Hospice

The $19 billion hospice industry is at an important inflection point, balancing ongoing transformation and increased consumer demand. These two forces will trigger innovation, consolidation and investment in the years ahead.

TRIPLE TREE

TripleTree is a healthcare merchant bank focused on mergers and acquisitions, growth capital, strategic advisory and principal investing services. Since 1997, the firm has advised and invested in some of the most innovative, high-growth businesses in healthcare.

We are continuously engaged with decision makers including best-in-class companies balancing competitive realities with shareholder objectives, global companies seeking growth platforms, and financial sponsors assessing innovative investments and first-mover opportunities.

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EXECUTIVE SUMMARY

Hospice and palliative care has become an important part of the U.S. healthcare system since first appearing on the scene in 1974. As the U.S. population has aged and awareness of hospice services has increased, the hospice industry has grown to become a nearly $19 billion industry, with more than 6,600 programs[1] meeting the needs of more than 1.7 million people annually.[2] Throughout its history, the hospice industry has thrived and adapted to changing market forces, including:

- ***Periodic reimbursement changes*** mandated by the Centers for Medicare and Medicaid Services (CMS)
- ***Regulatory and administrative changes*** requiring more detailed patient coding, patient satisfaction and quality performance reporting
- ***An aging population*** that is fueling demand for hospice services
- ***Increased awareness*** and expectations from more engaged healthcare consumers, patients and their families

In response to an aging population and increasing utilization of the Medicare hospice benefit, recent studies have attempted to determine the impact of this dynamic industry. In many cases, these studies demonstrate the profound impact of hospice, including:

- ***Improved*** patient quality of life
- ***Reduced*** caregiver stress
- ***Lower*** costs for the U.S. healthcare system

The number of innovative supply chain partners supporting the hospice industry has also grown in recent years. Outsourced service providers focused on operational efficiency, business intelligence, cost containment and customer satisfaction have enabled the industry to comply with changing regulations, manage new quality reporting requirements and enable smarter healthcare consumers.

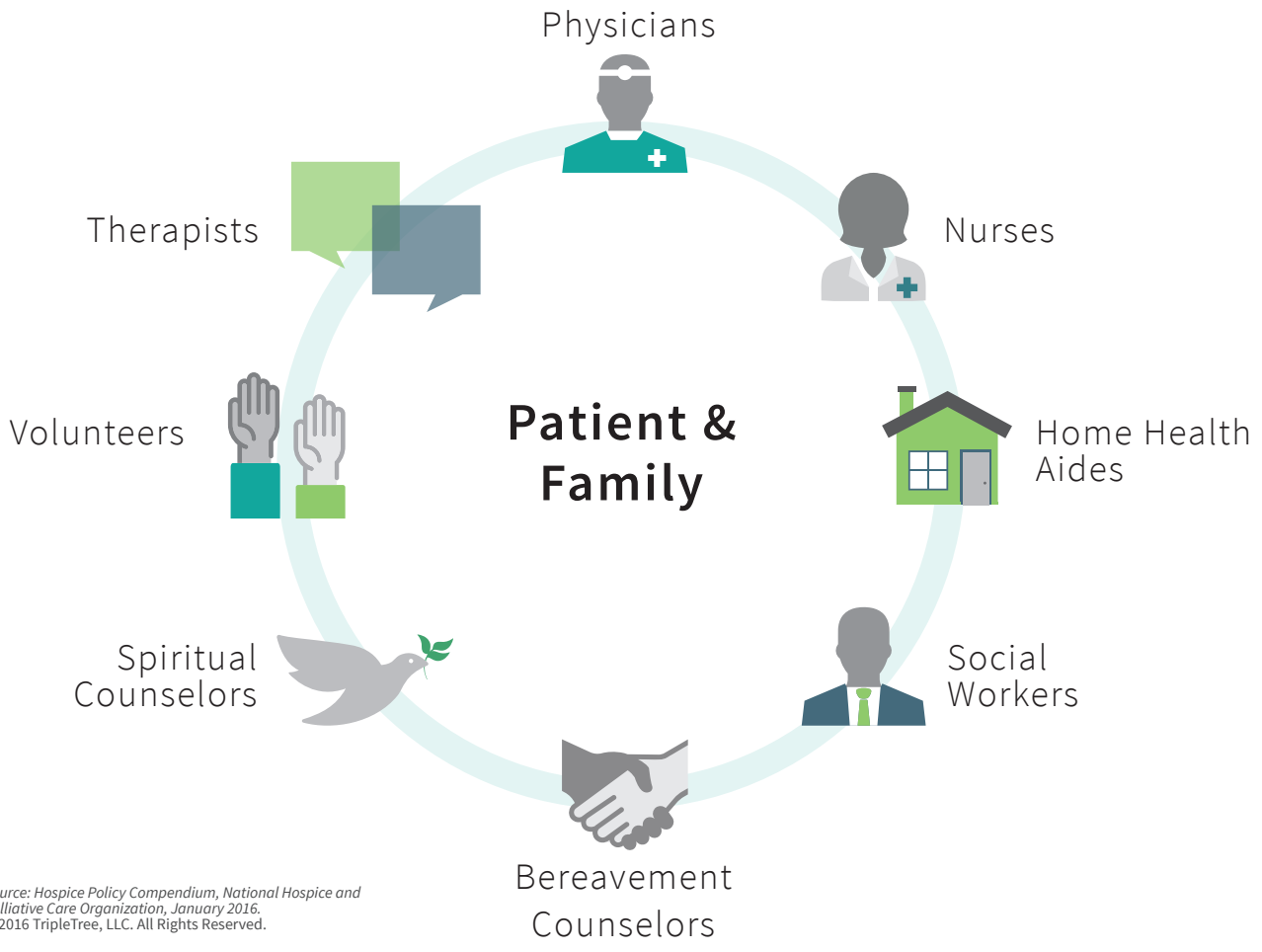
Today, the hospice industry is at an important inflection point, balancing ongoing transformation and increased consumer demand. The juxtaposition of these market forces creates an ideal backdrop for ongoing industry innovation, consolidation and investment in the years ahead. In this *Industry Perspective*, TripleTree provides a history of hospice, details the many forces driving structural change and outlines why the industry is poised for continued success in the coming years.

INTRODUCTION

At its core, hospice is about caring for – not curing – people with life-limiting illnesses. Specifically, hospice provides expert medical care, pain management and emotional and spiritual support expressly tailored to the needs and wishes of the patient and their family at the end of life.[3] Hospice care can be delivered in a variety of settings, including a patient's home, assisted living and skilled nursing facilities (SNFs), hospitals or a specialized hospice facility. An important component of hospice care is the creation of a personalized care plan, including the formation of an interdisciplinary care team (see Figure 1).

This team can include the patient's personal physician, hospice physician, nurses, hospital aides, social workers, bereavement counselors, clergy/spiritual leaders, trained volunteers and physical and/or occupational therapists, as needed.[4] An important function of the interdisciplinary care team is around-the-clock, 24/7 access to hospice staff and services.

FIGURE 1.
INTERDISCIPLINARY CARE TEAM



Source: Hospice Policy Compendium, National Hospice and Palliative Care Organization, January 2016.

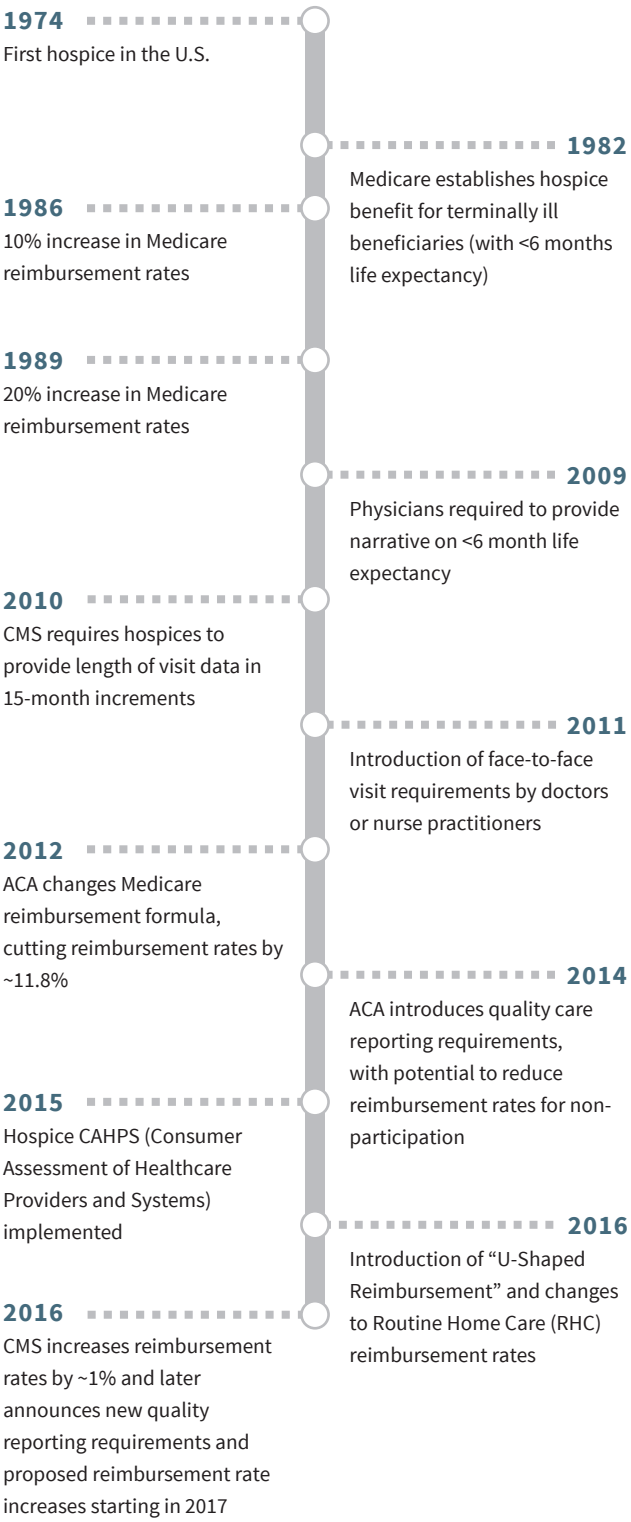
HISTORY OF HOSPICE *(1974 THROUGH 2016)*

