment and receive hospice care, Medicare reimburses a hospice for a full array of ameliorative and palliative benefits.

The hospices' payment is a per beneficiary, per diem rate provided at one of four levels of care, without regard for the actual costs of care associated with the patient. At a time when Medicare - and health care more broadly - has been shifting from fee-for-service (FFS) to value-based payment arrangements and has begun sharing risk with providers, the hospice benefit remains a legacy of Original Medicare. While Medicare beneficiaries are increasingly enrolling in Medicare Advantage (MA) plans, now accounting for nearly half of all beneficiaries, hospice remains the last Medicare FFS benefit "carved out" of MA.

## A CHANGING HOSPICE MARKETPLACE

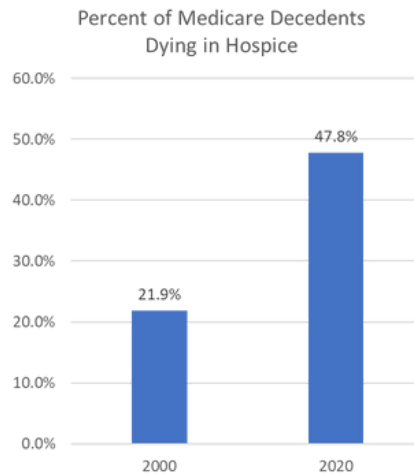
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Medicare beneficiaries have been increasingly electing hospice care at the end-of-life. Over the last 20 years, the proportion of Medicare decedents utilizing hospice care has more than doubled - from 22 percent in 2000 to 48 percent in 2020 (see graph on the next page).

## More Beneficiaries Are Using Hospice

Change in Percent of Medicare Decedents in Hospice -- 2000 and 2020

- In the last 2 decades:
- The percent of beneficiaries choosing hospice **doubled**.
  - **Half** of all Medicare decedents today have chosen to die in hospice and not in a hospital.

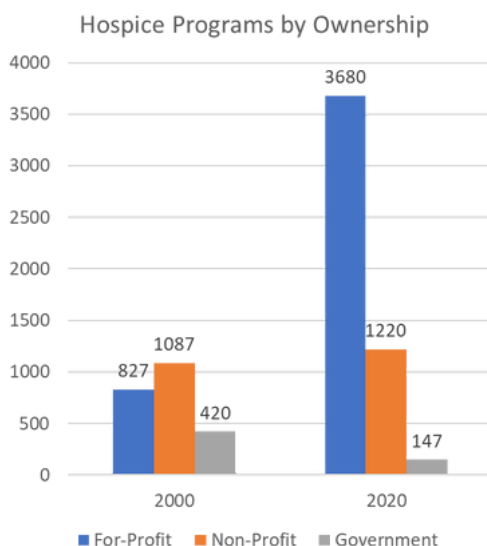


HHS/ASPE – Medicare’s Hospice Benefit: Revising the Payment System to Better Reflect Visit Intensity. ASPE Issue Brief. May 28, 2015  
 MedPAC Report to Congress: Medicare Payment Policy. Chapter 11: Hospice Services. March 2022.

The growing awareness and preference for hospice care, along with the projected growth in the Medicare beneficiary population and the attractiveness of the reimbursement arrangement has caused new providers to flood into the market. As the population in hospice has grown substantially, so has the number of hospice programs – from around 2,000 in 2000 to around 5,000 in 2020 (see graph below).

## There Are Many More Hospice Providers

Change in Number of Hospices -- 2000 and 2020



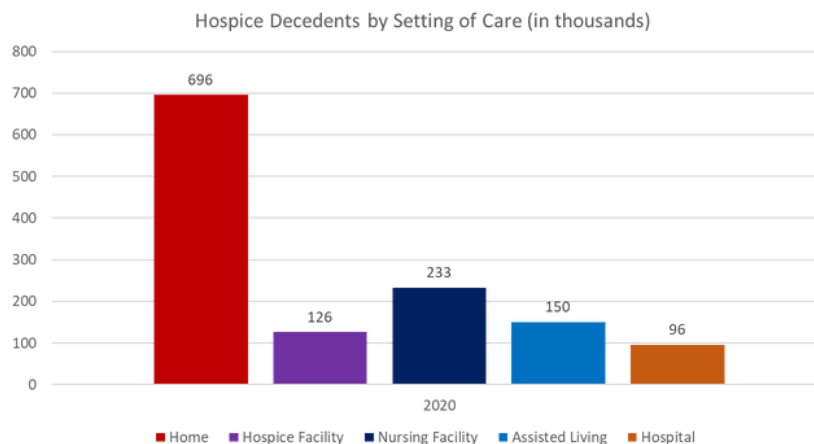
- In two decades:
- Non-Profit Hospices – **12% increase**
  - For Profit Hospices – **345% increase**

HHS/ASPE – Medicare’s Hospice Benefit: Revising the Payment System to Better Reflect Visit Intensity. ASPE Issue Brief. May 28, 2015  
 MedPAC Report to Congress: Medicare Payment Policy. Chapter 11: Hospice Services. March 2022.



