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OCTOBER 2023

Provision of Hospice Services by Critical Access Hospitals: Strengths and Challenges

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KEY FINDINGS

- Of the 929 Critical Access Hospitals (CAHs) responding to the 2021 American Hospital Association annual survey, 60% (562 CAHs) reported that they provide hospice services.
- Seven CAHs were interviewed and shared common barriers to providing hospice care, which included low hospice benefit reimbursement rates that do not account for added costs in a rural setting, in addition to challenging community demographics and a shortage of at-home caregivers to assist with end-of-life care.
- Strengths of providing hospice care in a CAH include familiarity with patients and the community, in addition to the ability to provide personalized, one-on-one care.

PURPOSE

Critical Access Hospitals (CAHs) play an integral role in rural communities, serving families from birth through end-of-life and across generations.[1] Previous work has described rural-urban disparities in access to hospice services; however, little is known about the state of hospice provision in CAHs and about the types of CAHs that are currently providing hospice services. This policy brief describes the characteristics of CAHs that report providing hospice services and describes findings from qualitative interviews with seven CAHs who report providing hospice care. Topics discussed in these interviews included details on how CAHs provide hospice services, the unique advantages CAHs may have when providing end-of-life care, and what CAH-specific barriers exist in providing such care.

BACKGROUND

Over the past two decades, there has been a substantial increase in the number of hospice facilities operating in the U.S., and hospice use has become increasingly common among Medicare beneficiaries.[1] However, rural-urban disparities exist in access to and utilization of hospice care.[2–5] While the proportion of rural Americans deciding to enroll in hospice remains lower than that of their urban counterparts, overall rates of hospice use have increased over the years. This trend has led to a greater need for hospice services, particularly in rural communities which have seen a decrease in the number of hospice providers in operation.[6,7]

For a Medicare beneficiary to receive hospice care, the Medicare Hospice Benefit (MHB) requires a physician's certification that the patient has a life expectancy of six months or less. The MHB covers four levels of hospice care, each covered under a different per diem rate. Routine home care (RHC) is the most common level, representing approximately 98% of all hospice days and is provided in the patient's residence. Continuous home care (CHC), which is intended to address symptoms or complications on a short-term basis, also occurs in the home and involves at least eight hours of nursing care per day. A patient receiving inpatient respite care (IRC) can be moved to a hospital or other medical facility for up to five days to provide respite for the patient's family and caregivers. Finally, general inpatient care (GIC) is provided in a facility for patients whose symptoms cannot be addressed in any other setting.[8] A CAH can provide any of the four levels of hospice care covered under the MHB itself, or the CAH can work with a partner providing hospice care and serve as the location in which the patient receives GIC.

There are significant rural-specific barriers that may make it more difficult for a CAH to operate a hospice program.[2] Reimbursement under the four levels of the MHB, each of which cover all aspects of hospice care at a flat rate, does not consider rural-specific expenses such as longer travel distances through remote areas. This results in a lower effective reimbursement rate for rural hospice providers, though some studies have shown that the total average cost per day may be lower in a rural setting.[1,9] Other previously documented challenges facing rural hospice agencies include staffing shortages, higher demand due to a disproportionately aged population, and low hospital inpatient volumes that lead to decreased financial stability.[2,7] While there is previous literature describing the availability of hospice in rural communities and the characteristics of the communities with Medicare-certified hospice providers,[5,10–12] there is limited research describing the characteristics of CAHs providing hospice services and exploring how hospice care is provided in a CAH context.

Providing hospice services as a CAH can be challenging, and at the same time, distinct advantages also exist for a CAH providing hospice services. This study aims to identify common characteristics of CAHs providing hospice services, to explore the processes by which CAHs provide hospice care, and to investigate the strengths and challenges of providing such care in communities served by CAHs.