The growth of the hospice industry has been staggering in the last 42 years, moving from one hospice program in 1974 to more than 6,600 in 2015.[5] This aggressive pace of growth can be attributed to three milestone decisions by Congress: the establishment of a Medicare hospice benefit in 1982, a 10% increase in Medicare reimbursement rates in 1986 and a further 20% reimbursement increase in 1989 (see Figure 2). As a result, more than 92% of industry revenue is derived from Medicare and Medicaid outlays.[6]

In response to the proliferation of hospice programs (and other providers), states began to enact Certificate of Need (CON) requirements. These requirement declare the need to prove a lack of supply of hospice services within the market (today, 16 states have CON requirements for hospice). More recently, the growth in number of programs has slowed, triggered by the implementation of the Affordable Care Act (ACA), which lowered the overall reimbursement rates and introduced new quality guidelines linked to future reimbursement rates.

Throughout the industry's history, there has been much discussion about the impact and value of hospice. Does hospice enrollment reduce costs for beneficiaries at the end of life? Do hospice services improve the quality of life for the patient and their caregivers?

FIGURE 2.
HOSPICE TIMELINE



Source: TripleTree Analysis.

Both of these questions were addressed in research conducted by Mount Sinai's Icahn School of Medicine and published in the March 2013 issue of *Health Affairs*. The research study confirmed that hospice enrollment improved the quality of care and saved money for Medicare.[7]

- ***Medicare costs*** for hospice patients were lower than non-hospice Medicare beneficiaries with similar diagnoses and patient profiles[8]
- ***Fewer 30-day readmissions*** and in-hospital deaths were associated with hospice enrollment[9]
- ***Fewer hospital and ICU days*** were associated with hospice enrollment[10]

An earlier study, conducted by Drake University, concluded that during the last year of life hospice saves an average of $2,309 for each Medicare beneficiary served.[11] While these two research studies are not the only two voices in the debate, the results from both are positive and demonstrate the economic potential of hospice care to help lower overall costs for the U.S. healthcare system.

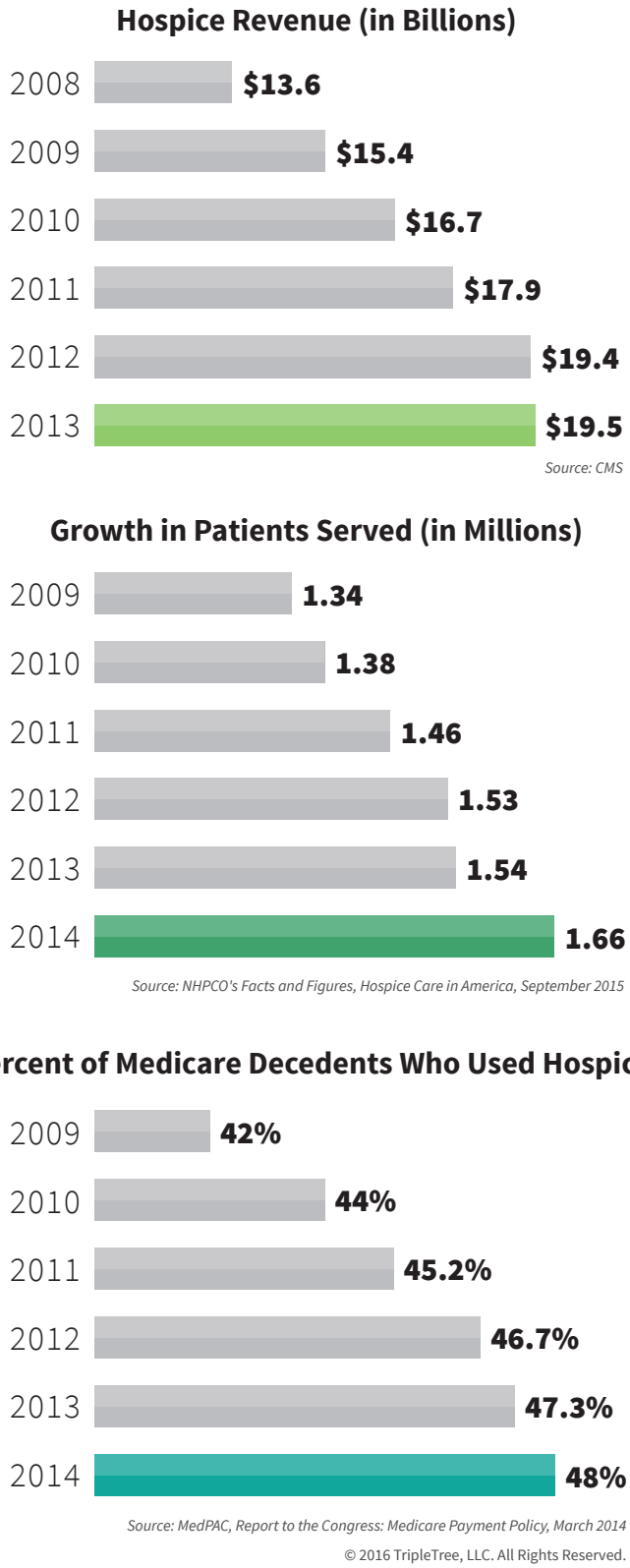
In addition to the economic potential, the human impact must also be considered when discussing hospice care. Almost no other part of the U.S. healthcare system is as patient-centric as hospice. As mentioned previously, the creation of an interdisciplinary care team is an essential part of how hospice works. These care teams not only help manage transitions in care, but they connect different parts of the healthcare system while reducing caregiver stress. Even more importantly, hospice care has a profound impact on the process of dying, helping patients die with dignity and aiding their loved ones through the bereavement process.

"In addition to the economic potential, the human impact must also be considered when discussing the hospice industry. Almost no other part of the U.S. healthcare system is as patient-centric as hospice."

INTRODUCTION CONTINUED

The hospice industry as a whole has seen tremendous growth fueled by the demographic shifts occurring in the U.S. population, an increase in the number of Medicare-eligible Americans aged 65 or older, an increase in the understanding of, and appreciation for, the types of services provided and an increase in the number of people with multiple chronic conditions. In 2015, it was estimated that 48 million Americans were age 65 or older. This large population of Medicare-eligible consumers comprises more than 80% of hospice patients, with 40% of hospice patients older than 85.[12] Industry expansion has also been driven by other forces, including the desire and preference to receive care at home, rising healthcare costs that place more financial burden on patients, and the general trend by Americans to provide family members and friends with greater emotional support during end-of-life or serious illness periods.[13]

FIGURE 3.
HOSPICE MARKET GROWTH



Allina Health

Allina Health is one organization that has integrated hospice services into a broader care delivery strategy. Headquartered in Minnesota, Allina is a not-for-profit healthcare system that cares for patients from beginning to end-of-life through its 61 clinics, 13 hospitals, 15 pharmacies and specialty medical services, including hospice care. Today, Allina provides hospice care in 2 residential facilities as well as in-home services at patient's homes, assisted living facilities, SNFs and group homes.

"Hospice is the hardest part of healthcare," according to Julia Crist, Allina's Director of Senior Care and Care Navigation. "It improves our patient's quality of life, but it also means our patients and their loved ones have to accept their own mortality." As part of its strategy to thrive in the era of value-based payments and Accountable Care Organizations (ACOs), Allina is leveraging its capabilities in managing transitions in care to help the right patients utilize hospice services. "We use our palliative care expertise and Homecare Service Liaisons to introduce hospice to patients at the right time, primarily during discharge planning," according to Crist. "Our Homecare Service Liaisons are incredibly thoughtful about if and when to discuss hospice, as every patient requires a different approach. For those patients who are receptive to a conversation about hospice, the outcome can help the patient and their caregivers through the dying process."

