Through the Looking Glass: Future Landscape of Hospice

September 2023

UNC Palliative Care Grand Rounds

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Disclosures

- None

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Goals

- Review where we started
- Understand current state of hospice, challenges and gaps
- Understand Medicare Advantage VBID
- Discuss new models and future opportunities

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CATCH THE JOY
SHARE THE
PAIN

A Grassroots Movement

HOSPICE
OF WAKE COUNTY
Celebrating Life in Your Community

Early Days of Hospice

Tax Measure Offers New Benefits For Hospice Care of Terminally Ill

WASHINGTON, Aug. 31 (UPI) — The tax bill recently passed by Congress contains a provision that is regarded as sure to strengthen a movement providing special care for the dying.

The hospice provision would allow Medicare to pay for the care of the dying at home instead of in the hospital.

In 1978 there were 59 organizations offering hospice care; by mid-1981, there were 440, according to the Congressional Budget Office. The $98.1 billion tax measure, which President Reagan is expected to sign soon, is scheduled to take effect Nov. 1, 1983.

The hospice provision is aimed at giving participants in Medicare, the Federal program of health care for the elderly, an alternative to sometimes costly hospital treatment.

Focus on Relief From Pain

Hospices care for the terminally ill chiefly by concentrating on relief from pain. Some hospices are in separate buildings, but that is more common in England, where the movement began.

The budget office estimates that hospice services care for 50,000 people in this country, about 10 percent of the potential users. Virtually all are cancer patients. The office predicts the measure will make it possible for an additional 109,000 people to seek hospice services.

The bill provides a comprehensive Medicare benefit for people expected to

"A hospice," she went on, "really provides not only competent care, but it provides a more loving and more compassionate and more appropriate care for the patient at this stage in the illness. The hospice recognizes when illness is no longer curable. A hospice just allows death to come naturally."

The hospice benefit would cover some items Medicare cannot pay for, such as counseling for the patient and family, outpatient drugs, medical supplies for a patient's comfort, the respite service and custodial home health care. The measure has an expiration date of Oct. 1, 1986, giving Congress time to evaluate the program and make changes.

After the costs of a transition period, the budget office estimates the program would save $48 million before it expires in 1986. In 1983, the budget office estimates, each hospice user would spend $1,100 less than in a hospital.

The Reagan Administration had opposed the program because it wanted to wait for results of a hospice study, expected to be completed in September 1983. But when Congress, in response to the lobbying of the hospice movement, indicated it might go ahead, the Administration assented.

Although most hospice care must be provided at home, a provision in the bill would allow Medicare benefits to be paid for care in an institutional hospice near New Haven, Conn.

Nov 1st 1983- 40 years ago

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How it Started- 1985

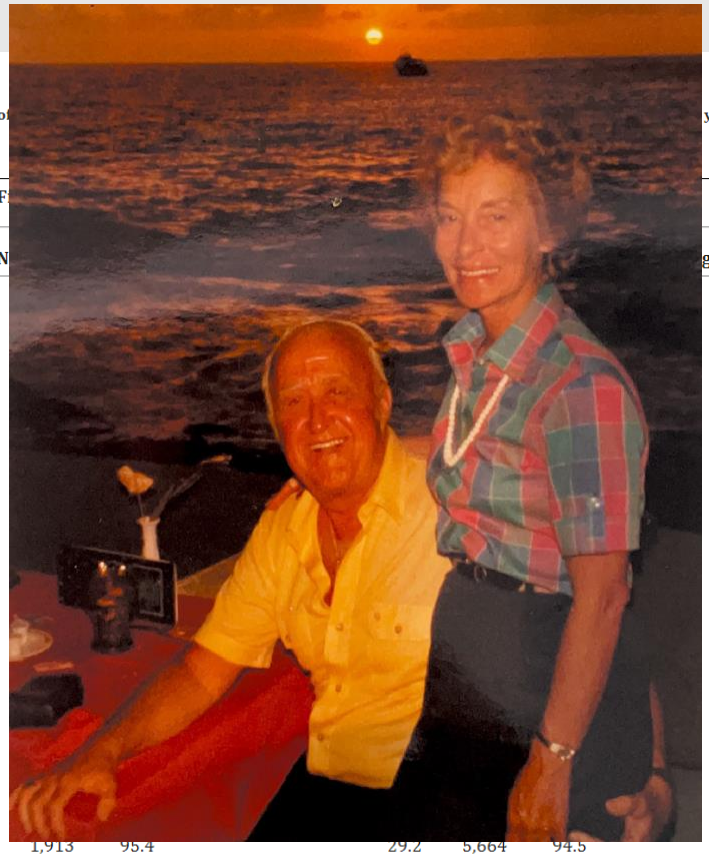


Table 2

Number and percent of … years 1984-85

Characteristic	N…	…	…	…	…	…gth of stay in days
Total						32.1
Age						
Under 65 years						33.5
65-74 years						31.5
75 years or over						32.5
Sex						
Male						30.1
Female						34.3
Race						
White						32.1
Black						33.6
Other						24.1
Unknown						—
Diagnosis						
Cancer						32.1
Noncancer						30.8
Died in hospice	1,913	95.4		29.2	5,664	94.5	31.6
Left hospice, died	92	4.6		31.4	327	5.5	39.3

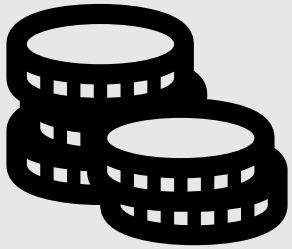
[1]The data are obtained from the social security master enrollment file.

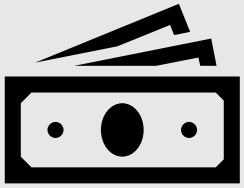
- <5% of Medicare Decedents received hospice at time of death
- Most were home based
- 99% cancer
- Average Length of stay 30-45 days

Davis Health Care Finance Rev 1988

Hospice Payment

- 1985-2016
  - Largely unchanged
  - 4 tiers
    - RHC-routine
    - GIP- general inpatient
    - CHC –continuous home care
    - IRC- intermittent respite





- January 2016
- Tiers for RHC
  - Days 1 – 60 ($211.34 in 2023)
  - Days 60+ ($167.00)
  - Service-Intensity Add-on
    - In-person visits by RN, SW while patient on RHC level of care last 7 days
    - Up to 4 hours per day (15-minute increments)
    - Paid at CHC hourly rate ($63.42 for FY2023)
- FY2020
  - Rebased levels of care
  - Significant increases for GIP, CHC, IRC
  - Relatively small reductions to RHC
  - Based on hospice cost report data

How It's Going- 2023

Trends in Hospice Care

Over the past decade, hospice use has grown steadily. Medicare paid **$21 billion** for hospice care in 2019.

Since 2010:

