Executive Insights

Opportunities for Health Systems and Investors Within Post-Acute and End-of-Life Care

The confluence of several key trends in U.S. healthcare, including an aging population, shifts away from inpatient care, and a rise in healthcare consumerism has led to an increased emphasis on post-acute care, particularly care that permits aging in place.

By 2030, 1 in 5 Americans will be over the age of 65.[1] This cohort makes up ~14% of the U.S. population but represents nearly half of the top decile of healthcare utilizers.[2] Consumer demand for lower-cost healthcare and payer pressures (e.g., utilization management and value-based contracting (VBC)) are driving a migration from high-cost, inpatient care. Outpatient services as a share of overall hospital revenue increased from 28% in 1994 to nearly 50% in 2020.[3] Given these macro trends, healthcare providers and investors are thinking more critically about post-acute care offerings, including palliative, hospice and home-based care.

From 2012 to 2016, approximately 50% of all Medicare beneficiaries utilized some form of post-acute care within 90 days of a hospital discharge.[4] While skilled nursing facilities represent the bulk of this 50% (see Figure 1), home health utilization is expanding, and it is positioned to become the top form of post-acute care within a few years.[5] This follows an ongoing shift in patient and provider preferences toward home-based care: According to one 2017 survey conducted by the Kaiser Family Foundation, 7 in 10 Americans would prefer to die in their home.[6] As a result, end-of-life care continues to gain acceptance and penetration.

Let us consider hospice care in more detail.

There are currently about 5,000 hospice agencies across the U.S., serving roughly 1.6 million Medicare fee-for-service (FFS) beneficiaries (~2% of all Medicare FFS beneficiaries, or ~50% of decedents). While penetration of hospice services among Medicare FFS decedents varies by state — with the highest levels seen in the upper Midwest and mountain West states (Figure 2) — use of hospice services is rising across the nation, including in regions with below-average penetration, such as California, New York and parts of the southern United States (Figure 3).

Hospice care grew to serve approximately 51% of Medicare decedents in 2018 versus an estimated 48% in 2014.[7] This implies that nearly 53% of Medicare decedents may be served by hospice care in 2021, if trends continue at historical rates. The shift is driven not only by patients but also payers and providers. For example, Medicare Advantage, which is incentivized to reduce total cost of care via its value-based insurance design, represented 37% of hospice patients in 2018 versus 30% in 2014 (which suggests that Medicare Advantage beneficiaries might comprise as much as 43% of hospice patients in 2021, if historical growth continues).[8]

Opportunities for Health Systems and Investors Within Post-Acute and End-of-Life Care was written by **Kevin Grabenstatter**, Managing Director at L.E.K. Consulting (San Francisco), **Rozy Vig**, Engagement Manager at L.E.K. Consulting (San Francisco). The authors would like to thank **Sam Rude** for his invaluable contribution to this piece.

