HOSPICE FACTS & STATISTICS

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Hospice care agencies provide supportive and palliative care to people at the end of life. Hospice agencies focus on comfort and quality of life, rather than curative treatments. Although the concept of hospice care dates to ancient times, the first hospice in the United States, The Connecticut Hospice, began providing services in March 1974.

Hospices rely on the combined knowledge and skills of an interdisciplinary team of professionals (e.g., physicians, nurses, medical social workers, therapists, counselors, hospice aides, volunteers) to coordinate an individualized plan of care for each patient and family. Services, provided primarily in clients' homes, include medical, emotional, and spiritual care for terminally ill patients and their families. These are designed to bring comfort, peace, and a sense of dignity at a very trying time. Hospice reaffirms the right of every patient and family to participate fully in the final stages of life.

Medicare-Certified Hospices

In 1982, Congress created the Medicare hospice benefit, reserving such services for terminally ill Medicare beneficiaries with life expectancies of six months or less "if the disease runs its normal course." Effective with the enactment of the Balanced Budget Act of 1997, the Medicare hospice benefit was divided into the following benefit periods:

1. An initial 90-day period;
2. A subsequent 90-day period; and
3. An unlimited number of subsequent 60-day benefit periods as long as the patient continues to meet program eligibility requirements.

Beneficiaries must be re-certified by the hospice medical director as terminally ill at the beginning of each benefit period. The following covered hospice services are provided as necessary for palliative treatment for terminal illnesses:

- Nursing care
- Medical social worker services
- Physician services
- Counseling (including dietary, pastoral, and other)
- Inpatient care (including respite care and short-term inpatient care for procedures necessary for pain control and acute and chronic symptom management)
- Hospice aide and homemaker services
- Medical appliances and supplies (including drugs and biologicals)
- Physical and occupational therapies
- Speech-language pathology services
- Bereavement services for families (up to 13 months following a patient's death)

From 1984 to January 2010, the total number of hospices participating in Medicare rose from 31 to 3,407, a nearly 110-fold increase (Table 1). Of these hospices, 2,278 are free-standing, 578 are home health agency-based, 531 are hospital-based, and 20 are skilled nursing facility-based. There are also an estimated 200 additional volunteer agencies that are not Medicare-certified.

According to a NAHC survey of state home health and hospice associations, 44 states require licensure and 14 required Certificate of Need (CON) for hospices in 2010.[1] In 2008, Medicare-certified hospices served 1,054,722 Medicare patients.[2] Table 2 shows the calendar year 2008 distribution of Medicare-certified hospices by state as well as each state's number of patients, total charges, and program payments. These data provided by the Centers for Medicare & Medicaid Services (CMS) for Medicare-certified hospices are slightly dated, and little is known about hospices that do not participate in Medicare or Medicaid.

Hospice Financing

In 2009, total national health care expenditures were projected to be $2.47 trillion.[3] Although little specific information is available on national expenditures for hospice, detailed data are available on Medicare hospice expenditures and utilization. Some data also are available on hospice spending under the Medicaid program. In addition to Medicare and Medicaid, another source of hospice revenue is private insurance companies. Community donations and grants also contribute to the revenue base, often to fund non-reimbursed hospice services for patients with little or no insurance. Table 3 provides the breakdown of hospice expenditures by source of payment for 2006 and 2007.

Medicare

The Medicare hospice benefit represents a relatively small proportion of total Medicare spending. In 2009, an estimated 2.8 percent of Medicare benefit payments were spent on hospice care, with the same percent anticipated for 2010 (Table 4). Meanwhile, approximately 37 percent of the estimated $434 billion in Medicare spending for FY 2009 and 38 percent of the projected $453 billion in spending for FY 2010 will go to hospitals under Part A and Part B. In FY 2009, physicians received approximately 14 percent of Medicare spending and are expected to get approximately 13 percent in FY 2010.

Despite the consistent portion of spending from Medicare, a growing number of Medicare beneficiaries are receiving hospice care, and the outlays for hospice have grown. Table 5 provides past year expenditures on hospice, as well as the number of Medicare beneficiaries served by Medicare-certified hospices, the average number of days per patient, and the average cost per patient.

Free-standing hospices served the majority of Medicare hospice clients, while skilled nursing facility-based hospices served the fewest. The average length of stay for patients in these facilities ranged from 52.6 to 69 days. (Table 6 details Medicare-subsidized hospice utilization for FY 2005 by type of hospice.)

Table 7 illustrates Medicare hospice expenditures and utilization by type of care for FY 2002 through FY 2005. Table 8 reveals average Medicare reimbursements per unit of care for the four categories of hospice care for FY 2004 through FY 2010.