59% **increase** in payments for hospice care

39% **increase** in number of hospice beneficiaries

38% **increase** in number of hospices

32% **increase** in number of claims

15% **increase** in average hospice payment per beneficiary

OIG data brief 2022

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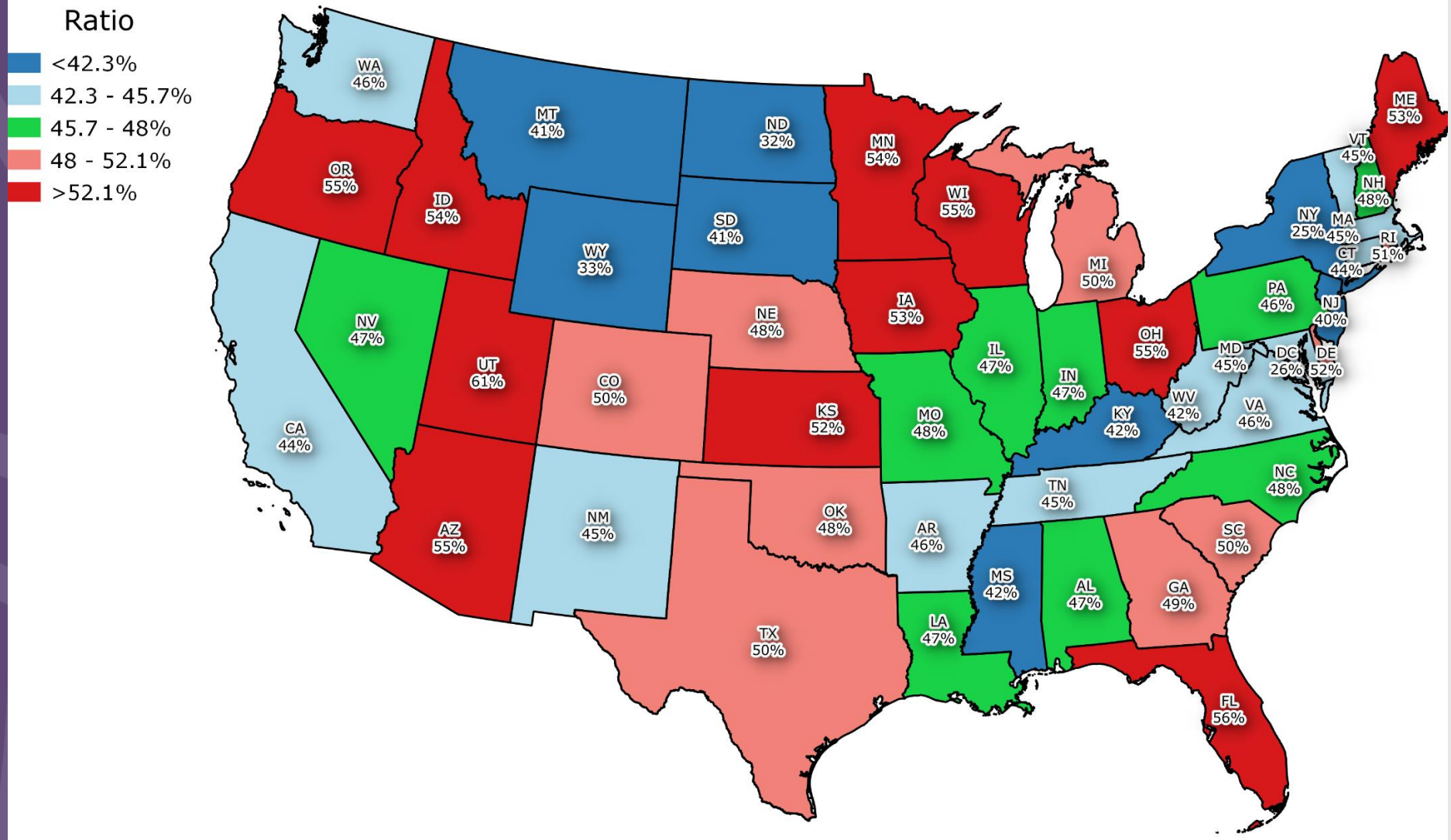
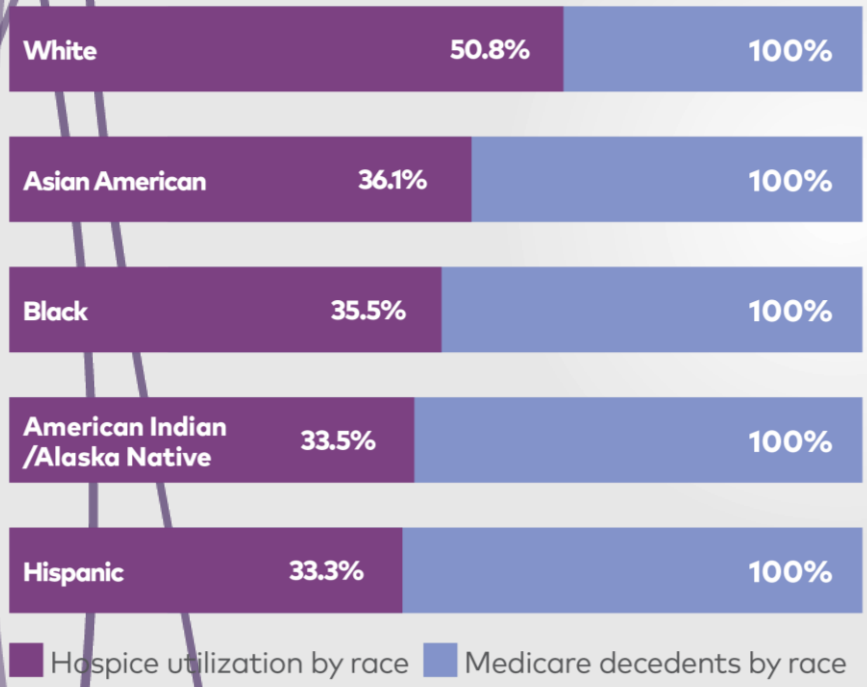
DEATH SERVICE RATIO FOR 2020

Hospice Deaths / Total Deaths for Medicare Enrollees



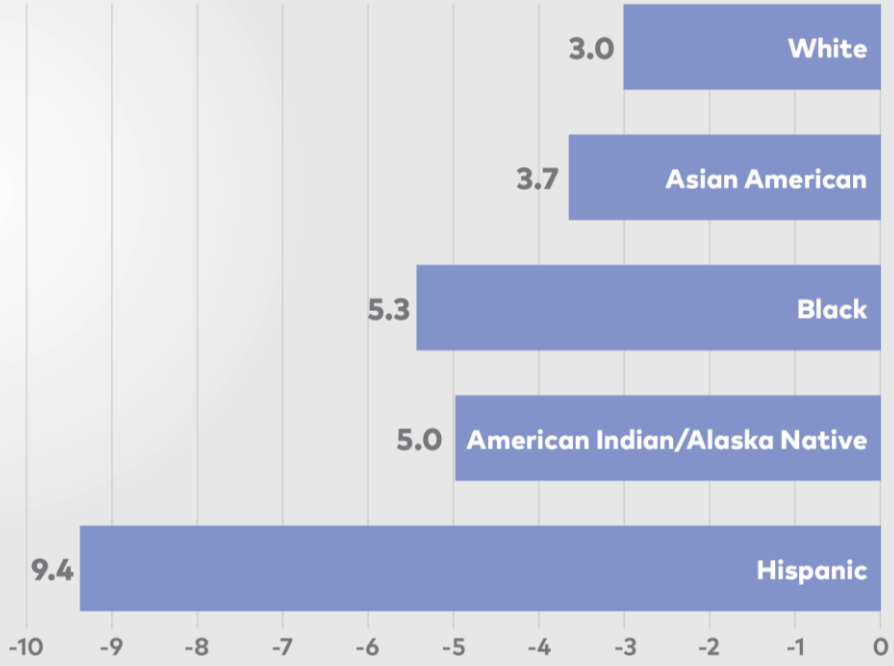
Disparities in Care

Figure 9: Share of Medicare decedents who used hospice, by race



Source: *MedPAC March 2022 Report to Congress, Table 11-3*

Figure 10: Percentage point change of decedents who use hospice, by race



Health Care

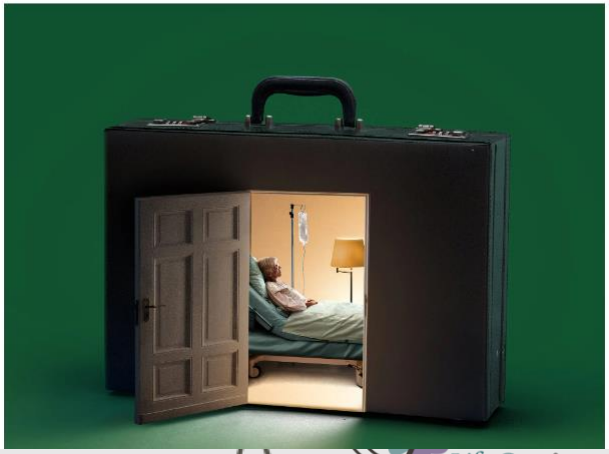
Hospices in Four States to Receive Extra Scrutiny Over Concerns of Fraud, Waste and Abuse

Federal regulators have announced enhanced oversight of new hospices in Arizona, California, Nevada and Texas, targeting providers highlighted by a ProPublica investigation.

Hospice Is a Profitable Business, but Nonprofits Mostly Do a Better Job

Nearly three-quarters of hospice organizations are now for-profit. Complaints of fraud and profiteering are growing.