APPROACH

Data Analysis

Data for this policy brief were primarily sourced from the 2021 American Hospital Association (AHA) annual survey. Of the 1,353 total facilities designated as CAHs as of December 31, 2021, 929 responded to the 2021 AHA survey. In the AHA survey, hospitals were provided a list of hospital services and instructed to indicate how each service was provided "as of the last day of the reporting period." Respondents were asked to indicate whether these services were provided by their hospital, their health system, or through a joint venture with another health care provider and were instructed to select all options that applied at their facility. For the primary variable in this analysis, hospitals that selected at least one of the affirmative responses for hospice services were coded as providing hospice.

Additional variables from the 2021 AHA survey were also considered in this analysis, including those indicating health system membership (hospitals with a health system on record with the AHA), type of hospital ownership/governance, geographic region, and other relevant services reported, such as palliative care, home health, and assisted living. Finally, a variable indicating the number of acute care beds in each CAH was included, from a public dataset maintained by the Flex Monitoring Team (FMT).[13] Summary statistics were produced using SAS software.

Interviews

In addition to the secondary analysis of AHA survey data, qualitative interviews were conducted between March and May 2023 with CAHs that provide hospice

in their communities. From the 562 CAHs reporting a hospice program in the 2021 AHA survey, a random sample of 22 was selected across the categories of hospital-operated and system-operated hospice services as well as across the four census regions to include CAHs located throughout the U.S. Of these 22 CAHs, representatives from seven completed an interview with the FMT.

The interviews included questions regarding how and in which settings CAHs most often provide hospice care, their hospital's collaboration with partners in providing hospice care, and strengths of and barriers to providing hospice in a rural community. To identify key themes, the seven interviews were analyzed inductively by two individuals on the research team using Dedoose software.

RESULTS

Data Analysis

Table 1 summarizes the characteristics of all respondents to the 2021 AHA survey who reported a hospice program, comparing CAHs to all other non-CAH survey respondents. Overall, CAHs are less likely to provide hospice than their non-CAH counterparts (57% vs. 80%). CAHs providing hospice are more likely to be located in the Midwest than in any other region. Non-CAHs providing hospice are more likely to be in the South. Finally, CAHs providing hospice care are much less likely to provide palliative care (48%) as well as home health (67%) than non-CAHs with hospice (85% and 80%, respectively).

Overall, 60% (n=562) of CAHs responding to the 2021 AHA survey reported providing a hospice program. Table 2 summarizes the characteristics of all CAH respondents to the 2021 AHA survey, comparing those with a hospice program to those without. CAHs providing hospice services are more likely than CAHs without hospice to be affiliated with a health system (57% vs. 43%), provide palliative care services (48% vs. 16%), and provide home health services (67% vs. 19%). A majority of CAHs providing hospice (56%) are located in the Midwest. The majority (73%) of all CAHs responding to the 2021 AHA survey have 25 acute care beds, and a similar proportion (75%) of CAHs reporting a hospice program have 25 acute care beds; however, there is still a wide range of number of acute care beds among CAHs with a hospice program (3-24).

TABLE 1: Characteristics of 2021 AHA Annual Survey Respondents Reporting a Hospice Program, by CAH Status

Characteristic	Total (n=2,638)	Hospital Designation	
		Non-CAH (n=2,076)	CAH (n=562)
System member	1,976 (75%)	1,658 (80%)	318 (57%)
Regions			
Northeast	411 (16%)	363 (18%)	48 (9%)
Midwest	874 (33%)	558 (27%)	316 (56%)
South	922 (35%)	804 (39%)	118 (21%)
West	404 (15%)	324 (16%)	80 (14%)
Services			
Swing bed	1,603 (61%)	515 (25%)	520 (93%)
Palliative care	2,046 (78%)	1,771 (85%)	275 (49%)
Home health	2,042 (77%)	1,663 (80%)	379 (67%)
Assisted living	490 (19%)	373 (18%)	117 (21%)

TABLE 2: Characteristics of CAH Respondents to 2021 AHA Annual Survey, by Hospice Program Availability