Medicare's Payment Structure

Medicare payments for hospice services are made on a prospective basis under four levels of care, and are adjusted by an area wage index. This local adjustment is necessary to permit higher rates in areas with higher wage levels, and proportionately lower rates in areas with wage levels below the national average. During the late 1990s, industry representatives, including the Hospice Association of America, participated in a negotiated process for rulemaking with the Health Care Financing Administration (HCFA, now CMS) to derive a new wage index. This new index, which for a period consisted of a blend of old and new area wage indexes, is based on hospital wage data. As part of the negotiated agreement, a budget neutrality adjustment factor (BNAF) was applied to the new wage index to ensure

[1] National Association for Home Care & Hospice, July 2010.
[2] Centers for Medicare & Medicaid Services, Office of Information Services, March 2010.
[3] Truffer, C., et al. "Health Spending Projections Through 2019: The Recession's Impact Continues." Health Affairs: March 2010.

that hospices would not lose financial standing as the result of the transition.

Beginning in FY2010, CMS began a seven-year phase out of the BNAF. A 10 percent reduction in the BNAF was imposed in the first year, with 15 percent reductions planned for the subsequent six years. CMS estimates that elimination of the BNAF will result in Medicare hospice outlays that are 4 percent less than they would have been without the change.

Medicare hospice rates also vary according to the level of care received by the beneficiary. Current rates, effective October 1, 2010, are listed below:

Routine Home Care Day: $146.63. This category is for individuals receiving hospice care at home. The rate does not vary by volume or intensity of services.

Continuous Home Care Day: $855.79 for 24 hours, or $35.66 per hour. Individuals in this category must need services for a period of at least eight hours (one-half of which must be skilled nursing) within a 24-hour period beginning at midnight, but only for brief periods of crisis and only as necessary to maintain the terminally ill individual at home.

Inpatient Respite Care Day: $151.67. Care may be provided for no more than five days at a time in an inpatient facility.

General Inpatient Care Day: $652.27. Care may be provided in a Medicare-certified hospital, skilled nursing facility, or inpatient unit of a hospice.

Medicare payments to hospices are subject to an overall aggregate per patient "cap amount." The Medicare fiscal intermediary calculates each hospice's cap amount by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period, beginning November 1 and ending October 31 of the following year. Each hospice must refund Medicare payments in excess of this aggregated cap amount. The cap amount is adjusted annually for inflation or deflation. For the year ending October 31, 2010, the cap amount is $23,874.98. The percent of hospices exceeding the aggregate per patient cap rose from 2.6 percent in 2002 to 10.4 percent in 2007.[4] In recent years a number of hospice programs have posed legal challenges to CMS' application of the per beneficiary cap on the grounds that the methodology does not accurately reflect the legislative language authorizing the cap.

A second cap limits the overall number of inpatient service days provided to 20 percent of a hospice's total patient days. According to the Medicare Payment Advisory Commission (MedPAC), "[t]his cap is rarely exceeded, and when it is, any inpatient days provided in excess of the cap are reimbursed at the routine home care payment rate."[5] Consequently, the inpatient cap poses limited financial risk to hospice programs.

Hospice Profitability and Payment for Medicare Beneficiaries

A 2004 Government Accountability Office (GAO) report estimated that the Medicare per diem rate for all hospice care in free-standing hospices was 8 percent higher than Medicare costs in 2000 and more than 10 percent higher in 2001. The per diem costs for smaller hospices were, on average, higher than per diem costs for medium or large hospices for each of the payment categories. Costs were higher than Medicare payments for inpatient respite care days, but lower for continuous home care, routine home care, and general inpatient care days.

According to an analysis by McCue and Thompson in 2005 total margins of free-standing hospices varied by agency size and for-profit/non-profit status based on 2003 free-standing hospice cost report data. This analysis showed that the median profit margin

[4] Medicare Payment Advisory Commission, A Data Book: Healthcare spending and the Medicare Program, June 2010. June 2010
[5] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy. March 2010

for large for-profit agencies was 18 percent, but the median for large non-profits was 2 percent. These total margins were calculated using all payers' payments and all patients' costs, so they may differ from Medicare margins.

In more recent analysis, the Medicare Payment Advisory Commission (MedPAC) has estimated that Medicare hospice financial margins averaged 5.9 percent in 2007; for 2010 the average margin estimate is expected to be 4.6 percent. MedPAC calculations indicate a significant variance between financial margins for profit versus non-profit providers: 10.5 and 1.8 percent, respectively.[6] This value does not include the cost of bereavement services, which are unreimbursed by Medicare.

MedPAC has suggested that changes in the use and provision of hospice care should lead to a re-evaluation of the hospice payment system. Such an evaluation would assess whether changes to the benefit structure and payment rates, which were developed more than 25 years ago, would improve the accuracy of the payment rates.