Share full article 168



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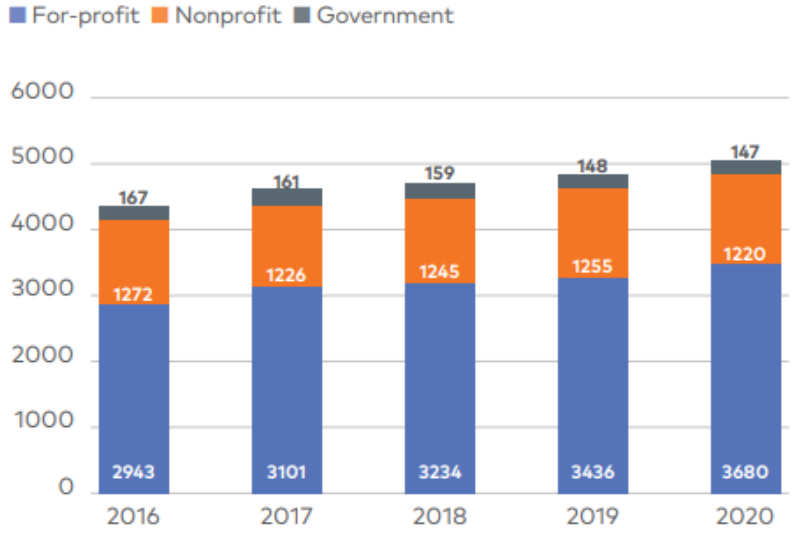
For-Profit Hospice >72%

Figure 19: Providers by Type



Source: *MedPAC March 2022 Report to Congress, Table 11-1; MedPAC March 2021 Report to Congress, Table 11-1*

Figure 9: Payments and Number of Providers Associated With For-Profit Hospices Relative to Nonprofit Hospices Increased Over 10 Years

Hospice Payments and Providers by For-Profit and Nonprofit Status

Hospice payments and number of providers associated with for-profit hospices have grown significantly over 10 years.

	For-Profit	Nonprofit
Hospice Payments	87% increase	34% increase
Number of Providers	78% increase	12% decrease

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Length of Stay

2020 LOS/Diagnosis		2020 LOS/Location of Care	
Cancer	53 days	Home	90 days
COPD	135 days	Nursing facility	133 days
Neurological conditions	161 days	Assisted living facility	172 days

MedPac 2022

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Live Discharges

- Live discharge rates
  - 2020 – 15.4%
  - 10% of hospices have live discharges of 43%
- High live discharge rates signal potential
  - Quality of care concerns
  - Program integrity concerns

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Goldilocks and the OIG

- OIG Audit of Inappropriate general inpatient hospice billing
  - Focused on GIP provided directly preceded by hospital stay
- OIG is planning a nationwide audit of hospice eligibility
  - The audit will focus on patients who did **not** have a hospitalization or emergency department visit prior to electing hospice.
- Live discharge rate is too high, too early, too late
- Live discharge followed by hospitalization and readmit to hospice and/or death.
- Too many patients in ALFs
- In 2022 the OIG published a report: “Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight.”

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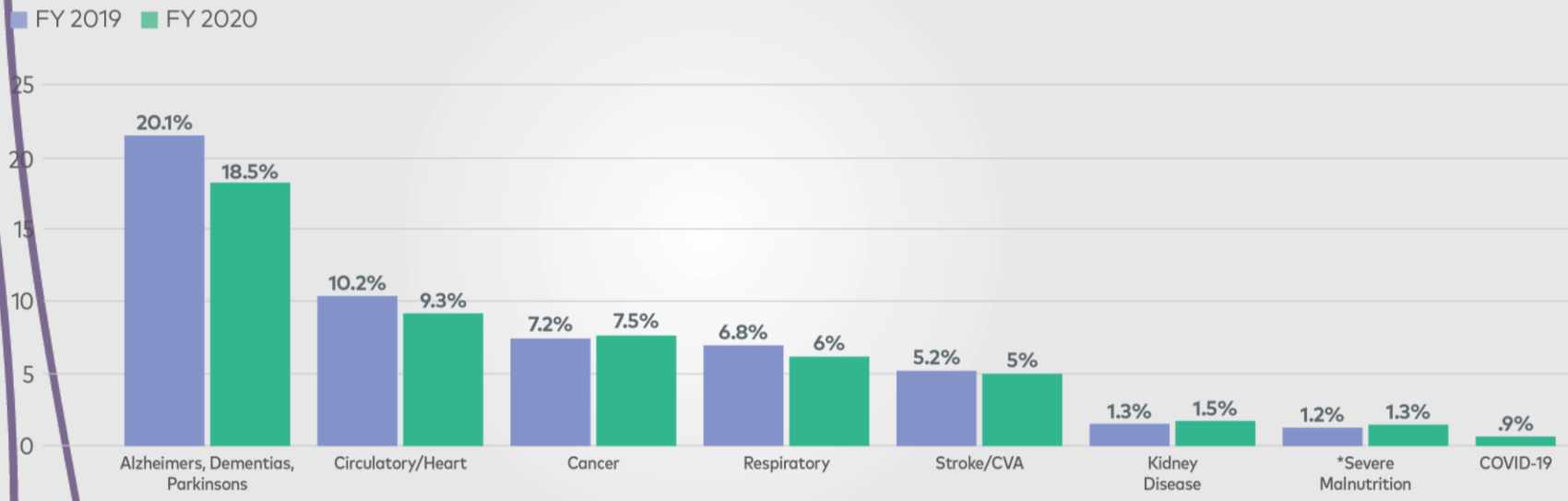
Dementia is Leading Diagnosis in Hospice

Figure 11: Medicare Decedents Using Hospice by Top 20 Principal Diagnoses (percentage)



Note: *Only the top 20 diagnoses were included in these groupings. Additional diagnosis that could fall under these groupings are outside of the top 20 diagnoses.*
Source: *Hospice Analytics*

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NORTH CAROLINA
2023 ALZHEIMER'S STATISTICS

NUMBER OF PEOPLE AGED 65 AND OLDER WITH ALZHEIMER'S

YEAR	TOTAL
2020	180,000
2025	210,000

ESTIMATED % INCREASE

16.7%

PREVALENCE

158 # OF GERIATRICIANS IN 2021

238.6% INCREASE NEEDED TO MEET DEMAND IN 2050

65,150 # OF HOME HEALTH AND PERSONAL CARE AIDES IN 2020

26.0% INCREASE NEEDED TO MEET DEMAND IN 2030

WORKFORCE

UNPAID CAREGIVERS (2022)

369,000 # OF CAREGIVERS

533,000,000 TOTAL HOURS OF UNPAID CARE

$8,067,000,000 TOTAL VALUE OF UNPAID CARE

CAREGIVER HEALTH (2021)

58.8% OF CAREGIVERS WITH CHRONIC HEALTH CONDITIONS

41.0% OF CAREGIVERS WITH DEPRESSION

18.1% OF CAREGIVERS IN POOR PHYSICAL HEALTH

CAREGIVING

HOSPICE (2017)

8,486 # OF PEOPLE IN HOSPICE WITH A PRIMARY DIAGNOSIS OF DEMENTIA

17% HOSPICE RESIDENTS WITH A PRIMARY DIAGNOSIS OF DEMENTIA

HOSPITALS (2018)

1,684 # OF EMERGENCY DEPARTMENT VISITS PER 1,000 PEOPLE WITH DEMENTIA

21.5% DEMENTIA PATIENT HOSPITAL READMISSION RATE

MEDICAID

$1.332B MEDICAID COSTS OF CARING FOR PEOPLE WITH ALZHEIMER'S (2020)

22.2% PROJECTED CHANGE IN COSTS FROM 2020 TO 2025

MEDICARE

$26,019 PER CAPITA MEDICARE SPENDING ON PEOPLE WITH DEMENTIA (IN 2022 DOLLARS)

HEALTH CARE

OF DEATHS FROM ALZHEIMER'S DISEASE (2019)

4,508

161.3% INCREASE IN ALZHEIMER'S DEATHS 2000-2019

MORTALITY

Hospice Experience in Dementia

MEDICARE

For NC people with dementia, Medicare's hospice program holds caring comfort, but also contains pitfalls.

Backed by Medicare health insurance, hospice offers a range of valuable services, typically for people within six months of death. But for people with dementia, with a timeline that's difficult to de

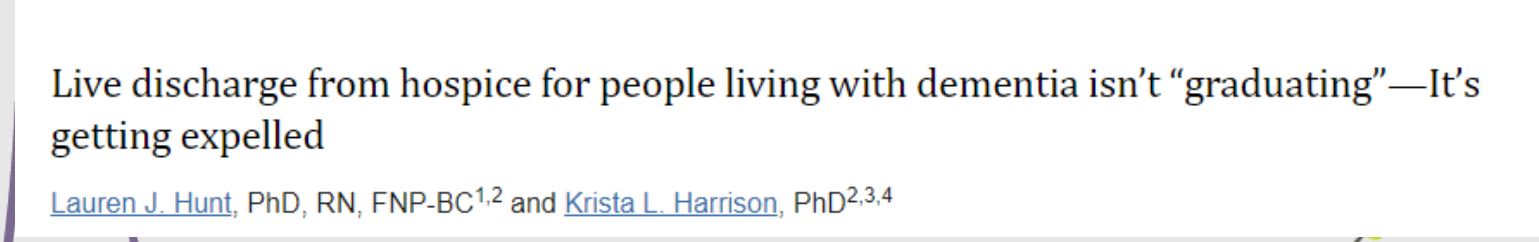
by **Thomas Goldsmith**
March 20, 2023

J Gerontol A Biol Sci Med Sci. 2023 Jun 1;78(6):1053-1059. doi: 10.1093/gerona/glad003.