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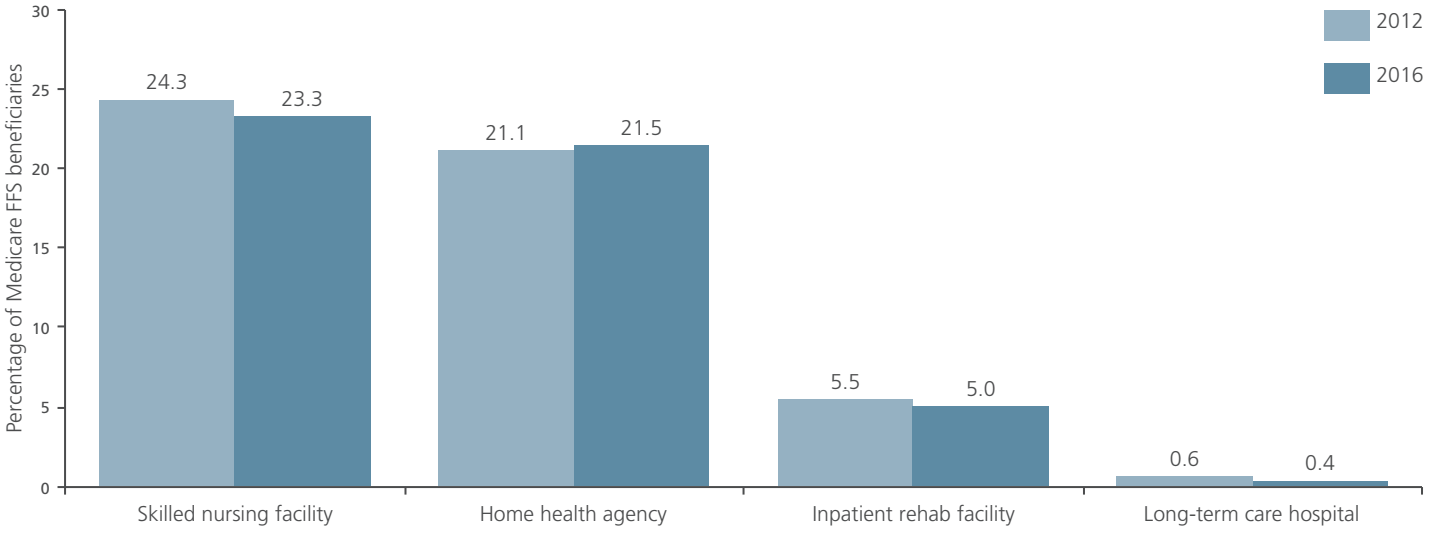
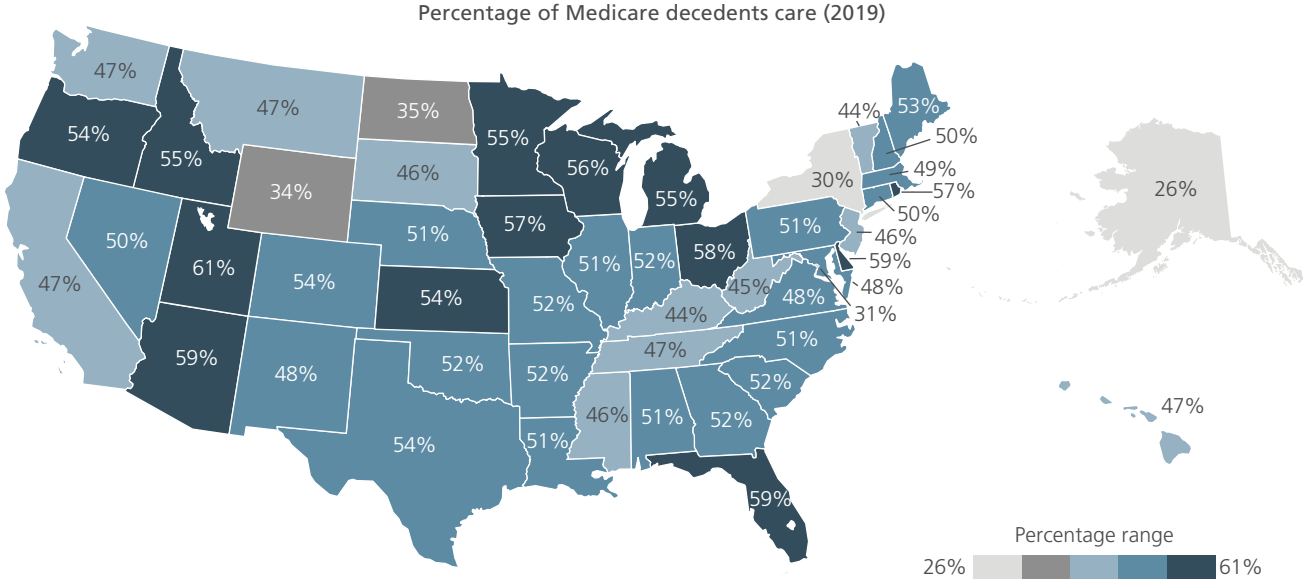
Figure 1
Site of first post-acute care use among Medicare fee-for-service (FFS) beneficiaries (2012-16)