Increasingly, these programs are providing care through freestanding hospice programs in the home and in community settings (see graph below).

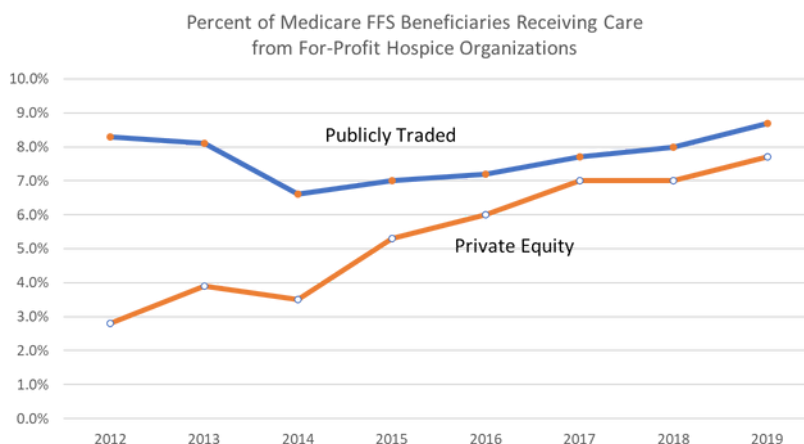
### Most Hospice Care is Provided at Home Number of Medicare Decedents Receiving Hospice by Setting, 2020



MedPAC Report to Congress: Medicare Payment Policy. Chapter 11: Hospice Services. March 2022.

This growth in the number of hospice programs has been fueled by for-profit organizations, and particularly, in recent years, by private equity funding. While the number of non-profit hospice programs has remained constant at approximately 1,500 over the last 20 years, the number of for-profit providers has grown tremendously over the same period – from 500 in 2000 to roughly 2,500 in 2020. The rate of growth for for-profit providers has been greatest in recent years among private-equity-backed programs, with beneficiaries receiving nearly 8 percent of care from these providers in 2019 compared to less than 3 percent in 2012 (see graph below).

### Growth of Private Equity in Hospice, 2012-2019



R.T Braun, et al. Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations. Research Letter. JAMA Internal Medicine. 181:8. August 2021. Pp 1113-1115.



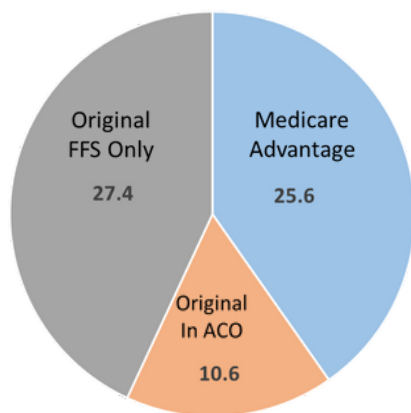
Private equity firms and publicly traded companies are attracted to the hospice industry by a combination of the enrollment growth opportunities, a favorable FFS payment structure with per diem rates, and the potential to impose low-hanging cost reduction strategies to achieve higher profit margins. Often, these firms have a short-term investment horizon – attracted by the opportunity to adapt the business model and quickly turnaround to sell at a profit. Private equity firms have been investing in acquisitions of existing non-profit and publicly traded organizations and, in many cases, consolidating the operations of multiple providers. Private equity firms are also launching a host of new competitor organizations nationwide but specifically in markets with a large proportion of Medicare beneficiaries.