Dementia's Unique Burden: Function and Health Care in the Last 4 Years of Life

Ila Hughes Broyles [1], Qinghua Li [1 2], Lauren Martin Palmer [3], Michael DiBello [1 4], Judith Dey [5], Iara Oliveira [5], Helen Lamont [5]

Affiliations + expand



Live discharge from hospice for people living with dementia isn't "graduating"—It's getting expelled

Lauren J. Hunt, PhD, RN, FNP-BC[1,2] and Krista L. Harrison, PhD[2,3,4]

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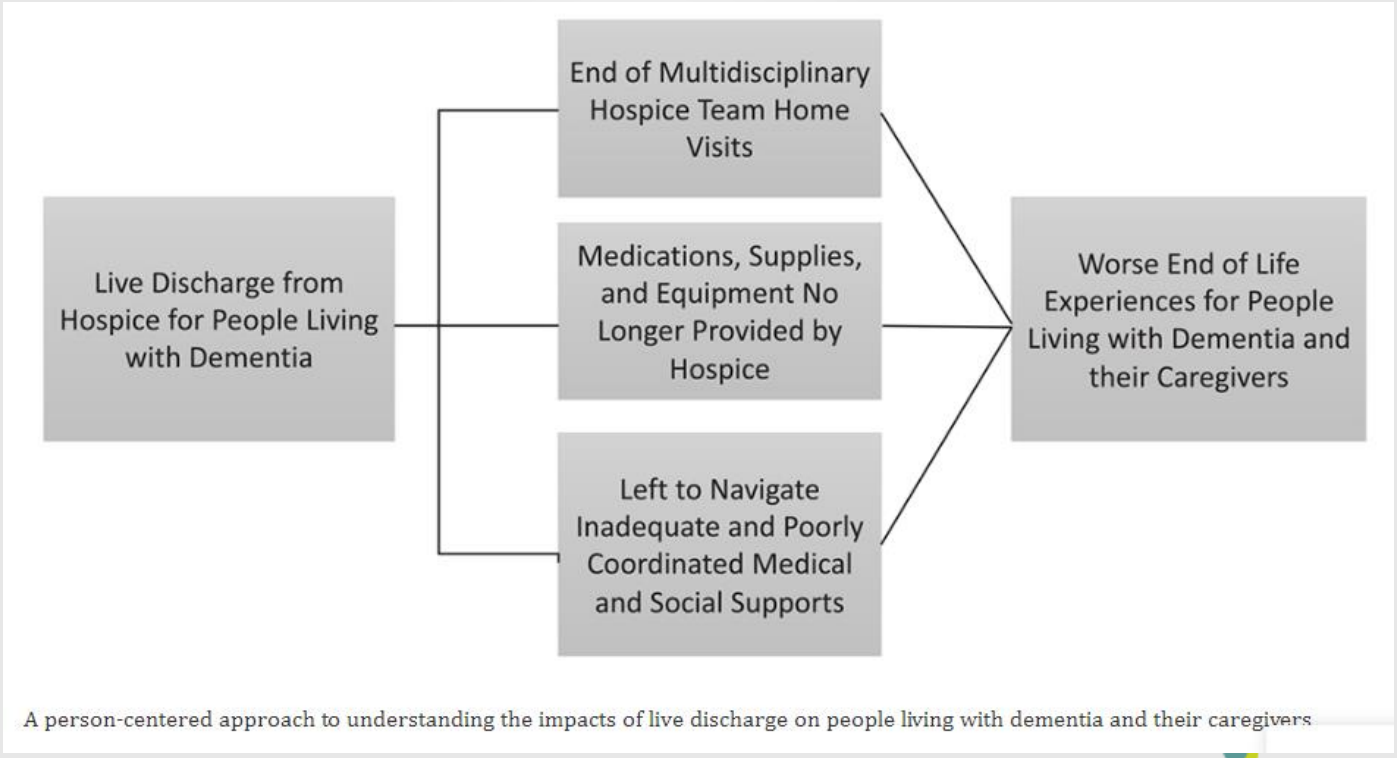
Negative Consequences of Live Discharge



A person-centered approach to understanding the impacts of live discharge on people living with dementia and their caregivers

Hunt, Harrison 2021

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The Quandary of Dementia

- Hospice is filling a gap, but doesn't exactly support the needs
- People need longer period of care with increasing support for dependence.
- Need quality of life support, home based supports and guidance in transitions to facility based care if/when needed.
- Yet….Hospices are under constant scrutiny to discharge people with long length of stay or not take them at all because of concern for long length of stay.

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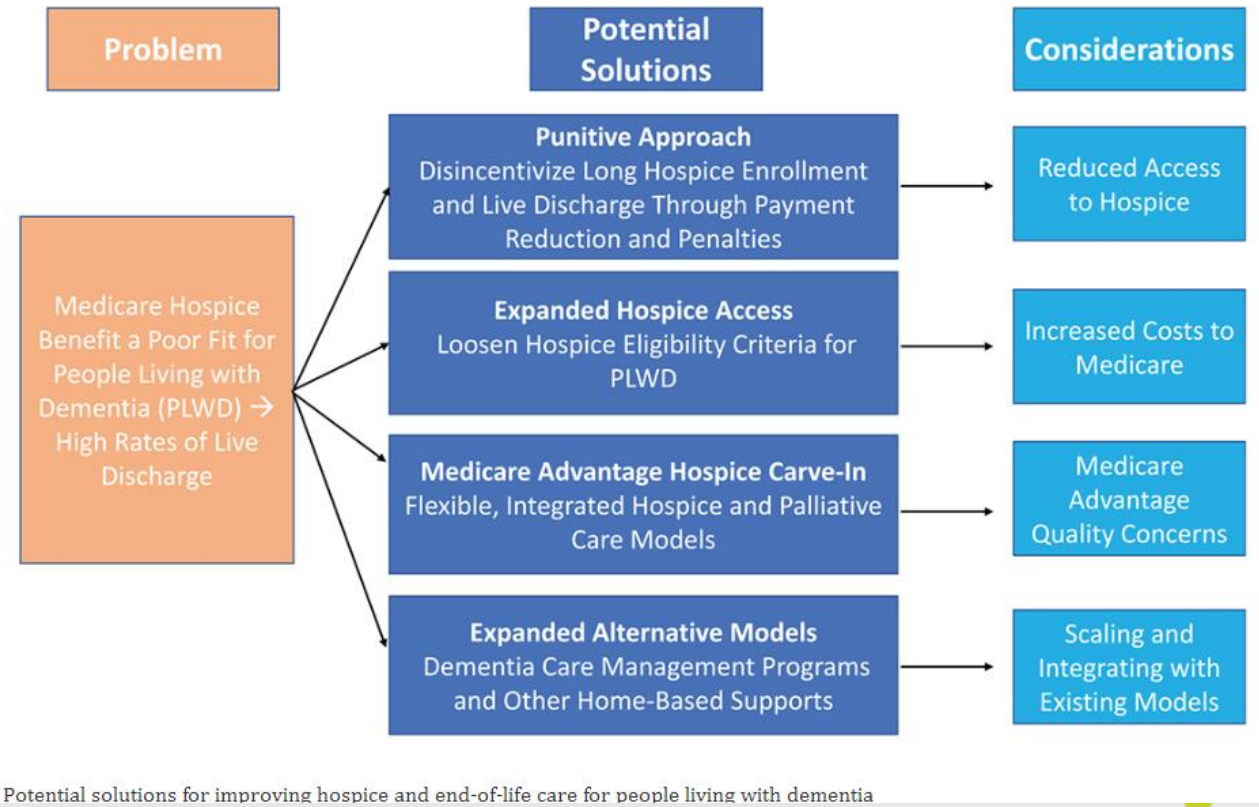
Potential Way Forward

FIGURE 2



Potential solutions for improving hospice and end-of-life care for people living with dementia