Source: L.E.K. research and analysis

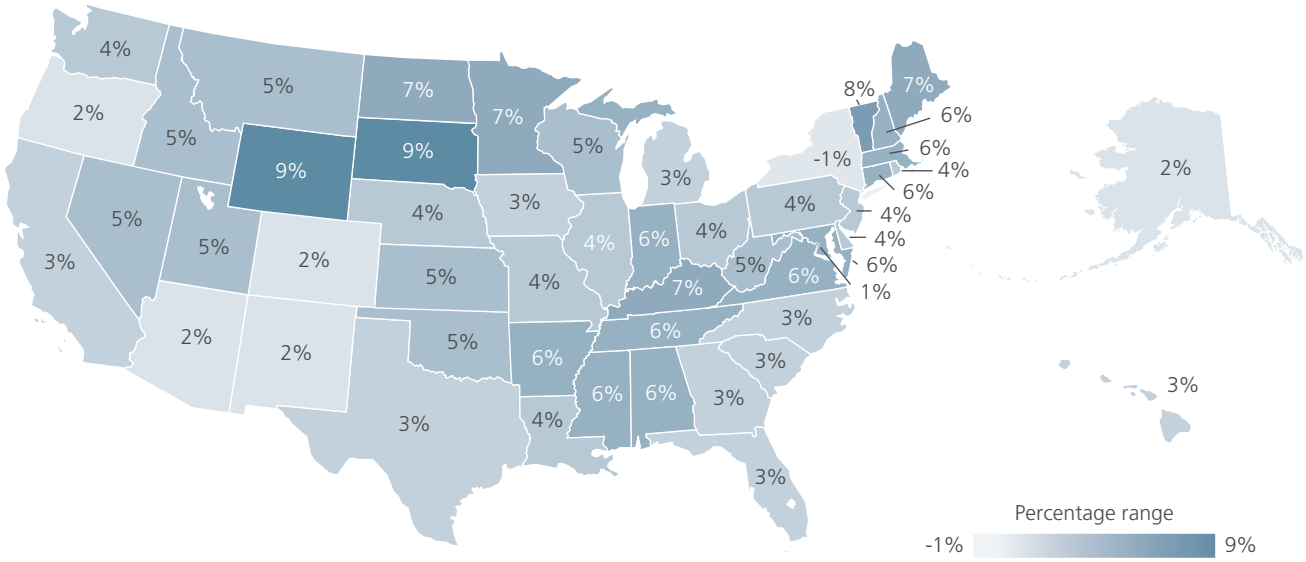
This trend is poised to accelerate as Medicare Advantage plans begin to reimburse hospice care. Hospice services were traditionally paid for by Medicare Part A, but the hospice "carve-in" that began in 2021 allows Medicare Advantage plans to administer this benefit directly. Direct contracting and Serious Illness Population payment models under the Primary Care Initiative at the Center for Medicare & Medicaid Innovation are also expected to launch this year and should provide opportunities for hospice providers to expand their advanced illness care programs and offer concurrent curative care.[9]

Figure 2
Percentage of Medicare decedents care (2019)



Source: L.E.K. research and analysis

Figure 3
Change in percentage of Medicare FFS decedents in hospice care (2015-19)



Source: L.E.K. research and analysis

Combined, these trends signal an increasingly attractive market for hospice providers and investors.

Implications for hospitals and health systems

Having an effective end-of-life care strategy can improve total cost of care for a health system while also driving improvements in care quality and patient satisfaction.

Cost containment

Better integration of hospice and palliative care is an important part of the broader effort to contain costs. One study from the Journal of *Palliative Medicine*[10] found that cost per admission for patients receiving inpatient palliative care was $1,401 less on average than for comparison patients, and another study from *Health Affairs*[11] similarly found that each admission of a patient to hospice care 53-105 days before death saved Medicare $2,561, on average. These savings are particularly pronounced among patients receiving catastrophic care. One 2014 study from *JAMA*,[12] for example, found that patients with poor prognosis for cancer who leveraged hospice services incurred nearly $8,700 less in costs than those who did not. The slow but steady march toward value-based care, which is expected to accelerate in the current political environment, will enhance the benefit of investing in areas such as hospice.