A major transformation in the Medicare market has been occurring over the last two decades as Original Medicare has given way to a wide array of payment models that shift risk to private health insurers or health care provider organizations. The most notable trend has been the enrollment growth in Medicare Advantage (MA) plans that contract with Medicare to enroll beneficiaries and provide all Medicare services for a single capitated rate. Enrollment in MA has grown from 17 percent of all Medicare beneficiaries in 2000 to 42 percent in 2021 and is projected to reach 50 percent in the next five years (see graph below)

## Medicare Marketplace

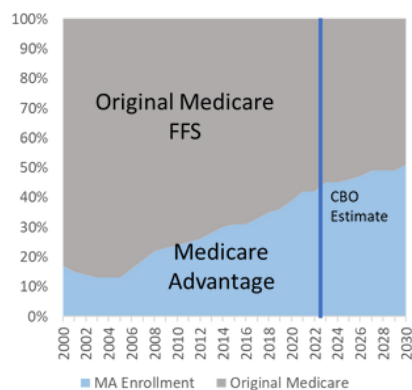
Percent of Medicare Beneficiaries by Type of Enrollment, 2021

Medicare Beneficiaries (in Millions)



CMS. Fast Facts - November 2021;  
MedPAC. Medicare Payment Basics: Accountable Care Organization Payment Systems. Revised November 2021

Actual and Projected MA Enrollment  
(as a percent of total Medicare)



Kaiser Family Foundation. Medicare Advantage in 2021: Enrollment Update and Key Trends. June 2021.



At the same time, the Center for Medicare and Medicaid Services (CMS) through its Center for Medicare and Medicaid Innovation (CMMI) has been testing and promoting a variety of value-based provider payment models as an alternative to FFS payment in traditional Medicare. In these models, hospitals or other providers assume risk and share savings with the government, creating incentives to manage costs and improve health outcomes. One of these models – accountable care organizations (ACOs) – has grown over the last decade to enroll nearly 11 million Medicare beneficiaries in Original Medicare and another 25 million members in commercial health plans (see graph above).

As hospice has grown in popularity with beneficiaries and in the number of programs available, its payment model increasingly stands out as an anomaly in Medicare - receiving FFS per diem payments absent any direct connection to quality outcomes while being carved out of the Medicare Advantage program.

## **COMPETITIVE CHALLENGES FOR NON-PROFIT HOSPICE PROVIDERS**

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Transformation in Medicare and the hospice and advanced illness marketplace is making local hospice markets more competitive and riskier for established, community-based, non-profit providers. The entry of large numbers of for-profit providers offering a reduced care model creates an unequal playing field for non-profit providers who work tirelessly to maintain the comprehensive and holistic care model that was the basis for the Medicare benefit. These non-profit providers have served as the community-focused, safety-net providers, accepting patients with the most intensive care needs and providing uncompensated care when Medicare benefits were denied. They have also raised donations and provided community-wide services. Non-profit hospices have kept the multi-disciplinary care team intact, providing all aspects of support at all levels of hospice and palliative care, including inpatient care either in a hospice facility or shared hospital space.

Non-profit hospices are facing increasing competition from for-profit/private-equity-backed hospice programs that select patients with low-cost diagnoses, disaggregate the services provided and do not provide the intensive level of hospice care, often live discharging complex patients to be readmitted to a hospital or nursing home.

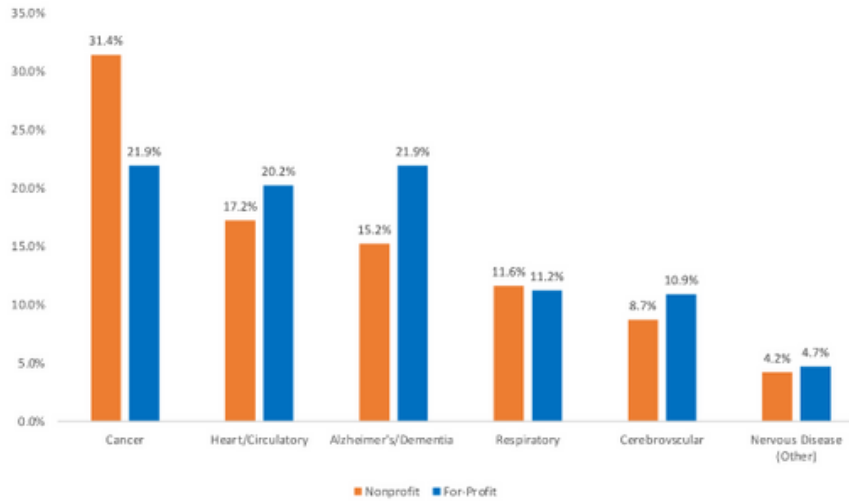
### **Differences Between Non-Profit and For-Profit Hospices**

In the aggregate, non-profit hospices:

- Are More Established: Many non-profit providers grew out of the voluntary hospice movement that created the Medicare hospice benefit four decades ago, while the majority of for-profit providers have appeared in the last 20 years.
- Provide a Full Care Model: Many non-profit providers originated caring for patients in a hospice facility or inpatient setting. Since then, the home has emerged as the primary setting for hospice care delivery. Today, the vast majority of hospice patients are cared for in their own homes and admitted to inpatient facilities only when their health and comfort require a more intensive level of care. Most non-profit providers continue to operate inpatient units (IPUs) and provide the general inpatient (GIP) level of care. Conversely, relatively few for-profit hospices operate inpatient facilities or care for patients in an inpatient setting, with the exception of some that may provide inpatient care in a skilled nursing facility (SNF) or nursing home.
- Care for Higher Acuity Caseloads: Non-profit providers' patients tend to have a higher proportion of higher acuity, shorter duration patients (such as those with cancer), whereas for-profit providers' patients tend to have a higher proportion of lower acuity, longer stay patients (such as those with Alzheimer's type dementia or heart disease).

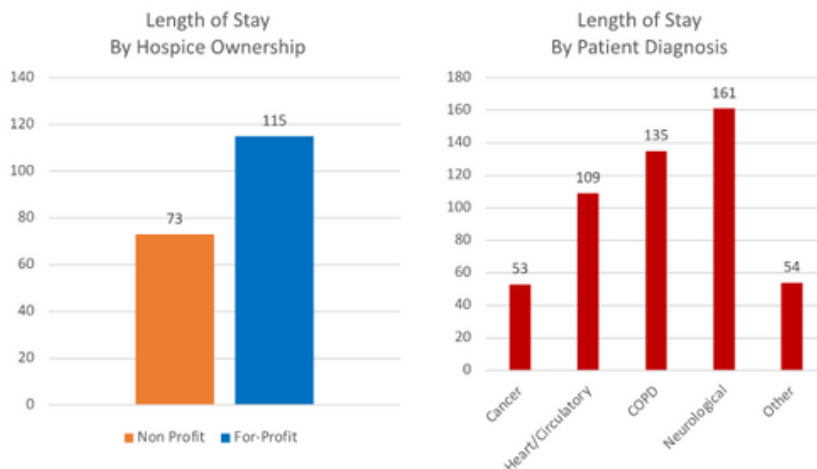


## Case Mix of Hospice Patients Distribution of Patients by Diagnosis by Ownership, 2017



Milliman. *Hospice Medicare Margins. Milliman Client Report for NPHI. July 2019*

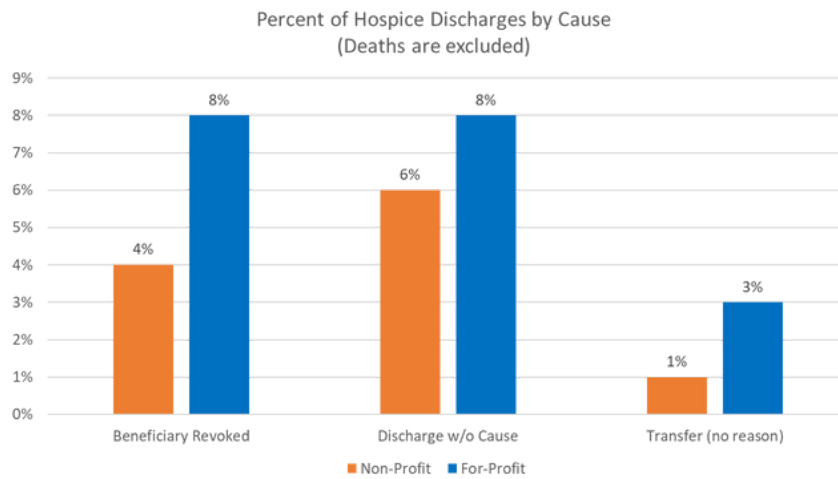
## Hospice Average Length of Stay (in Days) By Ownership and Patient Diagnosis, 2020



MedPAC Report to Congress: *Medicare Payment Policy. Chapter 11: Hospice Services. March 2022.*