Characteristic	Total (n=929)	Hospice Program	
		Yes (n=562)	No (n=367)
System member	474 (51%)	318 (57%)	156 (43%)
Ownership type			
Government-owned	349 (38%)	190 (34%)	159 (43%)
Not-for-profit	547 (59%)	365 (65%)	182 (50%)
For-profit	33 (4%)	7 (1%)	26 (7%)
Regions			
Northeast	69 (7%)	48 (9%)	21 (6%)
Midwest	458 (49%)	316 (56%)	142 (39%)
South	245 (26%)	118 (21%)	127 (35%)
West	157 (17%)	80 (14%)	77 (21%)
Services			
Swing bed	861 (93%)	520 (93%)	341 (93%)
Palliative care	339 (36%)	275 (49%)	64 (17%)
Home health	447 (48%)	379 (67%)	68 (19%)
Assisted living	145 (16%)	117 (21%)	28 (8%)
Number of beds*			
1-14	79 (9%)	42 (7%)	37 (10%)
15-19	87 (9%)	51 (9%)	36 (10%)
20-24	82 (9%)	47 (8%)	35 (10%)
25	682 (73%)	422 (75%)	259 (71%)

** From data managed by the Flex Monitoring Team[13]*

Interviews

The CAHs interviewed for this study are located throughout three of the four U.S. Census regions: Midwest (3), South (2), and West (2) (CAHs contacted in the Northeast did not respond). The number of acute care beds in each CAH range from 25 (5 CAHs) to 24 (1 CAH) and 21 (1 CAH). Based on 2021 AHA survey data, four are affiliated with a health system and three are independently operated. The backgrounds of CAH staff members interviewed varied, but included roles such as Chief Executive Officer, Chief Nursing Officer, Director of Hospice and Palliative Care, and Med-Surg Manager.

Throughout the interviews, CAHs discussed the settings in which they provide hospice care. All seven CAHs indicated they care for inpatient hospice patients, and two CAHs specifically mentioned that they utilize swing beds to care for hospice patients when needed. However, most respondents said that patients and families prefer in-home hospice. Four of the CAHs noted that they provide hospice care in the patient's residence.

The CAHs further described *how* they are providing hospice care and what partners they collaborate with to do so. All respondents mentioned providing a broad array of services and support to hospice patients. Such services included general nursing care and daily or regular visits from a hospice nurse, management and

direct delivery of medications to the patient, visits from a social worker, and chaplain services. CAHs also mentioned assisting and interacting with family members of hospice patients.

Four CAHs said they collaborate with an external hospice agency to provide hospice care. These CAHs only care for hospice patients while admitted to the hospital and typically provide the direct, day-to-day care for patients, while the hospice agency oversees care plans and sends a hospice-specific provider for regularly scheduled visits. Several respondents noted that the hospice agencies they work with officially oversee end-of-life care plans but that the CAH staff have wide latitude to suggest modifications. The CAHs collaborating with external partners to provide hospice said the external agencies usually bill insurance and then reimburse the hospital once they have received payment.

Three CAHs reported that they provide hospice services independently and provide inpatient and in-home hospice care. These CAHs have similar responsibilities to those that work with external hospice agencies detailed above, but have direct responsibility for all activities, including directly overseeing hospice patients' care plans, going into the community to provide care for patients wherever they reside (whether it's at home or in a nursing, assisted living, or other facility), and directly billing insurance for reimbursement.