Allina has also been thoughtful about how it builds the right path forward for hospice and palliative care. Currently, Allina integrates hospice into several different approaches to managing care transitions, including its in-patient and community-based palliative care programs, Allina's LifeCourse program and its SeniorCare Transitions program. As the organization considers the performance of each approach, Allina is evaluating the impact across multiple dimensions, including:

Did more patients self-select into hospice?

Did more patients enroll in hospice earlier in the dying process?

Did more patients refer into Allina's own hospice facilities or services?

Allina is one example of a health system that is proactively and strategically thinking about the role of hospice in its overall business strategy. As more providers and healthcare systems chart their course in the coming years, TripleTree expects others will follow Allina's path, with the emphasis on delivering an improved patient experience while building a sustainable and more diversified business.

REGULATORY CHANGES SHAPING THE INDUSTRY

In response to growing consumer demand and consistent high utilization of the Medicare hospice benefit, CMS has introduced a series of reform measures to drive more fiscally sound and patient-centric hospice policies.

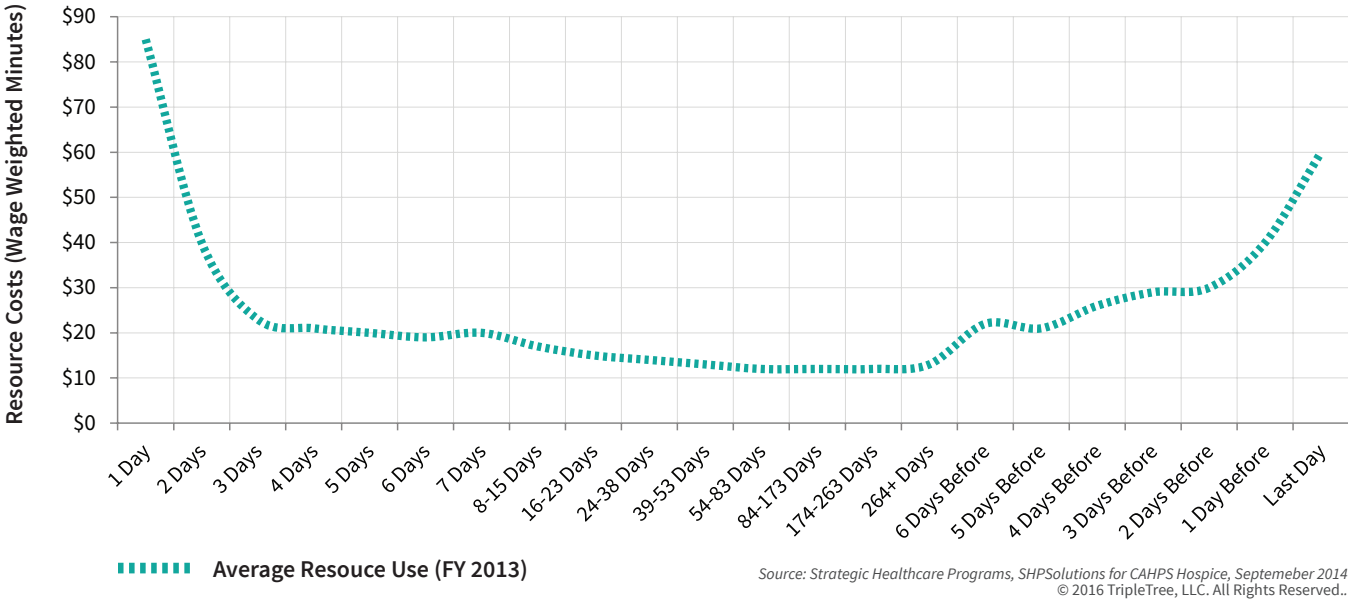
U-SHAPED REIMBURSEMENT

One of the most influential reforms has been the Fiscal Year 2016 Hospice Wage Index Final Rule (the Rule), the first meaningful change to hospice payment methodology since the establishment of the Medicare hospice benefit in 1982. Prior to this rule, hospice providers received per-diems based on the applicable level of care (i.e., routine, continuous, general inpatient and respite); however, this rate did not take into consideration the intensity and cost of the services rendered. During the initial enrollment period and the days leading to death, intensity and cost of care can exceed reimbursement. As a result, patients with longer lengths of stays and less frequent intensive care are more lucrative for hospices. In fact, David Williams, CFO of **Chemed Corporation** whose subsidiary **VITAS Healthcare** (VITAS) is the nation's largest hospice provider, stated that VITAS loses money on patients staying less than two weeks due to the cost of care associated with their conditions, and that patients with longer stays allow for VITAS to help offset losses from shorter-stay patients.[14] Hospice financial performance has thus been directly reliant upon its mix of patients as it operates within a system that has monetarily incentivized admission of patients with longer lengths of stay.

The Rule, effective January 1, 2016, attempts to combat this misalignment of incentives. The Rule features two components of reform: a two-tiered routine home care (RHC) rate and a service intensity add-on (SIA) payment. Both components create a U-Shaped reimbursement model by responding to the reality that expenses are significantly higher towards the beginning and end of a patient's stay under hospice care (see Figure 4).

"In response to growing consumer demand and consistent high utilization of the Medicare hospice benefit, CMS has introduced a series of reform measures to drive more fiscally sound and patient-centric hospice policies."

FIGURE 4.
AVERAGE RESOURCE USE FOR ALL BENEFICIARIES WHO ONLY RECEIVED ROUTINE HOME CARE (AND WHO RECEIVE HOSPICE SERVICES FOR AT LEAST 14 DAYS) (FY 2013)



Source: Strategic Healthcare Programs, SHPSolutions for CAHPS Hospice, Septemeber 2014

Under the revised payment structure, there are separate rates for RHC during the first 60 days and RHC past the first 60 days. Now, RHC between days 1-60 will receive $186.89 per day and $146.83 for day 61 and afterwards.[15] Additionally, the higher RHC rate will not be available to those who re-admit to hospice unless there is a gap in hospice enrollment of 60 days or greater.[16] This difference in payment reflects varying visit intensities and costs of providing care across a patient's length of stay, according to CMS's research contractor, **Abt Associates**.[17] As a result, the two-tiered approach more accurately reflects the costs hospices incur in order to deliver care.

The second component of this new policy is the SIA payment which applies to the other end of the "U" curve, when costs rise during the last seven days of a patient's life. This payment is paid in addition to the RHC per-diem rates. The SIA is thus an attempt to eradicate the disincentives associated with servicing short-stay patients. On an aggregate level, these new regulations are expected to increase federal Medicare payments to hospice providers by $160 million, creating a 1.1% increase, on average, of hospice base payments.[18]

THE DEBILITY DIAGNOSIS

CMS has also developed policy efforts towards enhancing the quality of care patients receive within hospice. One significant manner in which CMS is amending its regulatory guidelines is by prohibiting the use of debility, or adult failure to thrive (FTT), as a primary hospice diagnosis.

Debility is a condition that has been predominantly applied to patients with no known terminal illness, yet exhibit poor appetite, weight loss, increased fatigue and general progressive functional decline. Often, these patients suffer from a variety of medical conditions, none of which may individually qualify them as terminally ill. This population of patients accounted for 9% of the top 20 principal diagnoses in 2002, but this number has skyrocketed to nearly 20% just a decade later, prompting CMS to clarify its ICD-9-CM Coding Guidelines.[19] CMS expressed concern that the use of non-specific diagnoses could suggest that Medicare hospice patients were not receiving the most thorough assessments. As a result, a patient's quality of treatment may be adversely impacted by missing out on services they might be entitled to with a more accurate assessment.

CMS introduced this policy clarification in August 2013 and required that hospice providers eliminate debility and FTT as primary diagnoses on hospice Medicare claim forms before October 2014.[20] This policy clarification was consistent with its already established ICD-9-CM Coding Guideline which stated that "Symptoms, Signs and Ill-defined Conditions" were not to be used as principal diagnoses. CMS's effort to enforce more defined and thoughtful coding practices ensures that all hospice patients are receiving well-intentioned care for their conditions while simultaneously placing hospice at the forefront of providing this patient-centric care.