Quality improvement

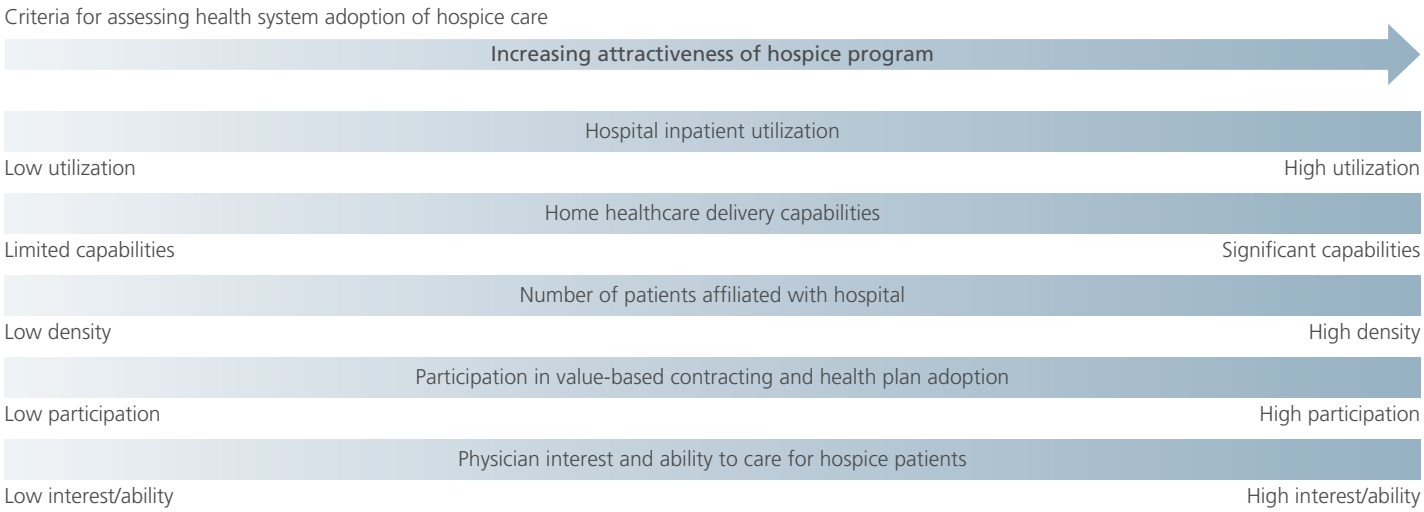
As hospital reimbursement becomes increasingly tied to quality, shifting appropriate patients to hospice can also help hospitals by taking the risk out of applying certain quality metrics and by influencing a broader segment of the care continuum. One study estimated[13] that seriously ill adults discharged to hospice have a hospital readmission rate of 5%, relative to 13% for those discharged to home health and 24% for those discharged to a nursing home.

Coordination with a hospice can help triage patients in real time to determine whether hospital admission is appropriate. For example, MedStar Mobile Healthcare (an ambulance service in Texas) partnered with Vitas (a national hospice provider) and reduced unnecessary ambulance transports by dispatching Vitas staff to the home of hospice beneficiaries when a 911 call was initiated, to evaluate the situation. Beyond hospital readmissions, well-coordinated hospice services can help reduce intensive care unit (ICU) admissions and utilization. According to a 2014 study from *Critical Care Medicine*,[14] hospice transfers saved 585 ICU bed days per year.

