

# *Margins and Dying*

## *Does Profit Status Affect Hospice Quality and Cost?*

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### *Introduction*

**T**he most significant trend in hospice is the growth in the number of for-profit providers--which has tripled in the last 15 years. Until recently, hospices were run by non-profit or community groups, with extensive volunteer participation. Today, 65 percent of hospices are for-profit and 31 percent are non-profit. For-profit hospice serves 49 percent of beneficiaries and receives 55 percent of hospice Medicare dollars (Office of the Inspector General, 2018). For-profit hospices have Medicare margins of 16.4 percent, compared to only .1 percent for non-profits (MedPAC, 2017). Medicare expenditures for hospice have increased from \$10 billion in 2007 to \$16.8 billion in 2016, primarily due to a growing number of enrollees and an increase in the number of Medicare participating hospices (CMS, 2014; Hargraves, 2016; Iglehart, 2009; MedPAC, 2017). This issue brief examines the research literature on hospice and profit status.

Hospice provides medical care and pain management as well as emotional and spiritual care to those who are near end-of-life. To qualify for hospice, the attending physician has to declare, along with the hospice physician, that the person has 6 months or less to live. Hospice payments are fixed, per diem Medicare benefits and patients must agree to forgo any Medicare coverage for curative treatment related to the diagnosed terminal illness. Hospice care reduces the number of hospitalizations, the likelihood of dying in a hospital, the use of feeding tubes, and is rated highly by patients and their families (Gozalo, 2015; Kelley et al., 2013). However, some research suggests that there are important differences in care by profit status.

### *Research on Profit Status and Hospice*

Most of the research on profit status and hospice has focused on enrollees' length of stay, the number and intensity of services provided, and staffing. Hospice care is expensive--especially during initial enrollment and near end-of-life. However, care is much less expensive in between these two times, with the relationship between cost and length of enrollment taking on a u-shaped curve (Carlson et al., 2012). This middle period can provide hospices with an incentive to increase the length of stay and to select patients with diagnoses that provide a longer stay (e.g., those without an aggressive cancer diagnosis). Other cost reduction strategies might include restricting services,

reducing the number of visits per patient from staff, or using less qualified staff when more qualified staff might be better suited to provide care.

### *Office of the Inspector General's Reports*

The Office of the Inspector General (OIG) in the U.S. Department of Health & Human Services commissioned several reports on hospice and found some differences by profit status. In 2009, the OIG found that over 80 percent of hospices in nursing facilities didn't comply with Medicare's coverage requirements which cost Medicare about \$1.8 billion (OIG, 2009). With regard to profit status, the OIG found that non-profit hospices were less likely than for-profit hospices to comply with Medicare's coverage requirements with regard to election, plan of care, service, or terminal illness requirements in nursing homes (89 percent of claims vs. 74 percent of claims). A second OIG report (2015) found that hospices serving patients in Assisted Living Facilities (ALFs) compared to hospices serving patients in other LTC settings, provided care for a longer period of time and received much higher Medicare payments. The report also showed that over a period of 5 years, Medicare payments to hospices serving ALF residents more than doubled for a total of \$2.1 billion in 2012. Additional findings in the 2015 report revealed differences by profit status. For-profit hospices, for example, were more likely than non-profit hospices to serve beneficiaries in ALFs and to generate more of their revenue from ALFs. The median amount paid by Medicare to for-profit hospices serving ALFs was over \$18,000 per beneficiary compared to a median of about \$14,000 per beneficiary to non-profit hospices. The 2015 report also showed that the length of stay for beneficiaries being served by for-profit hospices in ALFs, compared to similar non-profit beneficiaries, was 4 weeks longer.