When asked about the strengths of caring for hospice patients as a CAH, respondents' answers fit into four themes (see Table 3 for examples of quotes from

TABLE 3: Strengths of Providing Hospice Services as CAHs

Theme	Description	Quotes
Individualized care	Ability to provide hospice care based on the patient's needs and preferences	*"They get the more one-on-one care because usually the nurses have a little bit more time to provide that."*
CAH collaboration	Coordination of hospice care between CAHs and their hospice partners	*"I think because we're the health care provider for the entire community, it's easier to refer services. It's more seamless that it's all internal."* *"When we have hospice, our nurses work well together with the [hospice] provider."*
Connection to the community	CAH staff understanding the community context in which they are providing hospice care	*"We're local to the community, so we're familiar with the resources and the struggles and things that patients in our community face."* *"I think it's connection to the community. You know, the community knows that they can count on us."*
Familiarity with providers	Hospice providers and CAH staff knowing patients	*"I think the strengths are in a smaller community, you know them and so you know the family, you know the support personnel, you know their life history. They may have been your teacher. They may have been your neighbor. And so…there is a lot of compassionate care that's provided, where we know so-and-so was a lifelong, you know, member of the Catholic Church and so we can involve their priests."* *"Some we've taken care of for generations. I've been here almost 29 years, so I'm taking care of my third generation of people. They know us. We know them and they trust us. That's the connection."*

respondents). The most common theme mentioned was related to individualized care. This theme included the ability of patients to receive end-of-life care in their community and the CAH's ability to provide individualized care based on patients' preferences. CAH collaboration and connection to the community were two other common themes. CAH collaboration included references to positive relationships and effective cooperation between the CAH and hospice partners. Connection to the community focused on discussions of intimately knowing and understanding the struggles and resources unique to the CAH's local population, including knowing families and histories of individuals in the communities they serve. The final theme was related to familiarity with providers, which includes discussion of the personal connections between CAH staff and hospice patients and their families. Mentions of this theme centered around the idea that CAH staff often know their patients outside the context of the hospital and similarly have known and taken care of some families for generations.

CAHs were also asked to describe the challenges they face when providing hospice services, and responses to this question were grouped into five themes (see Table 4 for examples of quotes from respondents). The most common theme for challenges was community characteristics, which included discussions of the aging population in some rural communities that has led to a shortage of loved ones to assist in caring for hospice patients, whether those are children or other family members or a fellow aged partner. The next most common themes related to reimbursement for hospice care and staffing concerns. Under the reimbursement theme, some CAHs mentioned providing hospice care at a loss and others detailed barriers created by the flat rate of reimbursement paid through the MHB. The staffing theme focused on difficulty recruiting key

TABLE 4: Challenges of providing hospice services as CAHs

Theme	Description	Quotes
Community demographics	Community-level demographics, including an aging population and a lack of young and middle-aged adults in rural communities, which result in challenges finding caregivers	*"[The] biggest struggle with rural communities is when an aged couple want to use hospice, they—one or the other may not be strong enough to be the caregiver."* *"We're a very aged community, and so 30- to 60-year-old people have moved away and so they may not have—their children may have moved away and may not be available to help them pass at home. So then they have to come in to our hospital, which is kind of against their wishes. And I mean, we still help them pass with dignity, but it's not necessarily what they wanted. You know, some of these people have lived in our community their whole life and they're 90. They just want to pass away on their ranch."*
Reimbursement	CAHs facing difficult financial and cost-related barriers	*"We're Critical Access, and we're a nonprofit Critical Access Hospital, and so it's not like we're trying to make money. We just want to break even. If we had a whole bunch of hospice patients, we would not be able to. So it's just reimbursement, the way the reimbursement is to the hospice agency, and then in turn, the hospice agency to us."* *"I always tell everybody, it's like your own household bills. You can't keep paying more than you're bringing in or pretty soon it's not going to work anymore…There's a lot of barriers when it comes to that…For hospitals to go out and do [hospice], it costs a lot of money."*