# Reason for Discharge

## Hospice Discharges by Cause of Discharge, 2017



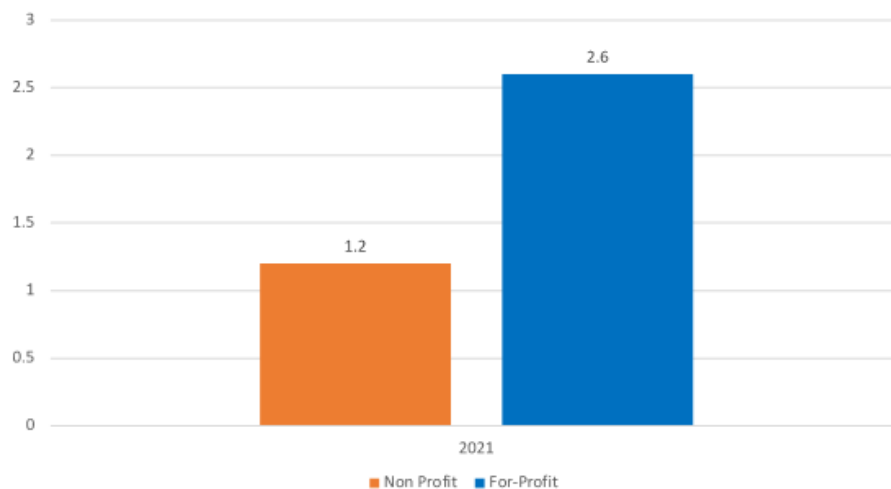
Milliman. Hospice Medicare Margins. Milliman Client Report for NPHI. July 2019

For-profit providers also tend to have a higher proportion of patients who are live discharged.

Many of these patients are readmitted to hospitals or nursing homes for more intensive care in the end.

## 30-Day Readmissions

Percent of all hospital discharges to hospice that are readmitted to a hospital within 30 days

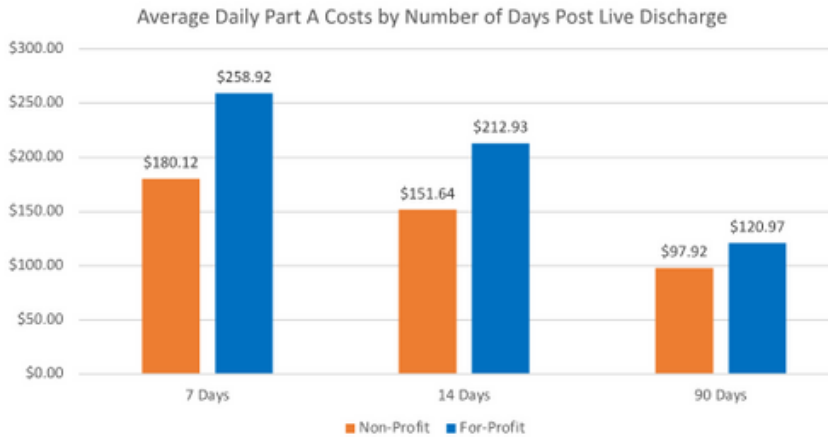


HealthPivots tabulations of data from CMS Medicare Hospice Claims



## Cost of Care Post Discharge

Average Daily Medicare Part A Cost for Patients Post Hospice Live Discharge, 2017

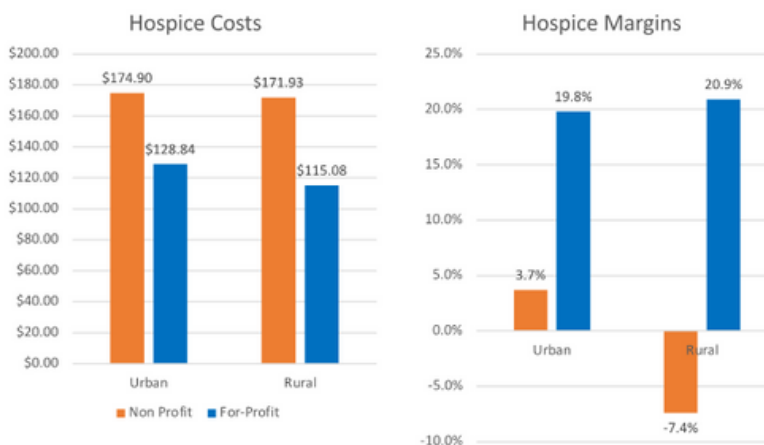


Milliman. Hospice Medicare Margins. Milliman Client Report for NPHI. July 2019

- Have a Higher Cost Structure: Non-profit hospices have higher costs resulting in lower profit margins than their for-profit competitors. In part this is due to their maintenance of a freestanding IPU and to providing services that are not fully reimbursed by the per diem payment, such as comprehensive palliative care, bereavement counseling, and other services that are provided to the community-at-large. Furthermore, for-profit providers achieve a higher margin from the per diem rates by maintaining a case mix with a higher proportion of low-acuity patients than is typical among non-profit hospices (as described above).