Patient satisfaction

Finally, offering hospice care can help improve patient satisfaction and comfort toward the end of life. Hospice utilization has increased dramatically among Medicare beneficiaries — up to 50% of decedents in 2017 versus 23% in 2000 — due to changing perceptions of hospice care and the preference to receive end-of-life care at home. When St. Joseph's Healthcare and Hackensack Meridian Health formed a jointly owned home

Figure 4
Parameters such as hospital capacity, home healthcare delivery capabilities and VBC adoption influence the benefit of developing a hospice program



Source: L.E.K. research and analysis

health and hospice agency in 2017, transitioning care to the home was a central part of this venture. Similarly, when Partners Healthcare (now Mass General Brigham) developed the Partners Hospice Collaborative with 18 Massachusetts hospices, the ability to better accommodate the wishes of their patients was cited as a key motivation behind the initiative.

Common characteristics of systems that have successfully launched a hospice care offering include high inpatient utilization, home healthcare delivery capabilities, high patient volume, adoption of VBC and/or a provider-sponsored health plan, and physician interest and buy-in (Figure 4).

Figure 4 reflects a direct correlation between the size of a hospital facility and its ability to accommodate hospice programs. Additionally:

- Hospitals with high inpatient utilization are less likely to have financial concerns about shifting patients from inpatient care to hospice
- Existing home healthcare delivery capabilities (e.g., home health, palliative care) are advantageous for developing a robust hospice program
- A greater number of patients will provide better economies of scale and support the deployment of a dedicated team for the hospice program
- Larger health systems that participate in VBC and/or have their own health plans are more likely to see financial value in a hospice program
- Given potential physician reluctance to engage in hospice programs, stimulating provider interest is crucial to ensure a successful program

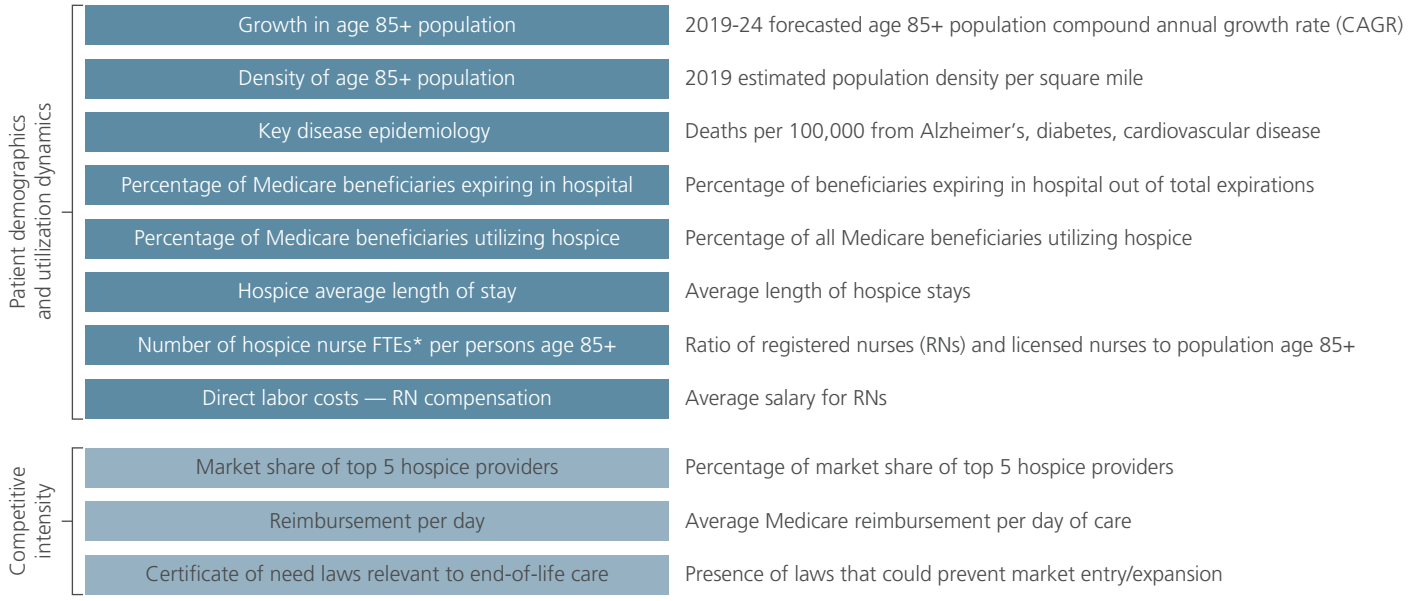
Implications for hospice providers and investors

Given market dynamics, hospice providers face several growth opportunities, including vertical integration into palliative and home healthcare, joint ventures (JVs) with hospitals and health systems, and continued investment from financial sponsors.