TABLE 4: Challenges of providing hospice services as CAHs, *continued*

Theme	Description	Quotes
Staffing	Difficulty finding staff to provide hospice-specific services	*"And yeah, just staffing, I think, is the challenge. Finding a social worker is also challenging, because they're just a resource that is also really hard to find. And it's a requirement, you know, the program. So what do you do when you can't find a social worker? Like, we've been in that situation before, where we're desperately looking, and when our current one retires, I don't know what we're going to do. You know, there's not a lot of social workers hanging out in [City]."* *"Larger hospices may have a full-time, volunteer coordinator and a full-time chaplain and a full-time social worker, and we have to find PRN or part-time or contracted services for those because we just don't have the census to hire a full-time for every different role. So I would say kind of where the specialty services are harder to fulfill in smaller areas."*
Stigma	Negative views of hospice care impacting patients' and families' decisions to enroll in hospice	*"I think the data shows that [rural] patients…have fewer days on hospice than in an urban area. So, for whatever reason, I believe that people are just waiting too long to go on care. The average days in hospice in a rural area are shorter—or historically they have been. And that's part of, you know, palliative care. People are, are more open to going on palliative care, because hospice has that sort of 'death sentence' to it. So it's an easier way to ease into it, and then we can transition them to hospice without them feeling like they're dying."* *"Sometimes the family is reluctant. They hear the word 'hospice' and they're reluctant to go that route because that's admitting to them that they're not doing all—they haven't done all they can do for their loved one. So I think that would be my perspective as far as a big challenge."*
Bed availability	Difficulty in finding the bed space needed to care for a hospice patient	*"I can tell you right now, I'm full. I'm a Critical Access Hospital, so I only have…on my medical unit, I have 18 beds. If I know I've got a couple of surgical admissions, and I've got 15 patients on the floor or whatever, I probably won't take a hospice patient."*

hospice staff, such as social workers and volunteer coordinators or other hospice-specific staff. Another theme, stigma, included the topics of stigmatization of hospice care as "giving up" and patients waiting to enroll in hospice until they have no other choice. The final theme, bed availability constraints, focused on the lack of space in some CAHs to accommodate hospice patients.

Finally, respondents were asked to list any resources their CAH would find helpful to support them in providing hospice services, and their responses fell into three themes. The most common theme related to policy changes and included suggestions to change Medicare hospice reimbursement rates, implement telehealth in the hospice setting, and to relax guidelines to allow LPNs to assume some tasks performed

by RNs. In one interview, a respondent mentioned their desire for such guidelines to be modified, saying, *"I think sometimes relaxing some of the guidelines, like you have to have an RN for this, an RN for that. We don't have a lot of RNs, so sometimes an LPN being able to do certain things would be very helpful. You know, if an LPN can make an end-of-life visit instead of an RN, that'd be wonderful. That would be great. Yeah, just realizing that that's what we have and they're more than capable." Another interviewee voiced support for expanded use of telehealth in hospice care: "If there were, you know, virtual options, social work options, or—which I know is hard in those situations—but some other resource outside of trying to have that person there."*

Another respondent at a CAH working with external partners to provide hospice care mentioned wanting educational materials to inform families about the hospice process and what to expect. CAHs were also asked if their State Flex Program (SFP) had provided any support related to hospice care, and none of the respondents were aware of any support explicitly received for this purpose.

DISCUSSION

While there has been a great deal of work published on the distribution of Medicare-certified hospice agencies in the rural U.S., there is little work on CAHs providing hospice care and what this looks like. This study has shed light not only on the prevalence of hospice services in CAHs, but also on key challenges and successes experienced by CAHs providing hospice care. These findings may be helpful for other CAHs looking to improve their hospice services or add this service line.

Throughout the interviews, CAH staff said they believed the unique characteristics of their facility and their community allow them to provide quality and compassionate end-of-life care to their patients. Several respondents mentioned they thought the ability to know patients and anticipate how they and their families might want to prepare for the end of their lives was a key strength. The opportunities for connection—both with patients and health care partners—mentioned by respondents in these interviews can be more broadly leveraged by CAHs to collaborate more effectively and to provide quality hospice care in their communities. While no respondents mentioned a familiarity with their patients as a challenge, it should also be noted that prior literature demonstrates that some rural nurses find caring for hospice patients they know difficult, especially when there isn't enough staff available to transfer care of a patient with which the nurse has a close personal relationship.[14] CAHs should be aware of this potential challenge and consider that caring for a patient they know might be too difficult for some staff.