## Hospice Costs and Margins

Avg. Costs per Day and Net Medicare Margins by Ownership, 2019



MedPAC Report to Congress: Medicare Payment Policy. Chapter 11: Hospice Services. March 2021.

- Are Not Investor Supported: Non-profit hospices cannot rely on outside investment for capital. They can raise money through donations, and many receive substantial donations from families whose loved ones have received care, often to support unreimbursed individual and community services.

### **Non-Profit Marketplace Challenges**

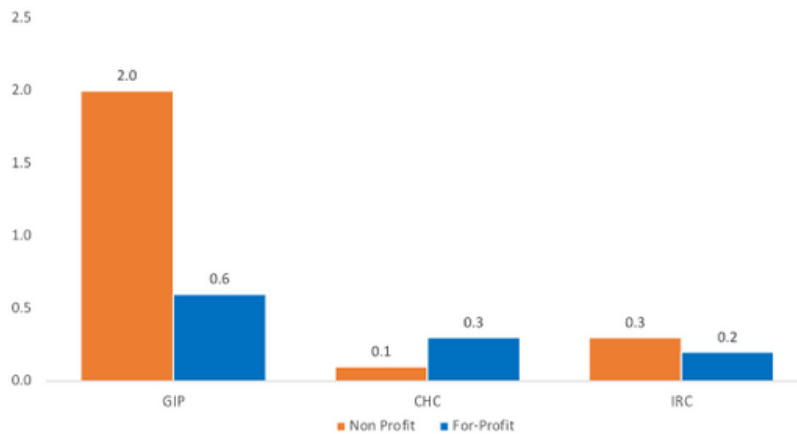
Community-based, non-profit hospice providers face substantial risks to their survival under the current Medicare hospice benefit payment model. Loss of these providers would lead to a change in the hospice benefit with a diminished experience of care for patients and their families. The risks come from:

- Competition with private equity-backed and other for-profit hospices:
  - In some markets the recent flood of private equity investment into the hospice industry runs the risk of incentivizing many established, non-profit hospice organizations to alter their business models in order to survive. These hospices can establish themselves as home-based providers or provide services in nursing homes without the cost of acquiring and operating an IPU and without genuinely offering all four levels of care as required by the Medicare Conditions of Participation (CoP). Private equity-backed providers are also known to develop referral relationships with local health care providers and seek to enroll a large number of low-cost, long-length-of-stay patients – a practice that non-profit providers largely regard as a practice to game the structure of the benefit.
  - For-profit hospices that are able to maintain low costs are yielding profit margins that are much higher than those that community-based, non-profit hospices are able to achieve. With their access to investment capital, for-profits are investing in other Medicare-reimbursed service lines that are profitable and can increase their margins.. Some for profit hospices are acquired by a large insurance carrier or health care system that can help lower their costs by consolidating back-office operations and expanding market share by capturing health system referrals.

- Increasing dominance of Medicare Advantage plans:
  - Given that nearly half of all Medicare beneficiaries are enrolled in MA plans, these plans are playing a greater role in shaping the market for hospice care. Currently, MA beneficiaries who elect to receive hospice care do so through a hospice agency outside of their MA plan – they transition back to Original Medicare for the duration of the hospice election.
  - Beneficiaries electing hospice but wishing to continue receiving care for conditions unrelated to their terminal illness may remain in their MA plan or may disenroll from MA and receive that care from Original Medicare. In either event, the MA plan is likely to play a role in the member’s selection of an agency and may contract with a hospice provider to provide pre-hospice palliative care or other home-based services which may act as a runway into hospice.
  - In 2020, CMMI launched an initiative to demonstrate a model for carving hospice into MA plan benefits and providing a supplemental capitation payment to the plans to pay for these services. The 34 MA plans participating in the model in 2022 are required to purchase hospice services from local providers by establishing networks as they do to provide other services.
  - Though it is not guaranteed that the hospice benefit will be carved-in to MA, hospice providers of the future will need to be prepared to compete for these and other performance-based/risk-bearing contracts. In the long run, there is a risk that MA plans would choose to provide palliative care and hospice in-house rather than through developing networks of established providers. In fact, some MA organizations have already acquired hospice programs with an eye to developing in-house capacity to provide hospice services in the future.
- Costs that disproportionately burden non-profit hospices:
  - Non-profit hospices were built around a complete model of care – providing all four levels of care. All hospice providers must offer access to each level of care but, in practice, programs that do not provide all levels of care may transfer patients needing the GIP level of care to hospices that provide it, contract with a nursing home to provide it, or live discharge the patient.