Accurate payment for all types of patients is important to ensure that the program is paying rates that cover providers' costs for all types of patients. Making this determination is difficult, as Medicare administrative data offer little detail about hospice services used by each patient. As part of health reform legislation enacted in 2010 (Public Law 111-148), Congress mandated that CMS revise the payment system for Medicare hospice services in a budget neutral manner; the payment revisions are to be implemented no earlier than Oct. 1, 2013. CMS has begun to collect hospice data on the type of services provided, type of personnel providing the care, frequency of visits and visit duration time for use in conducting a comprehensive evaluation of costs and services used by patients; the ultimate goal is revision of the hospice reimbursement system.

Medicare Beneficiary Liability

Beneficiary liability for the cost of hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside the inpatient setting, but that coinsurance may not exceed $5 per drug. For inpatient respite care, beneficiary liability is 5 percent of Medicare's respite care payment per day. The beneficiary copayment for respite care may not exceed the Part A inpatient deductible, which is $1,100 per year for calendar year (CY) 2010.[7]

Medicaid-Funded Hospice

Hospice is an optional service under Medicaid; it is currently not available in two states and all five U.S. territories (Table 9). In FY 2006, hospice services comprised 0.6 percent of total Medicaid payments. Medicaid hospice expenditures totaled $1,639 million in FY 2006, an increase of 22.9 percent from the $1,333 million spent in FY 2005 (Table 10).
As is true for Medicare, hospice services represent a relatively small part of total Medicaid payments. In FY 2006, 34.3 percent of nearly $269 billion in Medicaid vendor payments went to hospital and skilled nursing-facility services (Table 11).

As part of P.L. 111-148, Medicaid and Children's Health Insurance Programs (CHIP) were required to offer coverage of hospice care concurrent with curative services to children, effective upon enactment of the new law.

Managed Care and Hospice

Health care services in the United States are increasingly financed through managed care organizations. A managed care contract generally specifies a negotiated fee, often called a capitated payment, for the care of patients. A fully capitated plan specifies a lump sum payment per enrollee to cover all care provided through the plan.

[6] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy. March 2010

[7] Federal Register, Vol. 74, No. 203, Thursday, October 22, 2009, page 54579. http://edocket.access.gpo.gov/2009/pdf/E9-25372.pdf

An enrollee's choice of provider and access to specialty care varies under managed care arrangements, but there tend to be incentives for consumers to use certain providers who are part of the managed care organization's network. In contrast, traditional health insurance, commonly known as "fee-for-service," pays care providers based on the number of services delivered, with few limitations on which providers it will pay.

A MedPAC report released in June 2010 revealed that about 43.9 percent of the individuals in Medicare's managed care plan, Medicare Advantage, chose hospice compared to 39.2 percent enrolled in the traditional Medicare benefit at time of death.[8] (Figure 1)

Managed care is most prevalent in the employer-based health insurance market. In 2002, 95 percent of insured workers received health benefits through a managed care plan.[9]

Managed care enrollment has increased among Medicaid beneficiaries, particularly in states that have federal waivers to convert their Medicaid program to a managed care program. As of December 31, 2009, 72.91 percent of all Medicaid beneficiaries were enrolled in managed care.[10]

Medicare managed care enrollment has increased at a slower pace. As of September 2010, 25.4 percent of Medicare beneficiaries were enrolled in Medicare Advantage.[11] When a Medicare-eligible patient who is an enrollee of a Medicare Advantage plan elects hospice care, the hospice services must be provided through a Medicare-approved hospice, and the individual must meet the eligibility requirements specified by Medicare. The patient does not need a referral from the plan, and is not required to disenroll from the plan. Medicare pays the hospice for its services and the plan for attending physician services and services not related to the patient's terminal illness. In addition, plans are required to inform enrollees about the availability of hospice care if: 1) a Medicare-certified hospice is located in the plan's service area; or 2) it is common practice to refer patients to hospice programs outside their service area.

The increasingly competitive health care market has created incentives for hospices to enter managed care provider networks. Hospices have considerable experience managing payments under the Medicare prospective reimbursement system's aggregate per-patient cap. Little is known about the extent to which hospices have entered into managed care arrangements or what impact these arrangements have on hospice clients.

Private Insurance

A study sponsored by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services examined the use of hospice benefits and services through Medicare and private insurance (Tables 12-14). Of 52 Summary Plan Descriptions (SPDs), which explain private insurers' hospice benefits, hospice was identified as a covered benefit in 46. Table 12 indicates whether different plans offer a hospice benefit by plan type: indemnity, point-of-service, or preferred provider organization. A very high proportion of each plan type (84.4 percent to 100 percent) offered the benefit.