One key finding from these interviews is that reimbursement is a significant challenge for CAHs providing hospice care. By its very nature, hospice care needs to be specifically tailored to each patient and requires a multidisciplinary team of professionals to provide care, which can be a major burden on hospitals with fewer resources at their disposal. Prior literature shows that rural hospice providers are effectively reimbursed at lower rates.[2,15] This was echoed by the CAHs interviewed in this study. Several interviewees mentioned the conscious choice within their CAHs to provide hospice services at a loss because they believe they must still serve their communities, with one saying they receive "pennies on the dollar" when their hospice partner reimburses them, adding "We do it because they're our patients, but we certainly are losing money every day we take care of a hospice patient." Since 2021, CMS has been operating a pilot program called the Hospice Benefit Component of the Value-Based Insurance Design Model (VBID). While hospice services have typically been carved out from private Medicare Advantage (MA) plans, this pilot seeks to explore the feasibility of allowing MA plans to cover hospice as a value-based benefit rather than via a flat per diem.[16,17] This pilot may present an opportunity to decrease the disproportionate financial burdens placed on CAHs and other hospitals providing hospice services should the Hospice Benefit Component be implemented on a larger scale.

Connected to the challenges of payment is the barrier of long distances needed to travel to reach hospice patients in rural communities. This may put greater financial stress on CAHs and their hospice staff who travel to see patients, given that the rates for each of the four levels of reimbursement under the MHB do not take into account the greater distances rural hospice providers must travel.[1,18] One respondent mentioned they recently received a small donation and their CAH was able to purchase a vehicle that is used only for their hospice program. Their hospice staff are allowed to use this vehicle when conducting home visits instead of putting mileage on their personal vehicles, which lessens the individual burden, but still does not address the burden of time and cost for CAHs.

Many respondents also mentioned that they are dealing with the challenges associated with having an aging population in their communities. Interviewees report that these demographic challenges, particularly having fewer young adults in the community, lead to a shortage of caregivers at the end of a hospice patient's life. Since family support is typically a critical component of end-of-life care, this shortage of caregivers can create additional care burdens for CAHs. As time goes on, it is expected that the challenges with aging populations in many rural communities will continue to worsen, which could place further burden on CAHs providing hospice services.[19]

During the interviews, CAHs were not aware of any support they had received from their SFP for their hospice activities, but there are ways in which SFPs may support CAHs who wish to either begin providing hospice or improve their hospice services. Particularly given the workforce challenges and difficulties created by long distances to cover in rural communities, SFPs can support CAHs more broadly with workforce improvement initiatives. Additionally, through the realm of population health improvement, SFPs can assist CAHs in accessing resources to help in their understanding of strategies to incorporate telehealth in line with current CMS and clinical guidelines.[20–22]

This study has several limitations to highlight. First, identification of CAHs providing hospice relied on data from the 2021 AHA survey, which only had a response rate of 69% among CAHs, so it is possible that the true proportion of CAHs providing hospice differs from 60%. Also, the CAHs interviewed for this brief are a small sample of CAHs located in only a handful of states and are not representative of the entire CAH population in the U.S.

CONCLUSION

CAHs face significant challenges related to their unique characteristics, such as being smaller and more remote than other hospitals. At the same time, CAHs are pillars in their communities and are often the only health care providers within a reasonable traveling distance, providing care for their communities across the entire lifespan. As such, ensuring quality and compassionate end-of-life care is critically important for CAHs that choose to provide hospice services. The barriers CAHs experience when attempting to provide quality hospice care CAH are quite similar to the barriers they see in other areas of care provision in their facilities, such as recruitment of specialty staff and community characteristics. However, due to their locations in smaller and more tight-knit communities, CAHs are also uniquely suited to provide meaningful end-of-life care for those they serve.

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This report was completed by the Flex Monitoring Team with funding from the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS), under PHS Grant No. U27RH01080. The information, conclusions and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.