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U.S. House of Representatives

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May 10, 2023

The Honorable Gene L. Dodaro
Comptroller General
U.S. Government Accountability Office
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GAO Study: The Centers for Medicare & Medicaid Services Oversight of Medicare's Hospice Program

Medicare spends billions of dollars in hospice benefits each year, providing palliative care for beneficiaries with terminal illnesses and a physician-certified life expectancy of 6 months or less. In 2021, more than 1.7 million Medicare beneficiaries—nearly half of all decedents—received hospice services with spending on these services totaling about $23.1 billion.

In recent years, the hospice sector has seen a rapid growth of for-profit and private equity-owned (PE) hospices. The number of hospice providers billing Medicare has grown from about 3,200 in 2011 to over 5,300 in 2021—a 68 percent increase—with almost three-quarters being for-profit in 2021. Similarly, whereas 106 of 3,162 hospice agencies in 2011 were PE owned, that number grew to 303 of 5,615 hospices in 2019 with 72 percent of the hospices acquired by PE during that period having previously been non-profit.[1] The number of Medicare hospice enrollees receiving care from PE-owned hospices also increased by 328 percent between 2012 and 2019.[2] Financial reports indicate that private investors view the hospice sector favorably, likely due to low capital investment needs and profitable Medicare margins for for-profit hospices—about 21 percent in 2020.[3]

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[1] Robert Tyler Braun, et al., *Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations,* JAMA INTERN MED.181(8):1113–1114 (2021), https://doi.org/10.1001/jamainternmed.2020.6262.
[2] *Id*.
[3] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, (Washington, D.C.: March 2023).

Concerningly, this pattern of growing for-profit and PE hospices in the sector coincides with a trend of increasing costs and utilization among Medicare hospice patients. Despite the hospice benefit paying an all-inclusive per diem rate through Medicare Part A that is meant to cover all necessary services, analysis has shown an upward trend in payments for items and services provided to hospice patients outside of the standard hospice benefit. A recent report from the Office of Inspector General (OIG) indicated that Medicare incurred about $6.6 billion from 2010 through 2019 for such nonhospice services, raising concerns about whether such payments were inappropriate if they were for services already covered under the hospice benefit.[4]

In addition, researchers have raised concerns that longer lengths of stay—those exceeding 180 days—and live discharges may indicate potential inappropriate use of the hospice benefit. In 2021, about 60 percent of Medicare spending on hospice care was for stays exceeding 180 days.[5] Hospices that exceed the cap on total hospice payments ("aggregate cap") have substantially longer lengths of stay and higher live discharges, suggesting that they may regularly admit patients whose life expectancy may be more than 6 months in pursuit of greater profits.[6]

Several studies indicate that for-profit hospices receive a higher proportion of Medicare payments and serve patients who are more likely to have longer lengths of stay or live discharges compared than non-profit hospices. For example, of the $6.6 billion that the OIG estimated Medicare incurred for nonhospice services furnished to hospice patients over a decade, for-profit hospices accounted for 62 percent of those payments.[7] Moreover, Medicare Part B payments for nonhospice services increased by 61 percent at for-profit hospices compared to only 9 percent at non-profit hospices over the same decade.[8] Despite serving patients with similar demographics, for-profit hospices generally have a greater share of patients with non-cancer diagnoses than non-profit hospices.[9] In 2017, cancer was the most common diagnosis of nonprofit hospice patients (31 percent) compared to 22 percent of patients of for-profit hospices.[10] In comparison, the most common diagnosis of for-profit hospice patients was neurodegenerative disease/dementia (22 percent) compared to 15 percent of nonprofit hospice patients.[11] As hospices are paid per diem, longer stays are more profitable than shorter stays and hospices may have a financial incentive to seek out patients with diseases that generally have longer stays (i.e., non-cancer diseases) over patients with terminal cancer.

These trends in growing costs and utilization that are concentrated in the expanding for-profit segment of the hospice care sector raises concerns that underscore the need to ensure that CMS's monitoring of hospice providers is sufficient to safeguard the program integrity of Medicare's hospice benefit.

In light of these concerns, we ask you to study:

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[4] Department of Health and Human Services, Office of Inspector General, *Data Brief,* A-09-20-03015 (February 2022). The report described these additional payments but did not assess whether they were appropriate.
[5] MedPAC Mar 2023 report.
[6] MedPAC 2023. The Centers for Medicare & Medicaid Services imposes two payment caps on hospice payments — one that limits a hospice's number of inpatient days and one that limits a hospice's total Medicare payments in a given year.
[7] HHS OIG 2022, *supra* note 4.
[8] *Id*.
[9] Government Accountability Office, *Medicare Hospice Care – Opportunities Exist to Strengthen CMS Oversight of Hospice Providers*, GAO-20-10 (October 2019).
[10] Carol Bazell, et al., *Hospice Medicare margins: Analysis of patient and hospice characteristics, utilization, and cost*, MILLIMAN (July 2019), https://www.milliman.com/en/insight/hospice-medicare-margins-analysis-of-patient-and-hospice-characteristics-utilization-an.
[11] *Id*.

1) How has utilization and spending on hospice services changed in recent years?

   (Utilization and spending metrics could include length of patient stays, level of hospice care, proportion of live discharges, admitting diagnoses, and spending on additional services outside of the daily payment rate.)

2) To what extent are these trends associated with hospice characteristics such as ownership status (particularly PE ownership or other ownership characteristics, to the extent feasible), tenure in the Medicare program, geography, and whether the hospice exceeded the aggregate cap?

3) To the extent feasible, are there specific hospices that are outliers in their patient demographics and/or proportion of claims that are billed for services outside of the daily payment rate? What are the common characteristics of these outlier providers?

4) How does CMS monitor hospice services for potentially inappropriate utilization and spending, and what actions can it take to reduce incentives for such use?

Sincerely,

The Honorable Richard E. Neal, Ranking Member