## Hospice Level of Care Provided, 2020

Percent of Hospice days billed that are billed as GIP, CHC, or IRC



HealthPivots tabulations of data from CMS Annual Cost Reports

- Non-profit hospices that are providing GIP level of care are operating with higher overhead – maintaining facilities and staffing at higher levels to serve this population. Patients who need hospice inpatient care often cannot be supported at home and would otherwise die in a hospital ICU or a SNF. Hospices that operate their own inpatient care enters are also uniquely affected by the high costs of program integrity activity that targets this higher billing rate.
- While for profit providers tend to have a small census compared to non-profit providers, these smaller for profit providers are typically part of a large corporate entity that lowers administrative and operating costs by consolidating these functions.
- Non-profit hospices are typically the safety-net providers in the community, caring for high-acuity, high cost patients, accepting patients transferred from for profit providers, and absorbing uncompensated care costs for patients exhausting or not covered by insurance who would otherwise be in a hospital ICU or SNF.

## **Barriers Facing the Hospice Sector**

- Workforce Shortages:
  - Hospices are experiencing critical staffing shortages across the board, but most acutely with nursing personnel. The United States' current supply of approximately four million nurses and midwives is estimated to be roughly one million short of the expected demand in the coming years.
  - As the U.S. population ages, demand for nurses is increasing, all while the current supply of nurses is aging. Job burnout in the health professions, which has been exacerbated by working conditions throughout the COVID-19 pandemic, has increased the number and duration of vacancies in nursing positions.
  - Many non-profit hospices are unable to compete with large healthcare systems for the limited supply of nurses, particularly Registered Nurses (RNs). Staffing requirements are specified in Medicare's hospice CoP leaving providers with little room for creative staffing solutions which can lead to access issues for beneficiaries and prevent hospices from standing up and staffing related services and other lines of business, as they increasingly need the ability to do in order to survive in the marketplace.
- Regulatory Burdens:
  - CMS's Center for Program Integrity (CPI) administers audits of the Medicare hospice benefit through three Medicare Administrative Contractors (MACs) and through other specialized audit contractors. While audit and compliance activity is necessary to weed out bad actors and protect beneficiaries and providers alike, compliance with the audits is disruptive and costly to the hospice programs and diverts medical and nursing staff from their primary responsibilities. Frequently, claims denials and recoveries from audits are based on findings that are inconsistent with the statutory and regulatory definition of the hospice benefit.

- Regulatory Burdens (Cont.):
  - Audits can be financially devastating to hospices that operate at low margins. Hospices have the right to appeal denials or recoveries, though cases can take years to reach an administrative law judge (ALJ) – at which point the denials are frequently settled or overturned and large amounts that were previously withheld or recovered by the MACs are returned to the hospice. The arduous nature of this process can lead to both a negative impact on patient care and a chilling effect for clinical staff attempting to make their best medical judgements regarding a patient’s eligibility of the benefit.
  - The pace of audit activity has accelerated in recent years, with some hospices being subject to multiple audits from different contractors at the same time. CMS has launched a Target, Probe, and Educate (TPE) program to shift the emphasis to identifying and educating hospices with a high volume of compliance errors – and has recently announced a special focus on GIP billing. Additionally, the HHS Office of Inspector General (OIG) recently announced its intention to gather data regarding hospice eligibility determinations involving patients with no prior hospitalization or emergency room visit.
- Lack of Consistent Financing for Advanced Illness Care:
  - The structure of the Medicare benefit and its discontinuity from other Medicare benefits creates a string of perverse incentives in the hospice industry and is a barrier to the success of hospice providers.
    - Discontinuity of care: The U.S. is one of the few developed countries that does not offer viable public or private insurance coverage for non-medical, long-term services and support (LTSS) other than through its social safety-net (Medicaid). Patients with advanced illness who exhaust their 100 days of Medicare post-acute benefits are without financing for their ongoing home-based support needs until they forgo further medical treatment for their terminal condition and elect hospice.