Although critics have claimed that this revision would limit access to hospice care, CMS has maintained that hospice eligibility is based on prognosis, not diagnosis, and thus Medicare coverage would remain unaffected. It supports this notion with the finding that 75% of beneficiaries with debility had four or more chronic conditions, many of which contribute to a terminal prognosis, which would allow those beneficiaries to stay enrolled within the program.[21]

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Despite CMS's claim that this policy clarification will not unilaterally affect hospice coverage, the Medicare hospice aggregate cap along with reimbursements based upon length of stay may pose a serious problem for some hospices. The aggregate cap is a limit to the total aggregate payment a hospice can receive in a year based on the number of its beneficiaries.[22] The aggregate cap can be calculated by multiplying a cap value per beneficiary by the number of Medicare beneficiaries at a particular hospice. CMS determines cap values each year and set 2016's cap value at $27,820.75 per beneficiary. Patients with debility typically have longer lengths of stay due to the slower progressing nature of their conditions. Because longer lengths of stays are more lucrative to the provider, the Medicare hospice aggregate cap was created to disincentivize stays longer than 180 days. This cap requires hospice providers to reimburse Medicare if they exceed their aggregate cap value for the year.

Regardless of the possibility to restrict access and coverage, CMS's policy supports the hospice mission of providing quality service to terminally ill patients with six months or less to live. More equitable reimbursement practices, such as the two-tiered, U-shaped reimbursement model along with improved coding practices, allow for greater quality care for the patient.

St. Croix Hospice

St. Croix is a high-growth provider of hospice services operating in 5 states (Wisconsin, Iowa, Minnesota, Nebraska and Kansas) and 107 counties. The Company was recapitalized by Clearview Capital in 2013 and has maintained a strong growth trajectory resulting from a commitment to clinical excellence and a dedication to continuous education, training and strategic relationship building. As a result, the Company has been able to quickly adapt to regulatory changes and thrive as it delivers high quality and personalize end-of-life care.

Case Study: Debility as a Primary Diagnosis – St. Croix, Ahead of the Curve

In anticipation of CMS potentially enforcing regulatory changes that would eliminate debility as a primary patient diagnosis, St. Croix took multiple preemptive actions to adapt to this change:

As of May 2013, St. Croix no longer admitted patients with debility as a primary diagnosis, which was well ahead of when this regulatory change was ultimately implemented in October 2014;

St. Croix proactively educated its employees about the potential regulatory changes to enhance the Company's ongoing patient diagnosis and admissions practice and procedures; and

Leveraged its robust patient data base and records to analyze its patient census to confirm that all but four patients with a primary diagnosis of debility had a qualifying secondary diagnosis that met the requirements for hospice care with a prognosis of six months or less to live

As a result of these actions, St. Croix eliminated any operational, compliance or financial impact of this regulatory change.

Another significant contributing factor to St. Croix' success is its deep focus on training its marketing and nursing staff on how to engage with referral sources and when to educate patients, family members and caregivers about the benefits of hospice care. As a result, St. Croix currently delivers an 80%-85% conversation rate, which represents the rate at which the patient, family or caregiver selects St. Croix as its hospice provider. Supporting this statistic is a live discharge rate of 10-15%, which is below the national average of 15.9% and is strong testament to St. Croix's strict adherence to the guidelines for admissions criteria.

A byproduct of St. Croix's premier reputation and operational excellence is the expansion of the Company's referral relationships with local health systems, many of which operate their own hospice programs. Today, health system patient referrals represent approximately 30% of all of St. Croix's referrals. Pointing to superior service delivery and millions in savings from the avoidance of readmissions, hospital systems value St. Croix as a critical partner within their care ecosystem, positioning the Company well for opportunities with these health systems as patient-centric care and alternative payment models evolve.

Built upon a relentless pursuit to treat patients and their family members with dignity, respect and compassion, TripleTree looks forward watching St. Croix continue to raise the standard of care in the industry.

END-OF-LIFE CONVERSATION REIMBURSEMENT

The shift towards patient-centric hospice care is also apparent in new regulations that impact the types of hospice services that will be reimbursed. Effective as of January 1, 2016, healthcare providers are now reimbursed for conducting conversations with Medicare patients about advance care planning, otherwise known as end-of-life discussions. A similar proposal under the ACA was fiercely contested in 2009 and ultimately removed due to political backlash.[23] However, over time this legislation has garnered both bipartisan and public support. According to a **Kaiser Family Foundation** poll conducted in September 2015, 8 in 10 citizens believe that Medicare and private health insurers should pay for end-of-life conversations.[24] This once seemingly controversial topic is now a vehicle for patients to assume a larger role in making decisions regarding one of the most important periods of their lives, the time before their death.

This conversation not only contributes to the empowerment of the patient, but it also has positive implications for the outlook of hospice. Opponents of the regulation have stated that they believe encouraging conversations of this nature would compel patients to reject treatment or care. Many critics claim that healthcare spending would be lowered because these conversations encourage comfortable care versus costly operations intended to extend lifespans. However, this point of view prioritizes the healthcare system's financially motivated interests at the expense of its patients' interests. Although some critics believe that health systems could be negatively impacted by this reimbursement incentive, hospices will most likely financially benefit from this new policy change. These conversations will shed greater light on end-of-life options such as hospice care, likely propelling an increase in hospice enrollment in the near future. Enhancing advance care planning information accessibility and awareness by incentivizing providers further enables the hospice industry's shift towards providing patient-centric care and will result in the creation of a new breed of more empowered patients.

COMPLIANCE / REGULATORY REQUIREMENTS

In addition to reimbursement and eligibility changes, the ACA also created the Hospice Quality Reporting Program (HQRP), which requires all Medicare certified hospice providers to submit quality data to CMS (see Figure 5). Similar to the quality reporting initiatives in the acute and ambulatory care markets, HQRP's primary objective is to promote quality care by aligning financial incentives with patient satisfaction. The program comes with a 2% reimbursement penalty for non-compliance and is currently utilizing a "pay-for-reporting" structure, meaning hospice providers can remain in compliance by simply submitting data. Industry experts anticipate that as the program continues to evolve, hospice providers will be benchmarked and either rewarded or penalized based on their relative performance within the specified quality measure.[25]

FIGURE 5.
HOSPICE QUALITY REPORTING PROGRAM (HQRP) MEASURES REQUIRED BY CMS

Quality	Definition	Intent Of The Quality Measure
NQF #1641 **Treatment Preferences**	The percentage of hospice patients with chart documentation of preferences for life-sustaining treatments	Patients who are given the opportunity to express life-sustaining treatment preferences are more likely to receive care consistent with their values. Use of the Treatment Preferences quality measure is meant to enhance patient autonomy, facilitate patient-centered decision making and communicate patient preferences through clear documentation to the entire care team
Modified NQF #1647 **Beliefs/Values Addressed**	The percentage of hospice patients with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss	Hospice provides care for both the physical and spiritual needs of the patient and caregiver. Discussion of spiritual beliefs and values is essential to ensuring that these needs are appropriately met
NQF #1634 **Pain Screening**	Measures the percentage of hospice patients that were screened for pain during the initial nursing assessment	Pain is highly prevalent for seriously ill patients nearing end of life. In addition, patients and family caregivers rate pain management as a high priority when living with serious illnesses. Utilizing the Pain Screening and Assessment quality measures will increase the efforts and awareness to improve the presence and severity of pain
NQF #1637 **Pain Assessment**	Measures the percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of the screening	
NQF #1639 **Dyspnea Screening**	The percentage of patients who were screened for dyspnea during the initial nursing assessment	Dyspnea is prevalent and undertreated for patients nearing end of life – an effective screening is necessary to determine the presence and severity of dyspnea. Effective evidence-based treatments are available, but not consistently administered. Utilizing the dyspnea screening and treatment quality measures will help ensure consistent, timely and effective treatments
NQF #1638 **Dyspnea Treatment**	The percentage of patients who screen positive for dyspnea and who received treatment within 1 day of the screening	
NQF #1617 **Patients Treated with an Opioid who are Given a Bowel Regimen**	The percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Opioids are commonly used to treat moderate to severe pain, and constipation is often an adverse side effect. Reducing constipation through a bowel treatment regimen has the potential to result in improved medication adherence and patient quality of life
Hospice CAHPS	A post-death survey administered to the patient's primary caregiver that focuses on the experience of care	Utilizing a standardized caregiver satisfaction survey can (1) provide a decision aid for selection of a hospice program for patients, (2) aid hospices with internal quality improvement initiatives and external benchmarking, and (3) enable CMS to monitor care quality

Source: Hospice Quality Reporting - Current Measures, CMS.gov, April 2016

HQRP operates on a three-year cycle of data collection, data submission and payment impact. The program initially required the submission of just two measures, but has now expanded to include seven quality measures that are endorsed by the **National Quality Forum** (NQF).