Hunt, Harrison 2021

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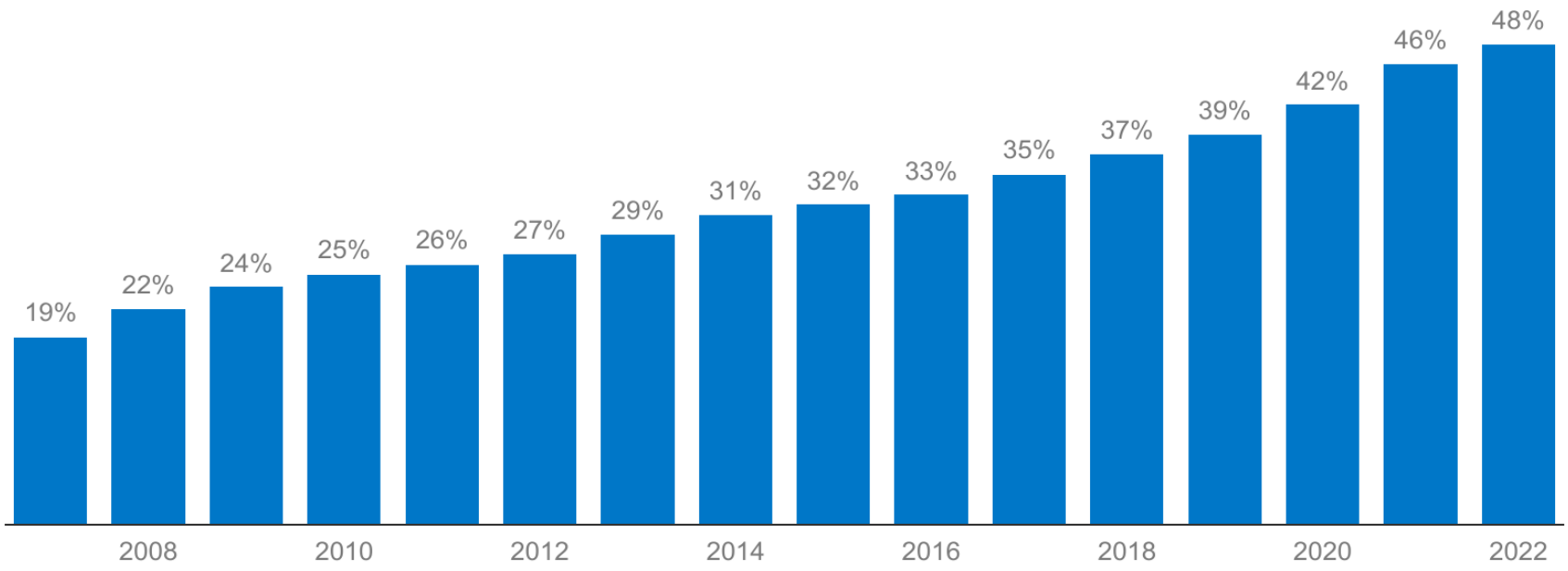
US MA Trend

Figure 1

Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration Medicare Advantage Enrollment



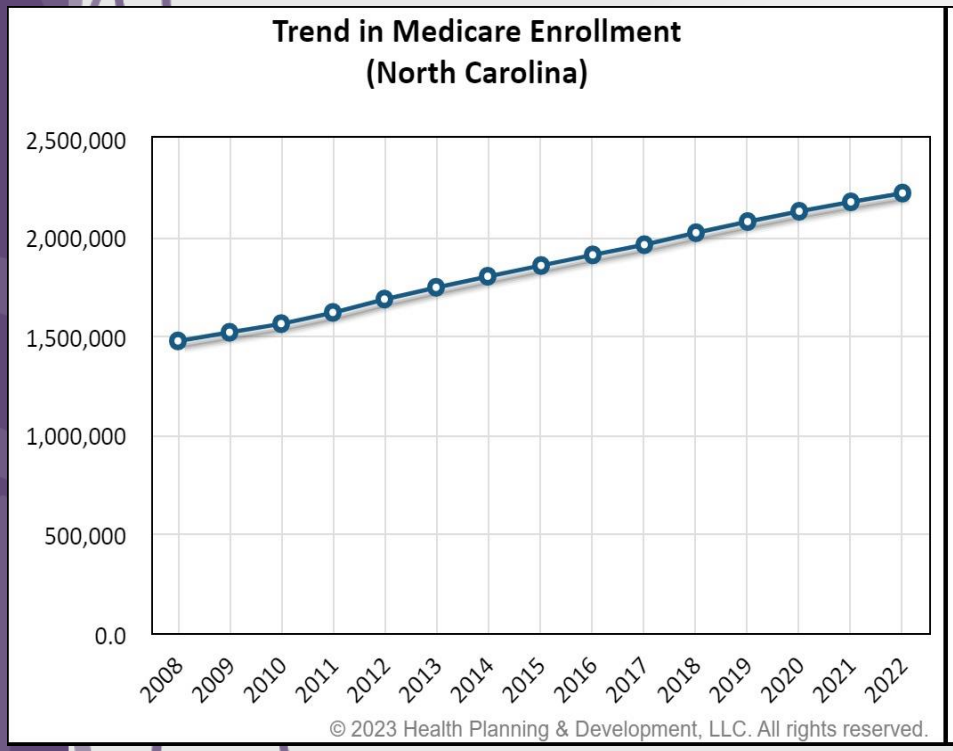
NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.

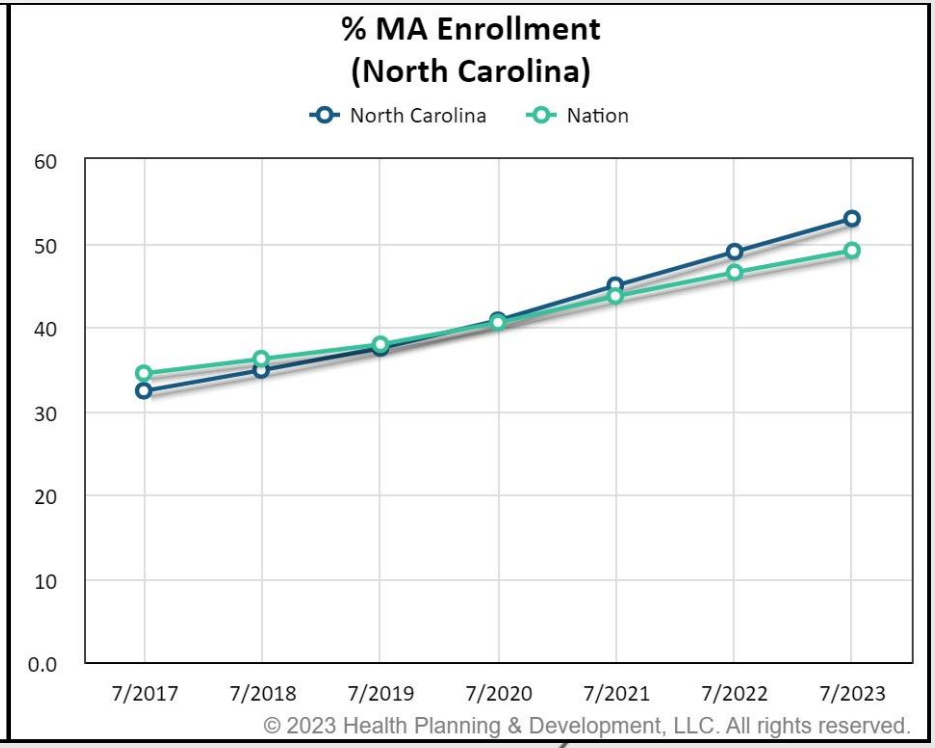
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022.