Recently, Florida's Community Hospice & Palliative Care rebranded itself as Alivia Care and is looking to launch home healthcare programs, private duty nursing services, personal care, PACE (Program of All-Inclusive Care for the Elderly) programs and advanced care management.[15] Last year, Louisiana-based home health, hospice and personal care services provider LHC Group expanded its existing JV partnership with Texas-based Christus Health, which culminated in 22 home health, hospice and palliative care locations across three states.[16]

The hospice M&A market has been quite resilient to pandemic-related headwinds, as interest among private equity firms as well as strategic buyers continues to drive up valuations. The sale price

Figure 5
L.E.K.'s geographic prioritization accounts for patient demographic and utilization dynamics as well as competitive intensity



*Full-time employees
Source: L.E.K. research and analysis

of Bristol Hospice by private equity firm Webster Equity Partners is expected to exceed $1 billion.[16]

Hospice providers and financial sponsors continue to push for growth via acquisition and de novo builds to develop economies of scale and market density. A number of criteria can be used to assess geographic market attractiveness, including supply-demand imbalance, referral network dynamics and competitive intensity (see Figure 5 for examples).

Careful thought should be given to the interpretation of prioritization criteria. For example, a higher utilization of hospice relative to hospitals for end-of-life care likely indicates a population receptive to hospice care but could also indicate that a market has become saturated. Lower volumes of hospice nursing full-time employees (FTEs) per age 85+ seniors may suggest unmet demand, but upstream referral dynamics and patient receptivity to hospice care may need to be pressure-tested to confirm this assumption. While certificate of need (CON) laws can make establishing de novo facilities more difficult for out-of-state providers, providers located within a CON state can benefit from limited competition from out-of-state providers.

The demand for home-based, palliative and hospice care will continue to rise. As payment systems gradually catch up to meet the rising demand, healthcare systems offering these services will be well positioned for long-term sustainable growth.

[1] *Census data*, March 2018
[2] National Center for Biotechnology Information (NCBI) website
[3] *Revcycle Intelligence*, "Inpatient No Longer King as Hospital Outpatient Revenue Grows," Feb. 24, 2020
[4] Health Care Cost Institute (HCCI), Nov. 25, 2019
[5] Ibid.
[6] Kaiser Family Foundation, April 27, 2017
[7] National Hospice and Palliative Care Organization (NHPCO), Aug. 20, 2020
[8] Ibid.
[9] *Hospice News*, Jan. 1, 2021
[10] *Journal of Palliative Medicine*, Sept. 17, 2014
[11] *Health Affairs*, March 2013
[12] *JAMA*, Dec. 22, 2014
[13] *Arkansas Hospice*, April 2019
[14] *Critical Care Medicine*, May 2014
[15] *Hospice News*, January 2021
[16] *Home Health Care News*, October 2020
[17] PE Hub, March 2021

About the Authors

Kevin Grabenstatter is a Managing Director and Partner in L.E.K. Consulting's San Francisco office. He joined L.E.K. in 2006 and focused on integrated health system strategy, value-based care delivery, provider operations and emerging technologies/HCIT. He advises clients on critical strategic issues across the healthcare value chain. Kevin formerly held several internal strategy roles at Kaiser Permanente, where he was responsible for the design of new initiatives in areas such as care transitions, patient flow and cost structure efficiency. Kevin received an MBA from Stanford University Graduate School of Business and earned a BS with honors in finance from Pennsylvania State University.

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