All Medicare certified hospice providers are required to participate or will face the 2% HQRP non-compliance penalty, with only two exemptions:[26]

> ***Size Exemption***: the criterion for this exemption is that the hospice must have served fewer than 50 decedents / caregivers in the reference year. Hospice providers must reapply annually for this exemption
>
> ***Newness Exemption***: this is a one-time exemption with the criterion being that the hospice must have received its Medicare Provider Number (also known as its "CNN") on or after the first day of the performance year for the CAHPS Hospice Survey

The quality measures are submitted to CMS through the Hospice Item Set (HIS), a standardized set of data elements that can be used to calculate the quality measures. Hospice providers are required to complete and electronically submit HIS records to CMS for every patient, whether or not they are Medicare beneficiaries. CMS requires two HIS records for each patient:[27]

> ***HIS-Admission***: contains data for patient identification and clinical items for calculating the quality measures
>
> ***HIS-Discharge***: includes data for patient identification and discharge information used to calculate any patient exclusions for the quality measures

The most recent update to the program was the 2015 expansion to include the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey. Similar to CAHPS surveys that have been introduced to other healthcare markets in recent years (hospitals, home health and Medicare ACOs) the CAHPS Hospice Survey is an experience of care survey sent to caregivers (e.g., family members) two months after the death of the hospice patient, intended to act as a catalyst for quality improvement (see Figure 6). The survey requires hospice providers to contract with an approved CMS vendor for submission/reporting and necessitates continuous administration.[28]

FIGURE 6.
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) HOSPICE SURVEY TIMING REQUIREMENTS

Month of Death	Survey Sent to Decedent's Caregiver	Data Submission to the CAHPS Hospice Survey Data Warehouse
January 2015	April 1, 2015	August 12, 2015
February 2015	May 1, 2015	
March 2015	June 1, 2015	
April 2015	July 1, 2015	November 1, 2015
May 2015	August 1, 2015	
June 2015	September 1, 2015	
July 2015	October 1, 2015	February 10, 2016
August 2015	November 1, 2015	
September 2015	December 1, 2015	
October 2015	January 1, 2016	May 11, 2016
November 2015	February 1, 2016	
December 2015	March 1, 2016	

Source: Strategic Healthcare Programs, SHPSolutions for CAHPS Hospice, Septemeber 2014.

The focus of the CAHPS Hospice Survey is not on the technical aspects of hospice care, but rather on patient / caregiver experience and satisfaction in areas such as communication, care access, provision of symptom relief treatments, etc. (see Figure 7). Some industry constituents challenge the value of attempting to create a standard measure for patient / caregiver experience given the personalized nature of hospice care and the subjective / perception-based orientation of the survey. Simultaneously, many hospice providers are supportive of CMS's slow, incremental approach to the CAHPS and broader HQRP initiatives and view the program as an opportunity to demonstrate the value of their services, drive differentiation in the market and identify best practices.[29]

FIGURE 7.
TOPICS / AREAS INCLUDED IN CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) HOSPICE SURVEYS

CAHPS Measure	Representative Survey Questions
Hospice Team Communication	*How often did the hospice team keep you informed about when they would arrive to care for your family member?* *How often did the hospice team explain things in a way that was easy to understand?*
Getting Timely Care	*When you or your family member asked for help from the hospice team, how often did you get help as soon as you needed it?* *How often did you get the help you needed from the hospice team during evenings, weekends, or holidays?*
Treating Family Members with Respect	*How often did the hospice team treat your family member with dignity and respect?* *How often did you feel that the hospice team really cared about your family member?*
Providing Emotional Support	*While your family member was in hospice care and in the weeks after your family member died, how much emotional support did you get from the hospice team?*
Getting Help for Symptoms	*Did your family member get as much help with pain as he or she needed?* *How often did your family member get the help he or she needed for trouble breathing?* *How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?*
Support for Religious and Spiritual Beliefs	*While your family member was in hospice care, how much support for your religious and spiritual beliefs did you get from the hospice team?*
Information Continuity	*While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care?*
Understanding the Side Effects of Pain Medication	*Did any member of the hospice team discuss side effects of pain medicine with you or your family member?*
Getting Hospice Care Training (Home Setting of Care Only)	*Did the hospice team give you the training you needed about what side effects to watch for from pain medicine?*

Source: CAHPS Hospice Survey Fact Sheet, October 2015.

REGULATORY CHANGES SHAPING THE INDUSTRY CONTINUED

The introduction, evolution and growth of HQRP and CAHPS will undoubtedly have a positive impact on the quality of hospice care and, if / when data becomes publicly available, will empower patients and caregivers with transparent data for decision-making.

TripleTree views the impact of these regulatory changes as highly positive to the hospice industry as a whole. Not only will patients and caregivers benefit from higher quality care and enhanced quality transparency, but hospice providers and industry technology vendors stand to benefit, as the program offers significant opportunities for innovation, disruption and differentiation.

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Perspective from Hospice Care Providers

A more holistic approach to care, especially during the dying process, requires a special type of person. Hospice nurses are critical members of a patient's interdisciplinary care team, often helping connect team members with other parts of the broader care team while delivering care across physical, mental and spiritual dimensions. In preparing this report, TripleTree spoke with individuals responsible for hospice care delivery, including a pediatric hospice nurse and a hospice administrator. Observations from our conversations include:

Hospice is redefining what it means to deliver quality care:

It has to be more holistic (beyond physical)

It has to extend to family members and caregivers

It enables patients and their loved ones to begin the grieving process earlier, improving quality of life for all involved

Talking about hospice is difficult, with many forces impacting the conversation:

Patient's understanding of their own mortality

Tension between curing and caring in a care setting

Expectations of family members and caregivers

Cultural differences about the role of healthcare and the dying process

Opportunity for more doctors to discuss hospice as one alternative

The ability to lower healthcare costs and improve quality of life are closely aligned with:

Having the conversation about hospice

Encouraging more patients to benefit from hospice earlier in their care

The transition from acute to hospice care can be disconnected:

A more patient-centric view could lower costs and improve quality of life by reducing "futile care", or the on-going provision of medical care with limited hope of a cure or benefit.

Our industry conversations confirmed the important role of people in hospice care, amplified the human impact of hospice and affirmed CMS's relentless focus on delivering more patient-centric hospice care.

INNOVATION AND GROWTH OF SUPPLY CHAIN PARTNERS

Regulatory and reimbursement pressures have created a growing need for hospice providers to partner with vendors that can help optimize clinical and administrative operations while enhancing patient care and satisfaction. As noted previously, the HQRP program is currently using a pay-for-reporting structure with a 2% penalty for hospice providers that do not report. However, CMS has stated that it will analyze the data submitted for purposes of establishing the reliability and validity of the measures. In addition, industry experts anticipate that CMS will use the aggregated data to establish national benchmarks and baselines that will be publicly available to inform consumer decision-making and have implications for future reimbursement. In anticipation of this, many providers are looking for solutions to help assess their performance so that any corrections to data collection procedures and / or clinical processes can be made before reimbursement is impacted or the data becomes publicly available. Companies like **Strategic Healthcare Programs (SHP)**, **eSolutions**, **Kinnser Software**, **HEALTHCAREFirst** and **ABILITY Network** are leading the way in the industry, leveraging data and analytics software platforms to build state and national hospice benchmarks with actionable reporting to proactively drive quality improvement for their clients.

Two additional areas of focus for hospice providers include the procurement, delivery and administration of Durable Medical Equipment (DME) and prescription medications. As part of the hospice benefit, hospice providers are responsible for ensuring patients receive the DME required for their care. This responsibility includes managing the relationships with local DME providers, ordering the equipment specific to each patient's

FIGURE 8.
THE VALUE OF TECHNOLOGY-ENABLED SOLUTIONS FOR HOSPICE PROVIDERS

Operational Efficiency

- Consolidated billing and single point of contact
- Efficient ordering and clinical documentation
- Simplified contracting
- Access to a broad provider network – especially helpful for hospice providers entering new markets

Business Intelligence

- Real-time visibility into key operational metrics
- Customizable dashboard to track clinical excellence and financial performance
- Improved decision-making capability

Cost Containment

- Greater control over expenses without compromising the patient experience
- Improved efficiency through automation of workflow and logistics

Customer Satisfaction

- 24/7 service
- Timely delivery
- Reduced services failures
- More time to focus on patient care

Source: TripleTree Analysis.

unique needs, tracking the status of each delivery and ultimately paying the DME provider for the equipment rendered. The traditional model is very similar to the prescription medication industry before the introduction of Pharmacy Benefit Managers (PBMs) – extremely resource intensive, inefficient and cumbersome for hospice providers to manage. As a result, many hospices experience increasing DME costs, avoidable service failures and less than optimal patient care and satisfaction.

Recognizing the need to optimize and streamline this process, a handful of outsourced services providers have entered the market with technology-enabled solutions that deliver tremendous value to hospices. Similar to PBMs, companies like **HospiceLink**, **National HME** and **StateServ** are acting as network / benefit managers on behalf of hospice providers, while leveraging sophisticated logistics and business intelligence technologies to deliver their solutions.