KFF

ns

North Carolina Medicare Population





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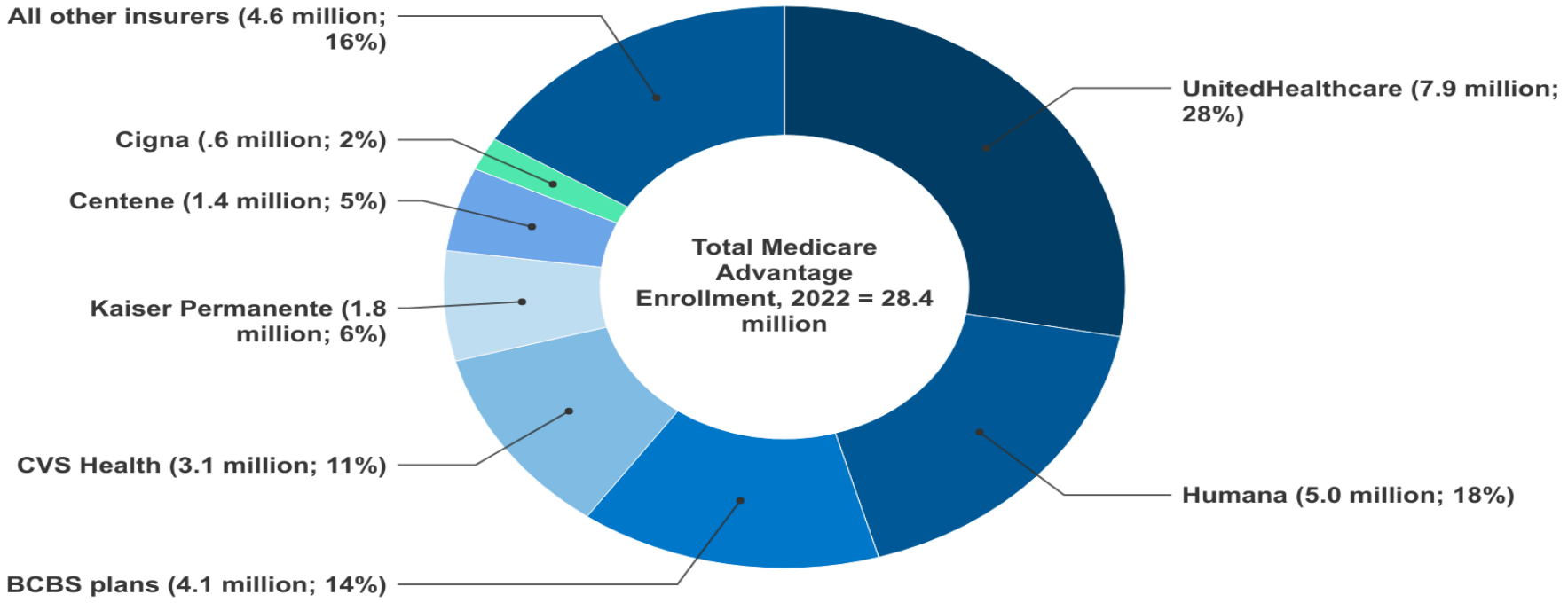
MA Market Share

Figure 8

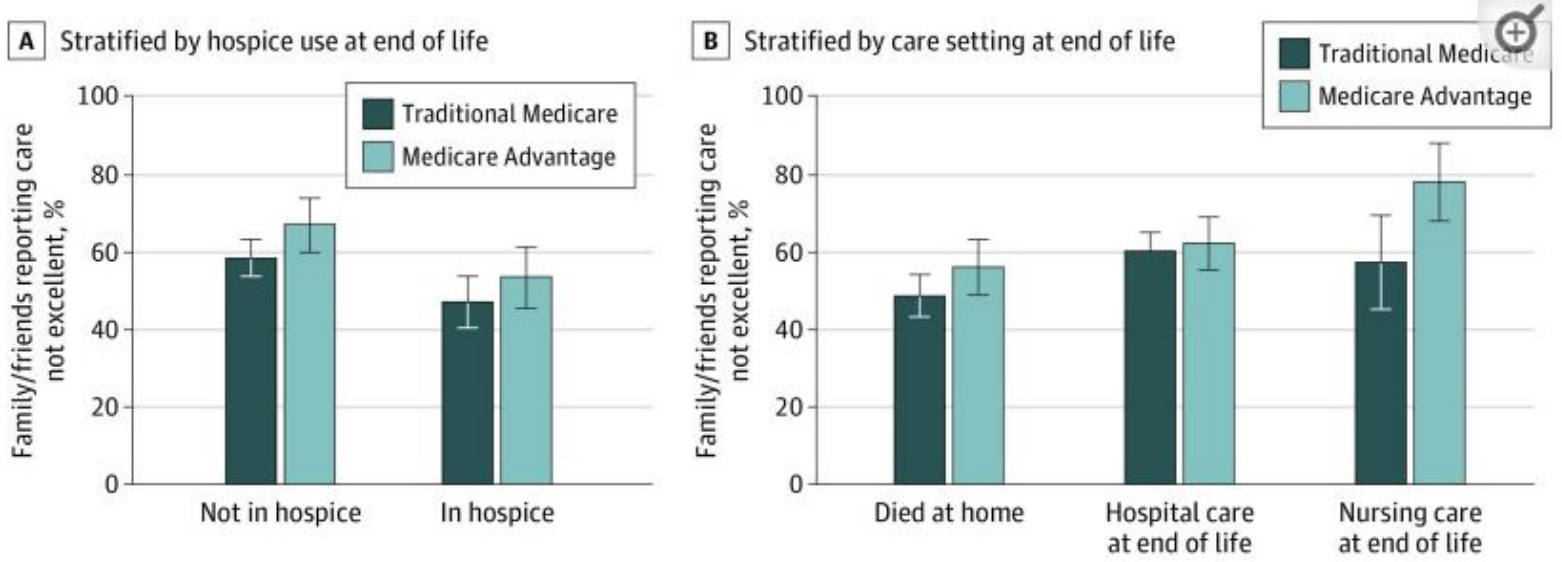
Medicare Advantage Enrollment by Firm or Affiliate, 2022



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are about 2% of total enrollment.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022.

KFF

Quality of Care at EOL in Medicare Advantage



Estimated Proportions Reporting Care Was Not Excellent in the Last Month of Life, Stratified by Subgroups

Ankuda et al JAMA Netw Open 2020

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MA VBID Hospice "Carve-in"

- Launched in 2021
- Initially planned to end 2025, but extended through 2030
- Expected to serve 20,000 people with serious/terminal illness enrolled in 15 MAOs across 23 states and Puerto Rico
- Goals of MA VBID Hospice Component model:
  - Eliminate fragmentation
  - Consolidate responsibility (financial, cost accountability, quality, outcomes)
  - Improve care coordination
  - Encourage timelier transition to hospice care when appropriate and preferred

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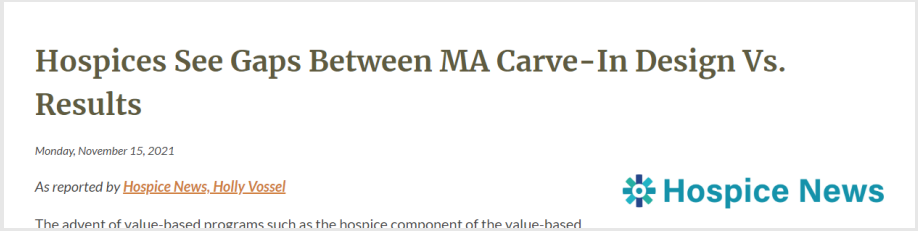
Real World Experience of VBID

- Maintain full scope of Hospice care
  - Providers in demo have already seen significant rate cuts which may change resources available.
- Improving access to Palliative Care
  - Palliative care benefit and eligibility is ill-defined
  - Services limited to top 1.5% sickest as defined by payor and limited to payor referral. Also limiting length of service to 6 months. Very low volumes



Hospices See Gaps Between MA Carve-In Design Vs. Results

Monday, November 15, 2021

As reported by Hospice News, Holly Vossel

Hospice News

The advent of value-based programs such as the hospice component of the value-based

RAND Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test Oct 2022

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Real World Experience of VBID

- Concurrent Care
  - Benefits vary by plan. Eg some have limitations to 31 days. Still a hard stop on concurrent care which is a barrier.
- Supplemental hospice benefits
  - Social determinents $$- requires prior auths
  - In home respite- limitations of amounts eg 40 hrs/year
- Promotes quality and transparency
  - Heavy admin burden on participating hospices. Lack of alignment. Hesitancy to share financial outcomes
- Maintains broad choice and improves access to hospice
  - Limited impact thus far.
  - Starting 2023, payors can limit to ‘in network’ providers. To be in network, hospices often have to take a steep paycut. Consolidation of payors/providers- concern that payors will push referrals to owned providers

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Consolidation, private equity, Vertical integration

DIVE BRIEF

Hospices bought by PE, public companies had more dementia patients, study finds

The findings suggest private equity firms and publicly traded companies shift their operational strategies to maximize profits, according to a study published in JAMA Network Open.

Published Sept. 26, 2023

Emily Olsen
Reporter

Deals

UnitedHealth bags Amedisys for $3.3 billion as home health firm scraps Option deal

Reuters

June 26, 2023 10:18 AM EDT · Updated 3 months ago

SCAN Group Makes Strategic Investment in Guaranteed

Date Posted: 09/12/2023

The First Tech-Enabled Hospice Care Company is Committed to Making End-of-Life Care More Personalized, Inclusive, and Accessible to All

CD&R, Humana-Backed Gentiva Ink $710 Million Hospice Deal

- Gentiva is buying ProMedica's Heartland hospice business
- Deal will expand patients Gentiva serves to 34,000: CEO

HEALTH TECH

Walgreens snaps up remaining stake in CareCentrix for $392M

By **Heather Landi** · Oct 12, 2022 07:20am

Walgreens | CareCentrix | home healthcare | mergers and acquisitions

MA Carve-In Summary

- Change is coming, TBD on whether MA Carve-In is the answer
- Lots of concerns for hospices and people with serious illness around access, administrative burden, payment, and choice.