The most recent OIG report (2016) examined Medicare expenditures for general inpatient care. General inpatient care (GIP) is intended for hospice beneficiaries who need short-term, intensive pain or chronic symptom management that can't be provided in non-intensive settings. GIP care is the second most expensive level of hospice care and a GIP stay costs about \$670 per day versus \$150 for routine home care (OIG, 2016). According to the report, hospice cost Medicare \$268 billion in 2012 for inappropriately billed GIP care (e.g., unnecessary GIP stay, the beneficiary didn't elect hospice, or the beneficiary didn't have a terminal illness). With regard to profit status, the report showed that over 40 percent of for-profit hospices billed GIP stays inappropriately, compared to 27 percent of non-profit and government owned hospices.

### *Research Findings on Enrollment, Disenrollment, and Length of Stay*

Several studies have examined profit status and hospice care with regard to enrollment, disenrollment, and length of stay. A study (Gandhi, 2012) of California's Medicaid certified hospices revealed that although for-profit hospices were more likely than non-profit hospices to enroll those with a cancer diagnosis, they were also more likely to enroll individuals who were referred by long-term care facilities and to have enrollees with longer lengths of stay. Aldridge and colleagues (2015) analyzed Medicare claims from 2000 and 2010 and found that for-profit hospices were more likely than non-profit hospices to enroll patients for more than 6 months and more likely to disenroll patients. For-profit hospices were also less likely to enroll patients for shorter lengths of stays (e.g., one week or less).

Using data from the National Home and Hospice Care Survey, Wachterman and colleagues (2011) found that for-profit hospices compared to non-profit hospices enrolled fewer individuals with a cancer diagnosis, enrolled a higher proportion of those living with dementia, and that enrollees in for-profit hospice had longer lengths of stay. Results from Vlemminck and colleagues (2018) also found that for-profit hospices enroll a higher proportion of those living with dementia.

Teno and colleagues (2014) found that discharge varies by profit status, with non-profits having a lower rate than for-profits--and when comparing within for-profit hospices--older for-profit hospices had lower discharge rates than newer for-profits. Another study (O'Neill et al., 2008) of 185 hospices in California revealed that length of stay was longer in for-profit hospices compared to non-profit hospices. Lorenz and colleague's (2002) study of 176 hospices in California, found that there was no difference in patient's length of stay by profit status but that for-profit hospice compared to non-profit hospice reported more discharges of those with a non-cancer diagnosis (17 percentage points higher), more referrals from long-term care facilities (15 percentage points higher), and more patients who use government payments (8 percentage points higher).

Taken together, these studies seem to indicate that for-profit hospices tend to enroll, disenroll, and have length of stays that are compatible with margin seeking behavior, although more research is needed to definitively determine if that's the case.

### *Research Findings on Services, Quality, and Staffing*

Other studies show differences by profit status in the types of services offered, quality of services, and staffing. Carlson and colleagues (2004), for example, examined 422 hospice agencies from a

nationally representative survey and found that after controlling for factors such as gender, disability, and location, for-profit hospices provided a narrower range of services than non-profit hospices. Similarly, Gandhi (2012) found that for-profit hospices offer fewer social services. Aldridge and colleagues (2018) found that lower spending on direct care was associated with higher rates of hospitalization and that for-profit hospices had the lowest spending and highest rates of hospitalizations. With regard to staffing, studies have found lower staff to patient ratios, fewer skilled nursing visits, fewer skilled staff employed, and higher staff turnover (Canavan et al., 2013; Dill and Cagle, 2010; Gandhi, 2012; Lorenz et al., 2002; O'Neill et al., 2008).

### *Conclusion*

Hospice provides care that gives those facing a terminal illness and their families the social support and medical care including pain management that makes the process of death and dying more palatable. Like other health care services, the core function and purpose of hospice could be corrupted if profit motives outweigh the original intent of the program. Although more research is needed, the above review of the existing literature indicates that there are some important differences in care by profit status including share of Medicare profit, Medicare payments, use of GIP care, enrollment, disenrollment, length of stay, quality and types of services provides, and staffing. Although CMS, in 2016, revised its payment system for routine home care in order to address payment issues, the research seems to indicate that more will need to be done to reduce profit seeking behavior in all hospice settings and to address the issues identified in this brief. Hospice provides a critical and humane service to over a million people and can only benefit from continuing research and increased accountability.

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