National HME

Tailwind Capital Acquires Therapy Support Following its Merger with National HME

Target Description:

National HME, Inc. (NHME) is the largest provider of outsourced medical equipment management solutions to the hospice market. Its Hospice Cloud platform offers transparency, coordination, and logistics tools to the hospice / durable medical equipment (DME) delivery model. Prior to its merger with Therapy Support, NHME served over 225 agencies in 35 states.

Therapy Support, Inc. is a full service provider of DME for the hospice and long-term care industries. Prior to its merger with NHME, Therapy Support operated 21 full service locations in 8 states.

TripleTree Perspective:

In July 2015, Tailwind Capital acquired NHME for an undisclosed amount and outlined future add-on acquisitions as a substantial growth objective for the Company. Therapy Support merged with NHME in January 2016 and started operating as its subsidiary following the merger (the financial terms of the deal were not disclosed). The merger supports Tailwind's growth vision for NHME and allows the combined entity to expand its DME benefit management geographic footprint while providing a higher level of DME expertise. Additionally, the combined entity's operationally efficient DME delivery service model better serves the care coordination and cost containment needs of the hospice market than the currently disjointed hospice / DME delivery model. Today, NHME operates 60 service centers as the nation's largest direct service hospice DME company.

INNOVATION AND GROWTH OF SUPPLY CHAIN PARTNERS CONTINUED

Through their services, the procurement process is simplified to a single solution that provides benefits across the hospice business (see Figure 9).

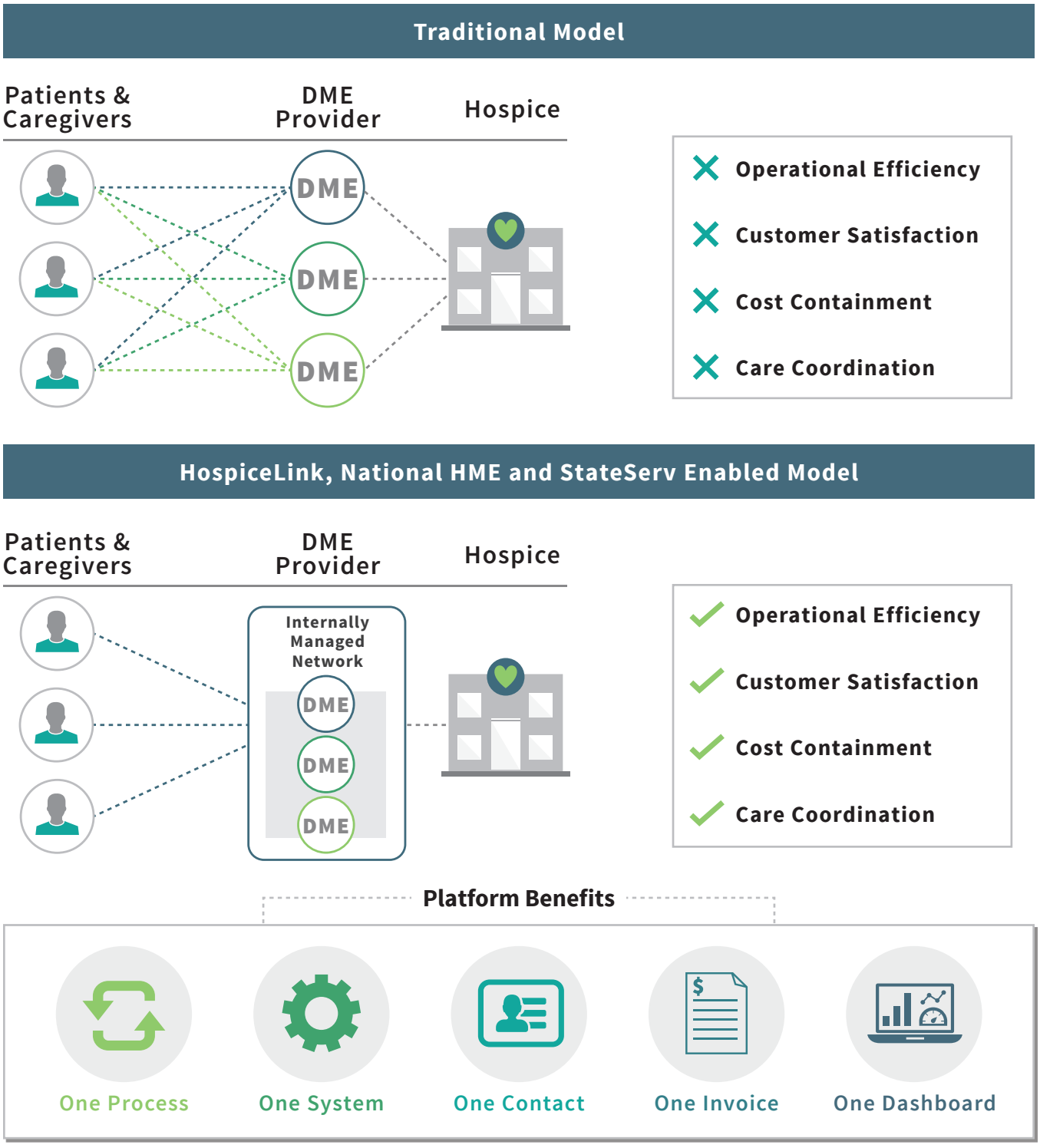
From the DME provider's perspective, the smaller / regional players are highly incented to join these networks due to the benefit from increased volume as a result of the rationalization of the hospice provider's network, improved billing procedures that drive enhanced cash flo w and administrative efficiencies through outsourced contract negotiations.

TripleTree has seen tremendous success with these types of benefit management models in adjacent markets and therefore expects HospiceLink, National HME and StateServ to experience continued growth.

One example of a successful company in an adjacent market is **Integra Partners**. In 2015, TripleTree represented the Company in its sale to **Tufts Health Plan**. Through a technology-enabled solution, the Company provides a broad set of network and benefit management solutions to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) market. Integra Partners has more than 50 payer customers and serves more than 15 million lives across complex, high-cost patient populations, including managed government programs and commercial health plans.

Similar to DME, there are vendors who specialize in pharmacy services for the hospice industry. These PBMs provide many of the same benefits described previously and ultimately deliver solutions to help hospice providers enhance their clinical and administrative operations within an increasingly regulated environment. By helping to provide effective patient-specific symptom management customized for individual patient goals, Hospice PBMs are a critical component to enabling hospices to better meet their mission to improve patient quality of life, reduce caregiver stress and lower costs for the U.S. healthcare system. As an example, **Enclara Pharmacia** formed from the combination of Hospice Pharmacia and Enclara Health in 2014. Enclara Pharmacia is the largest national provider of comprehensive pharmacy services in the U.S. The Company offers both a mail order solution and access to local PBM networks to serve the needs of hospice clients. Enclara also offers a range of complementary services including medication therapy management, business intelligence and cost containment tools, compliance documentation and quality assurance, full compounding services and e-prescribing. The Company serves over 500 hospices and 84,000 hospice patients per day. Given the increasingly pivotal role that PBMs play in the provision of hospice care, TripleTree expects strong growth and market activity in this segment as these PBMs continue being integrated with hospice interdisciplinary care teams.

FIGURE 9.
TRANSFORMATION DRIVING IMPROVED EFFICIENCY AND QUALITY



Source: HospiceLink, National HME, StateServ, and TripleTree.

ACTIVE M&A MARKET

As a result of market tailwinds, the hospice market has seen consistently strong growth over the last several years.

The rapid increase in hospice demand has been accompanied by an acceleration of M&A volume, with three common market themes underlying many of the transactions:

Increased Focus on Post-Acute Care: The need for cost-effective treatment solutions is propelling the transition of treatment of higher acuity conditions into lower cost settings such as the home and outpatient settings. Additionally, families and patients are choosing to prioritize comfort and independence when selecting treatment options, both of which are prominent in home-based settings. An increasing prevalence of chronic conditions worldwide has also fueled a demand for patient-centric models that minimize costs and maximize outcomes.

Diversification of Post-Acute Service Line Offerings: In November 2014, **HealthSouth**, an inpatient rehabilitation provider, announced the acquisition of **Encompass Home Health & Hospice**. With a $900 million price tag, the acquisition represented a significant diversification move for HealthSouth which views home health and hospice as highly complementary to its core offering. According to HealthSouth at the time of the acquisition announcement, HealthSouth's inpatient rehabilitation facilities (IRF) discharged approximately 72,000 patients per year to home health, but less than 5% went to either a HealthSouth or Encompass home health agency. As such, the acquisition represents a compelling opportunity to offer HealthSouth IRF patients who are discharged to a SNF a more cost-effective alternative. Additionally, Encompass provides HealthSouth the capabilities to participate in integrated delivery and value-based payment models.

Geographic Expansion and Economies of Scale: Many of the smaller transactions in the hospice marketplace are driven by local / regional players combining to expand customer footprints, move into new geographies and benefit from the enhanced profitability that can be achieved with increased scale. At the national level, **Kindred Healthcare's** $1.9 billion acquisition of **Gentiva Health Services** (Gentiva) added significantly to Kindred's already impressive scale in the hospice space, making the Company the largest and most geographically diversified home health / hospice provider and enhancing the Company's cost structure.