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CMMI- Traditional Medicare

- Renewed interest in palliative care
  - But…tension btw standalone community-based palliative care demo and a broader strategy that integrates palliative care across all relevant models, primary and specialty alike (this CMMI prefers the “threading” approach)
  - ACO REACH
  - Enhancing Oncology Model (EOM)
  - Kidney Care Choices (CKCC)
  - Other ACO models (MSSP, Primary Care First)

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CMS has all risk

--------Increasing levels of shared losses / savings-------> 63,964,675 Medicare (10.21)

Plan / ACO has 100% risk

FFS

Traditional Medicare members not aligned to an ACO

24 million

MSSP 2022

Members aligned to Medicare Shared Savings Program ACO

483 ACOs
41% Upside only
59% Upside/Downside

11.0 million members

Medicare Advantage (**MA**)

29.0 million members (5.22)
UHC 27% market share
Humana 18% market share

Members in Special Needs Plan (**D-SNP, C-SNP, I-SNP**) = 4.8MM (5.22)

D: 729 plans / 4.3 million
C: 283/ 405K
I: 186/101K

Primary Care First

Physician Group Program
Upside gain sharing and care management payments

OCM – EOM (6.23 ….)

Enhanced FFS + P4P
138 practices, 10 payers

Independence At Home

Upside only (shared savings)

15 orgs

REACH ACO Professional

Members aligned to a DCE with Professional Risk

50% Upside/Downside Risk

Cap payments (7% of budget)

Medicare Members in **PACE**

134 PACE programs in 30 states
53,528 members (5.22)

REACH ACO TCC or PCC

Members aligned to a DCE with Global Risk

100% Upside/Downside Risk

Cap payments of 100% (TCC) or 7% (PCC) of Target

343K 2021 participants

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CMMI-MCCM

- Success of Medicare Care Choices Model (MCCM) concurrent care demo driving interest and work
  - MCCM:
    - $26 million in savings
    - Improved patient and family satisfaction and outcomes
    - Facilitated more timely transition to hospice (~83% of enrollees transitioned from MCCM to hospice, which accounted for ~70% of the cost savings).

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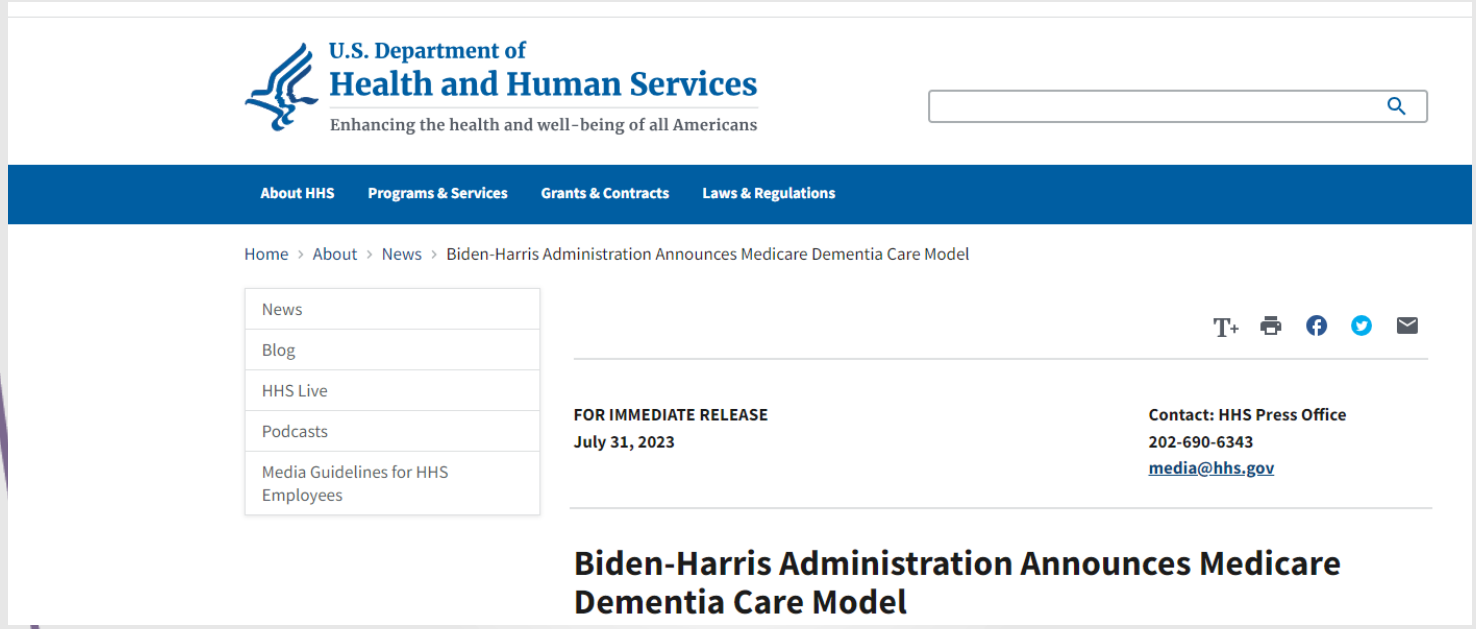
Guiding an Improved Dementia Experience (GUIDE) Model



U.S. Department of Health and Human Services
Enhancing the health and well-being of all Americans

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- Podcasts
- Media Guidelines for HHS Employees

FOR IMMEDIATE RELEASE
July 31, 2023

Contact: HHS Press Office
202-690-6343
media@hhs.gov

Biden-Harris Administration Announces Medicare Dementia Care Model

- Announced 7/31/23
- Three stated goals:
  - Improve quality of life for people living with dementia (PLWD)
  - Reduce burden and strain on unpaid caregivers
  - Prevent or delay long term nursing home care

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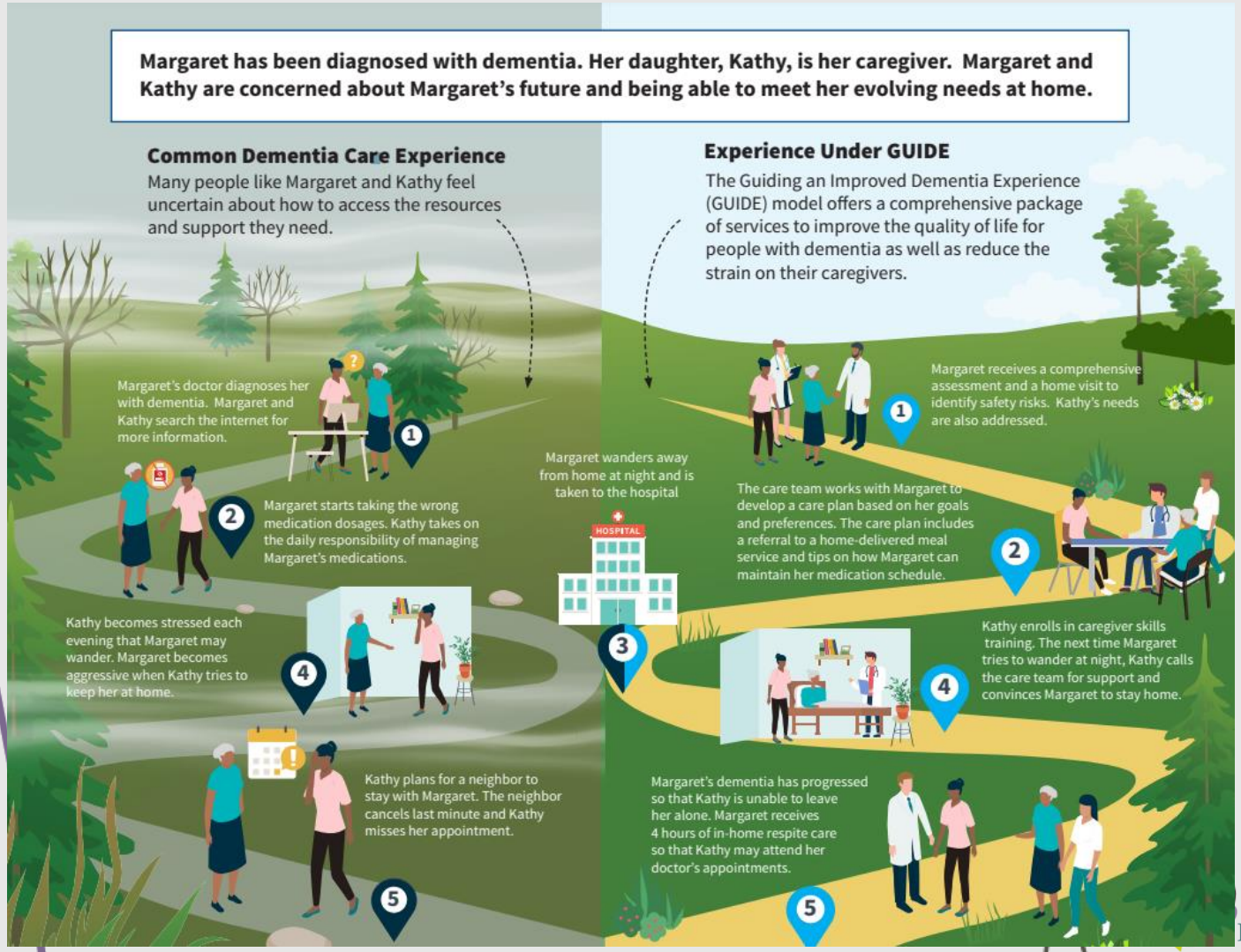
GUIDE Model