- This funding gap creates a huge financial burden for patients and their families who need ongoing palliative care and functional assistance with activities of daily living (ADLs) between termination of post-acute coverage and eligibility for hospice. Hospice eventually can provide the care needed to support a terminally ill patient at home who would otherwise have to be admitted to a hospital or SNF.
  - Eligibility for hospice: Hospice originated as an alternative to heroic, intensive hospital care at the end-of-life. The benefit is foundationally based on a terminal prognosis of illness. The diagnosis is by definition subjective since there is no agreed upon scientific basis, by the medical profession or the government, for accurately predicting mortality, and prognoses that prove inaccurate can be remedied with repeated recertifications. The 6-month prognosis and requirement to forgo other treatment is limiting in that many patients could benefit from earlier palliative care, and many who could benefit from hospice are unwilling to abandon the possibility of a curative treatment. The subjectiveness of the prognosis is also, an invitation for bad actors to game the benefit to maximize profit.
  - Structure of the hospice benefit: Once patients are admitted to hospice, they may remain in hospice for a long time, with periodic recertifications by a physician. The course of terminal illness will vary substantially for different types of illness and different patients. The single flat per diem payment that Medicare pays for nearly all hospice cases enables providers to game the benefit and realize substantial margins by recruiting low-cost patients likely to have long lengths of stay,
- Application of Technology:
    - The essence of hospice care is the in-person interaction with trained professionals who provide a mix of emotional, spiritual, medical, and physical aid to ameliorate pain and suffering and provide comfort to the individual and their family. While there is limited opportunity to replace human contact with telehealth or other forms of technology, protocols on home visits during the COVID-19 PHE enabled the use of telehealth when in-home visits were restricted to ensure the safety of patients receiving in-home hospice care.

- Telehealth services should supplement, not supplant in-person hospice care but as staff shortages continue and the need for for hospices to control costs becomes more pressing, congressional authorization for hospice use of telehealth following the termination of the COVID-19 PHE needs to be extended. In the future, more attention needs to be paid to the potential, particularly in rural areas, for technology applications that can improve connectivity and responsiveness of hospice care teams and their patients and families. Hospices also need to explore technologies that could improve the efficiency of the workflows that occur throughout the organization.
- Contracting with New Payor Entities:
  - The per diem payment model for hospice is a legacy of Original Medicare and as a result, many hospices have not successfully integrated with the fastest growing parts of the Medicare program. The hospice benefit remains carved out of Medicare Advantage and hospice programs have been eager but slow to participate in CMMI models such as Direct Contracting (now ACO REACH) and other provider-sponsored risk-sharing and shared savings models that are enrolling increasingly large portions of the Medicare beneficiary population.
  - In the future, participating in the MA hospice carve-in demonstration, ACO REACH Model, or other risk-based payment arrangement will require that hospices have the ability to collect and present data on the quality of care they provide in ways that are meaningful to MA plans and other payors. While most hospices are used to presenting the value of hospice and hospice outcomes in narrative form, few are prepared to quantify these. Hospices will need to develop more advanced data capabilities and learn to present the value of their care model in quantitative terms that MA plans and other purchasers can appreciate.
  - In addition, more work will need to be done to design risk-bearing payment arrangements that support and enhance the full hospice care model. Currently, the communication regarding quality, outcomes, and value between hospice programs and payers occurs in entirely different languages. With respect to value-based payment arrangements, an approach is necessary that values and articulates aspects of hospice care that are difficult to quantify but important nonetheless.

# CONCLUSION

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The survival of non-profit, community-based hospice providers in the context of the rapidly changing health care environment will require hospices to:

- Successfully measure and communicate - in contract negotiations - the value of hospice as a specialized component of advanced illness care, and its impact on total costs and quality of care at the end-of-life.
- Communicate the importance of maintaining high quality, independent, community-based organizations that serve the community and bring together a range of non-medical disciplines in order to provide a holistic, meaningful, and comforting palliative and end-of-life experience.
- Learn to manage the organization and delivery of high-quality services while managing financial risk, in the context of an increasing competitive market.

# OTHER PAPERS ON THE MEDICARE HOSPICE BENEFIT

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NPHI is developing recommendations for changes in the Medicare hospice benefit and in hospice operations to address the challenges and barriers detailed above, and to sustain the viability of non-profit, community-based providers.

- [Reforming Hospice Audits: Proposed Solutions for a Targeted and Effective Hospice Program Integrity Structure](#)

## ABOUT NPHI

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**The National Partnership for Healthcare and Hospice Innovation (NPHI)** is a collaborative of 80+ not-for-profit, community-integrated hospice and palliative care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values and preferences. Representing providers from 31 states and the District of Columbia, NPHI and its members help design more innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs, and build collaboration between national thought leaders, decision-makers, and other healthcare stakeholders to improve hospice care. [www.nphi.info](http://www.nphi.info)

Please contact NPHI's Chief Policy Officer, Larry Atkins, at [latkins@hospiceinnovations.org](mailto:latkins@hospiceinnovations.org) for further information.