Despite the strong M&A volume over the last several years, the hospice industry remains highly fragmented with the market's two largest players, VITAS (owned by Chemed Corp.) and Gentiva (owned by Kindred Healthcare), combining to account for just 10% of total industry revenue.[30] The remainder of the market is composed of

smaller community-based organizations and non-profits. As such, we expect the strong M&A activity from industry constituents, new market entrants, healthcare providers in adjacent markets and the professional investment community to continue as hospice continues to play a greater role in the U.S. healthcare system.

FIGURE 10.
SELECT M&A TRANSACTIONS IN THE HOSPICE INDUSTRY

Date	Buyer	Target	Enterprise Value
March 2016	Hospice Compassus	Genesis HealthCare*	$84M
January 2016	CURO Health Services	New Century Hospice	N/A
October 2015	Hospice Compassus	Hospice Advantage	N/A
October 2015	LHC Group	Halcyon Hospice	$59M
September 2015	LL*	Caring Brands International / Interim HealthCare*	N/A
July 2015	Hospice Partners of America	Kendallwood Hospice	N/A
May 2015	St. Croix Hospice	Saint Jude Hospice	N/A
February 2015	Hospice Compassus	Life Choice	N/A
January 2015	THL	CURO Health Services	N/A
November 2014	HealthSouth	encompass*	$898M
November 2014	Audax Group	Hospice Compassus	N/A
October 2014	Kindred Healthcare	GENTIVA*	$1.8B
May 2014	CURO Health Services	SouthernCare Hospice Services	$230M
May 2014	Wellspring Capital Management	Great Lakes Home Healthcare Services, Inc.*	N/A
April 2014	CelticHealthcare	VNA HealthCare*	N/A
October 2013	Clearview Capital	St. Croix Hospice	N/A
March 2013	Summit Partners	Heart to Heart Hospice	N/A
November 2012	Frazier Healthcare Partners	Abode Healthcare	N/A
August 2012	Kindred Healthcare	IntegraCare*	$75M

**Denotes presence of both hospice and home health services*

Source: TripleTree Analysis.

MORE TRANSFORMATION ON THE HORIZON

As the U.S. healthcare system responds to the ACA, continues to shift to value-based compensation models and prepares for an aging population, the hospice industry has a meaningful role to play in the coming years.

REGULATORY CHANGES

CMS is continuously evaluating the Medicare hospice benefit and adding or removing measures to make the program more effective. As reported in the 2015 Federal Register, high-priority concept areas that have been identified for potential future quality measures include:[31]

- *A patient-reported pain outcome* measure that incorporates patient and / or proxy reporting regarding pain management
- *Claims-based measures* focused on care practice patterns including skilled visits in the last days of life, transitions of care for patients in and out of hospice and rates of live discharge from hospice
- *Responsiveness* of hospice providers to patient and family care needs
- *Hospice team* communication and care coordination

Additionally, CMS has proposed a 2% increase in Medicare payment rates to hospice providers in 2017, representing as much as $330 million in additional payments. This proposed payment increase also coincides with further required quality measures focused on assessing the frequency of hospice staff visits to patients and caregivers in the final week of a patient's life, as well as the percentage of hospice patients who received care consistent with specific guidelines.

SHIFT TO VALUE-BASED CARE

From a broader healthcare system perspective, the hospice industry is well positioned to participate in the shift to value-based compensation models, the increasing prevalence of risk-bearing provider organizations (e.g., ACOs), and the emergence of provider-led care coordination and population health management (PHM) initiatives. In many ways, the hospice industry helped shape the concept of risk-bearing providers and provider-led care coordination / PHM with its long-standing emphasis on a more holistic and patient-centric approach that focuses on quality outcomes and lower costs. To achieve these goals, hospice providers have learned to work in interdisciplinary care teams and manage transitions in care, important capabilities for any risk-bearing provider.

In addition to the practical experience of delivering patient-centric care in a team-based approach, hospice providers also deliver valuable end-of-life services to risk-bearing provider organizations seeking to provide an integrated, coordinated and patient-centric care experience. In fact, several players within the industry have started to coalesce around the potential of risk-bearing providers, most notably VITAS and the **Toward Accountable Care (TAC) Consortium**. In the case

of VITAS, the Company is actively marketing its capabilities for risk-bearing provider organizations in the "Partners" section of its website, where it specifically notes its ability to improve customer satisfaction scores, coordinate care and collaborate with different stakeholders. The TAC Consortium, comprised of the **North Carolina Medical Society**, **The Physician Foundation**, **Smith Anderson** and **The Carolinas Center for Hospice and End of Life Care**, has published a guide highlighting the role of hospice and palliative care in ACOs and ACO-like provider organizations. *The Accountable Care Guide For Hospice and Palliative Care* includes a three-part framework to help hospice providers evaluate, structure and achieve success in ACO and ACO-like risk-bearing provider groups.

The **Michigan Pioneer ACO (Michigan ACO)** is a recent example of hospice participation in risk-bearing, value-based provider models. The Michigan Pioneer ACO is a partnership between the **Detroit Medical Center (DMC**) and its physicians and was selected to introduce a specialized case manager pilot program identifying terminally ill patients that require customized care at home (see Figure 11). To operate the program, the Michigan ACO signed a three-year contract with **Hospice of Michigan**, where through its HOMe subsidiary, terminally ill patients are provided with comprehensive home medical services. The goal of this pilot program is to reduce unnecessary costs associated with end-stage illness (HOMe also has contracts with several other leading Michigan payers to provide similar services, including **Blue Care Network**, **Priority Health** and **UnitedHealthcare**). This example highlights the growing acceptance of the vital role that hospice providers play in controlling healthcare costs (as well as their willingness to form partnerships in order to distribute these services effectively). In the case of the Michigan ACO, where efforts were directed towards controlling end-of-life spending through hospice care, the program is especially significant given that studies have shown that end-of-life services account for 10% of the nation's $2.6 trillion healthcare budget. Furthermore, for those aged 65 and older, the last 12 months of life account for 27% of total costs. Given the potential spending burden that these types of conditions create and the resultant pressures that would be placed on a risk-bearing provider, it is no secret that the post-acute space will be a critical focus area for risk-bearing provider organizations.

As risk shifts to providers and value-based care models continue to take shape and build momentum over the next few years, it is likely that more hospice providers will partner with risk-bearing provider organizations to address a critical and costly part of the care continuum.

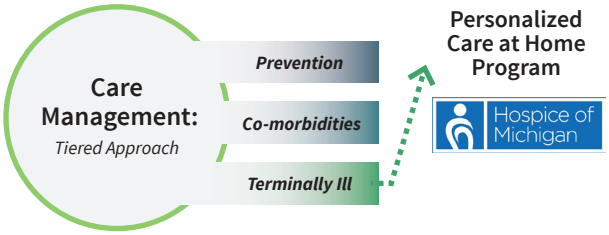
FIGURE 11.
THE ROLE OF HOSPICE IN THE MICHIGAN PIONEER ACO

Michigan Pioneer ACO
Detroit Medical Center

DMC
DETROIT MEDICAL CENTER

- Michigan ACO is among those selected to participate in the Pioneer ACO Program
- Michigan ACO is a partnership of the Detroit Medical Center (DMC) and its physicians
- The DMC is an academically integrated system in metropolitan Detroit and one of the largest healthcare providers in southeast Michigan
- Michigan ACO will be managed by the DMC PHO, a 1,100 member physician- hospital organization
- The ACO's primary service area consists of the tri-county Detroit metropolitan area

Personalized Care at Home Program



Michigan ACO introduced a case manager program that identifies terminally ill patients in the ACO that require customized care and provides medical care at home

Part of a tiered approach to care management where the initial tier focuses on preventive measures and the other tiers focus on patients with multiple conditions and terminally ill patients with less than 24 months to live (through the program)

Under the contract, HOMe will identify terminally ill hospice patients with the goal of reducing unnecessary costs that are associated with end-stage illness

HOMe also has contracts with leading Michigan payers to provide similar services to Medicare Patients, including: Blue Care Network, Priority Health and UnitedHealthcare

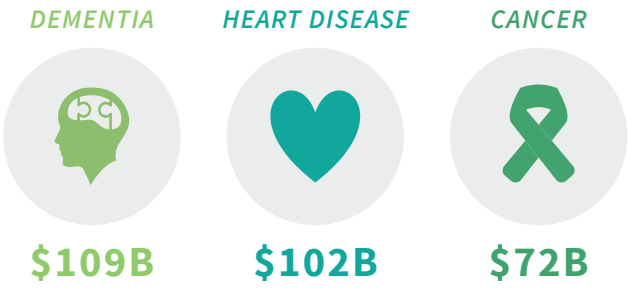
Source: TripleTree Analysis.