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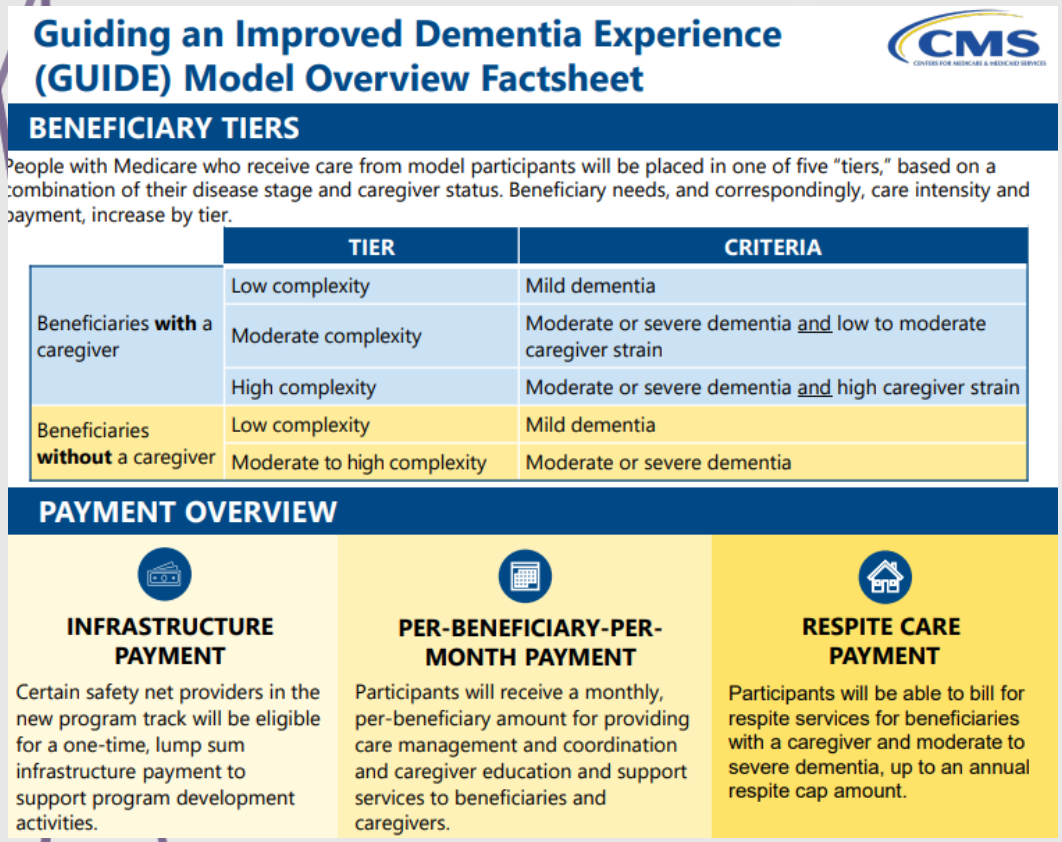
GUIDE Model



Guiding an Improved Dementia Experience (GUIDE) Model Overview Factsheet

CMS

BENEFICIARY TIERS

People with Medicare who receive care from model participants will be placed in one of five "tiers," based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, increase by tier.

	TIER	CRITERIA
Beneficiaries **with** a caregiver	Low complexity	Mild dementia
	Moderate complexity	Moderate or severe dementia and low to moderate caregiver strain
	High complexity	Moderate or severe dementia and high caregiver strain
Beneficiaries **without** a caregiver	Low complexity	Mild dementia
	Moderate to high complexity	Moderate or severe dementia

PAYMENT OVERVIEW

INFRASTRUCTURE PAYMENT

Certain safety net providers in the new program track will be eligible for a one-time, lump sum infrastructure payment to support program development activities.

PER-BENEFICIARY-PER-MONTH PAYMENT

Participants will receive a monthly, per-beneficiary amount for providing care management and coordination and caregiver education and support services to beneficiaries and caregivers.

RESPITE CARE PAYMENT

Participants will be able to bill for respite services for beneficiaries with a caregiver and moderate to severe dementia, up to an annual respite cap amount.

Minimum requirements for IDG

- Care navigator
- Clinician with dementia proficiency

Eligibility:

- Diagnosis of dementia
- Traditional Medicare
- Does not reside in a nursing home
- Not in hospice

https://www.cms.gov/files/document/guide-overview-slides.pdf

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Guide Model Payment

Payment Amounts

Model participants will use a set of new G-Codes created for the GUIDE model in order submit claims for the monthly Dementia Care Monthly Payment (DCMP). The DCMP is intended to cover the model's required care delivery activities.

Per Beneficiary Per Month Payment Rates

	Monthly payment rates for beneficiaries with caregiver			Monthly payment rates for beneficiaries without caregiver	
	Low complexity dyad tier	Moderate complexity dyad tier	High complexity dyad tier	Low complexity individual tier	Moderate to high complexity individual tier
First 6 months (New Beneficiary Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Beneficiary Payment Rate)	$65	$120	$220	$120	$215

In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICARE & MEDICAID INNOVATION

Respite annual cap of $2500/beneficiary

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GUIDE Payment Adjustments

Payment Adjustments

When participants bill the per beneficiary per month Dementia Care Management Payment (DCMP), the DCMP will be adjusted by a Performance-Based Adjustment (PBA), as well as a Health Equity Adjustment (HEA).

The Health Equity Adjustment (HEA) is designed to decrease the resource gaps in serving historically disadvantaged communities.

The Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year.

HEA will be based on certain social risk factors, which may include:

- **National Area Deprivation Index (ADI)**
- **State Area Deprivation Index (ADI)**
- **Low-Income Subsidy Status (LIS)**
- **Dual Eligibility Status**

PBA will calculate five model performance metrics across four domains that include:

DOMAIN	METRICS
Care Coordination and Management	High-risk medications (eCQM/CQM)
Beneficiary quality of life	Quality of life outcome (Survey-based)
Caregiver Support	Zarit Burden Interview (Survey-based)
Utilization	Total Per Capita Cost (Claims-based)
	Long-term nursing home stay rate (Claims-based)

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Key Considerations for Hospices of the Future

- Partnerships are key (esp with primary care/ACO)
- Data/HIT is essential to smooth collaboration and establishing value
  - STAR rating
  - Hospice Item Set
  - Reduced hospitalizations and emergency department visits
- Training and education and skills in palliative care
- Understand and accept that palliative care is not likely to be “owned” by a single type of provider- there are many hands in this space.
- Continued focus on health equity and access to care will be paramount

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Key Considerations for Hospices of the Future

- Percentages of long length of stay patients will start declining, either through punitive measures, new programs, VBID/Value based priorities
- If hospice is Carved in to MA:
  - Hospices will experience increased cost/administrative burden
    - Need to be thinking now about how to mitigate/share costs
  - Need to develop relationships with payors/MA plans and determine in-network status
  - Need to learn from experiences of our Home Health colleagues
    - Home health contracts have come with an average per-visit discount in the 35% to 40% range
- Hospices needs to be prepared to adapt and extend into new areas to serve complex patients and have a willingness to take on risk/participate in value-based models
  - Hospice will always be needed, but may look different/be paid for differently in the future

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Questions?