COULD HOSPICE BETTER MEET THE NEEDS OF DEMENTIA PATIENTS?

The growing number of dementia cases is another area where the hospice industry could transform the U.S. healthcare system. A recent study conducted by the RAND Corporation, and published in the *New England Journal of Medicine* in April 2013, highlighted the escalating cost of dementia. According to RAND, dementia is one of the country's most expensive medical conditions, costing the U.S. between $157 billion and $215 billion a year in medical care and other costs.

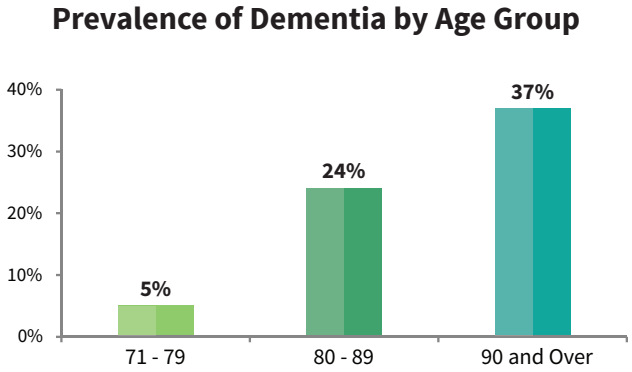
Compared to other common costly diseases, the direct medical costs of treating dementia, estimated at $109 billion in 2010, are in line with heart disease ($102 billion) and substantially greater than cancer ($72 billion) (see Figure 12). Beyond direct medical costs, it is estimated that an additional $48 to $106 billion is spent on the informal care for dementia, which primarily includes lost wages and care provided by family members at home. The projected growth is also eye opening – both the costs and the number of people with dementia will more than double within 30 years, a rate that overshadows many other chronic diseases (see Figure 13). These staggering statistics clearly reinforce the need for the U.S. to find better solutions for those suffering from dementia.

FIGURE 12.
DIRECT MEDICAL COSTS OF TREATMENT

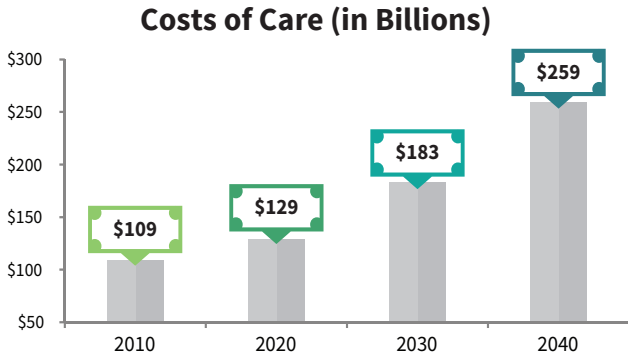


Source: New York Times, April 2013

FIGURE 13.
DEMENTIA CARE COSTS ARE PROJECTED TO DOUBLE



Source: The Aging, Demographics, and Memory Study Published in Neuroepidemiology



Source: New England Journal of Medicine

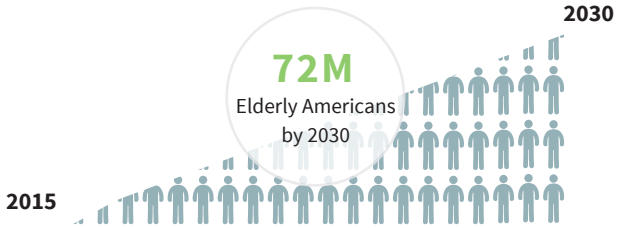
Today, dementia patients are grossly underserved, as fewer than 10% of people dying of dementia receive hospice services and often times are enrolled too late – within a few weeks of days of death (see Figure 14). Medicare regulations require a physician to certify that a patient entering hospice is likely to die within six months or less. As a result, too many dementia patients are denied access to hospice care, which could provide palliative care for the dying and support for their families. Without hospice, those suffering from dementia may be subjected to multiple hospitalizations, invasive treatments and poor pain / symptom management.

With better prognoses, on-going education and potential regulatory changes hospice providers have the potential to meet the needs of this unmet, and growing, base of patients – further demonstrating the industry's ability to improve quality of life while reducing costs to the U.S. healthcare system.

FIGURE 14.
THE GROWING DEMENTIA POPULATION IN THE U.S.

The Senior Population Continues to Grow

As U.S. seniors are expected to live longer, hospice care represents a high-quality, low-cost alternative for managing the most basic activities of life as dementia patients become increasingly impaired, both cognitively and physically



Today, Dementia Patients are Underserved

Fewer than **10%** of people dying of dementia receive hospice services – resulting in hospital admissions, poor pain and comfort management and unnecessary cost

Source: New York Time, November 2010.

Good Samaritan Society

The Evangelical Lutheran Good Samaritan Society (Good Samaritan Society) is the largest not-for-profit provider of senior care and services in the United States, serving more than 27,000 people of all beliefs and faith. As an organization focused on creating an environment where people are loved, valued and at peace, Good Samaritan Society is focused on meeting the needs of its patients across the full continuum of care, including the provision of hospice services. As part of its commitment to serving a growing senior population, Good Samaritan Society is expanding hospice services as part of its strategic plan.

"With the growing number of seniors and aging baby boomer population, there is an important need to help our patients formulate their end of life decisions and enhance overall quality of life," said Kim Johansen, Vice President of Operations for Home and Community Based Services at Good Samaritan Society. "Hospice can be the elephant in the room, with common misconceptions that hospice is only for patients who are giving up or that hospice is exclusively focused on cost containment." To help overcome these misconceptions, Good Samarian Society proactively trains its skilled work force to better understand the role of hospice in a patient's continuum of care. The goal of this education process is to empower staff to have a conversation about hospice care earlier in a patient's care plan, resulting in an enriched end of life experience (with reduced costs as a by-product).

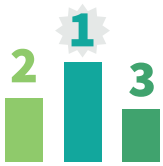
As Good Samaritan Society expands its hospice services, the Company is also keenly focused on the role of hospice with Accountable Care Organizations (ACOs), value-based compensation arrangements and providers who are bearing more financial risk. "Hospice is an important component in the continuum of care, and should be a choice in the emerging models focused on delivering better outcomes with lower overall costs," said Johansen.

Good Samaritan Society is another example of how one organization is thinking strategically about the important role of hospice in its overall business strategy. With its focus on meeting the needs of a growing senior population and addressing a more holistic continuum of care, TripleTree is excited to watch Good Samaritan Society's progress in the coming years.

TRIPLE TREE'S PERSPECTIVE

Given the increasing regulatory complexity, scope of quality reporting requirements and growing consumer demand, we expect far-reaching implications for the hospice industry:

Hospice Consolidation: the hospice industry is highly fragmented with the industry's two largest companies combining to account for just one-tenth of total industry revenue. In conjunction with reimbursement pressures from Medicare, HQRP has potential to drive consolidation and M&A activity in the space as players with scale will be better positioned to invest in the technology, redesign processes and implement training required for succes in the program.



Competitive Differentiation: because hospice services are uniform across the industry, the basis for competitive differentiation has not always been clear. However, CMS has indicated that HQRP reporting will be made publicly available along with national and / or regional quality benchmarks. This will equip hospice providers with objective, quantitative data to distinguish themselves from other providers in their local markets. The transparency provided by HQRP has the potential to become a key competitive factor for industry constituents.

Technology Innovation: hospice providers are looking for solutions that can keep pace with HQRP tracking and reporting requirements, and as quality data becomes publicly available, providers will be looking for ways to improve performance. This provides a natural opportunity for disruption and innovation through technology.

Capabilities that hospice providers are looking for include:

Automated Data Collection & Standardization: it is critical for providers to utilize solutions that drive workflow efficiency through seamless data collection for all HIS data elements and required quality measures in a standardized format, that can also be automatically submitted to CMS and leveraged for internal reports / dashboards.

Benchmarking: technology vendors with large client footprints can build quality measure benchmarks in order to give hospice providers the opportunity to improve performance relative to their peers prior to CMS making the data publicly available. SHP and Deyta are already offering benchmarking solutions.

Real-Time, Customized Reporting: providers need real-time reporting that is customizable for the various end-users (hospice c-suite, case manager, nurse, etc.) to track performance. Reporting technology with site, provider and patient-level drill-down capabilities, as well as segmentation by care setting, diagnosis, length of stay, etc. are particularly useful in providing the empirical data needed to drive performance improvement initiatives.

With the potential for increased Medicare payment rates from CMS, industry support for more patient-centric care and new quality measures, there is tremendous opportunity for innovative and leading hospice providers to thrive in the future.

"With the potential for increased Medicare payment rates from CMS, industry support for more patient-centric care and new quality measures, there is tremendous opportunity for innovative and leading hospice providers to thrive in the future."

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