The remaining results of this study are based on the 46 SPDs that offer an explicitly specified hospice benefit. They represent 19 large employers. The data were collected in early winter 1998, but since plans do not typically update their SPDs annually, the available SPDs are dated from 1986 to 1996.

The percentages in Table 13 represent the proportion of plan types with certain hospice

[8] Medicare Payment Advisory Commission, Report to Congress: New Approaches in Medicare. June 2004.
[9] Gabel, J., L. Levitt, J. Pickreign, et al. "Job-Based Health Benefits in 2002: The Latest Outlook." Health Affairs 21, no. 5 (September/October 2002).
[10] Centers for Medicare & Medicaid Services. "Medicaid Managed Care Enrollment as of December 31, 2009," http://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/09December31f.pdf (November 2010).
[11] MATHEMATICA Policy Research, Inc., "TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS Monthly Report for September." October 2010.

benefit-related criteria. As this table shows, most plans provide a definition of hospice and require pre-certification from a physician to prove terminal illness. All SPDs providing a description of the hospice benefit identified the terminally ill as its target group. But only half of the plans provided an operational definition of the term "terminally ill." In all cases where a definition was provided, "terminally ill" was defined as a prognosis of six months or less to live. The majority of plans do not impose a lifetime day or dollar limit. However, of the 10.9 percent that stipulate a day limit, 80 percent have a 180-day limit, and 20 percent (representing one plan) have a 270-day limit. Dollar limits are somewhat more common and exist in 37 percent of plans. They range from $5,000 to $10,000; 70 percent of plans with a dollar limit set it at $5,000.

The data in Table 14 indicate that indemnity and "point-of-service" plans offer the widest variety of hospice services. For both these plan types, there are several venues for the provision of hospice care in the hospital, in a hospice facility, or at home. A smaller proportion of plans will reimburse for hospice services provided in an extended care or skilled nursing facility. Counseling, both for the terminally ill individual and for family members, is also a benefit that is specified in the majority of indemnity and point-of-service SPDs. Other services such as respite care, homemakers, home health aides, equipment, etc. are less likely to be indicated as covered.

Hospice Providers

Hospices employ physicians, nurses, home care aides, social workers, chaplains, therapists, and counselors who work together as interdisciplinary teams to coordinate individualized plans of care for each patient and family. Little information is available on the total number of "formal" hospice caregivers. Neither the Bureau of Labor Statistics nor the major organizations that collect information on health care providers gather detailed information on the entire hospice industry. CMS collects information on Medicare-certified hospice staff. Table 15 demonstrates that the number of volunteers slightly decreased from 2008 to 2009 by two and a half percent, while the number of employees increased more than seven percent over the same period of time.

It is also important to note that many terminally ill patients receive informal care. Informal caregivers are family members, friends, or other unpaid helpers who are not trained as hospice volunteers.

A 2009 survey conducted by the Hospital and Healthcare Compensation Service (HCS), in cooperation with the Hospice Association of America (HAA), collected information from 495 hospices on staff productivity (measured as the number of visits per eight-hour day). Hospice staff conducted from 3.65 visits per day on average for social workers to 5.75 visits per day on average for licensed practical nurses (Table 16). Registered nurses provided an average of 5.06 visits per day; physical therapists provided a 5.49 visit average. Social work visits are generally more time-intensive, which may account for the differences by discipline. Table 17 addresses average caseload for visit staff.

The HCS survey provides information on salary and benefits provided to employees in 66 job categories, including both administrative and non-supervisory positions. Summary results for administrators are shared in Table 18. Table 19 provides summary data on the hourly and per-visit compensation rates for hospice caregivers.[12]

Table 20 shows data from MedPAC's March 2009 Report to Congress, examining hospices serving institutionalized patients (patients were considered institutionalized if they spent at least 90 days in a nursing facility leading up to or during their hospice stay). They discovered possible differences in the services that low- and high-institutionalized hospices deliver to beneficiaries. As more data become available,

[12] To order a copy of the 2009-2010 Hospice Salary & Benefits Report, contact the Hospice Association of America's Publications Department, 228 Seventh Street, SE, Washington, DC 20003-4306; 202/546/4759.

MedPAC plans to evaluate how the hospice services provided to institutionalized beneficiaries compare to those delivered to community-dwelling beneficiaries and assess whether a separate payment policy for patients in long-term care facilities is warranted.[13]

Hospice Patients

In a March 2009 MedPAC Report to Congress, the Commission's analysis found that patients with neurological, cardiac, or nonspecific terminal diagnoses made up a growing share of the Medicare hospice patient population. (Figure 2). The balance between hospice patients with cancer diagnoses and those with non-cancer diagnoses shifted dramatically over the 14 year period studied (1992-2006).[14]

MedPAC's June 2010 Report to Congress showed that hospice use among all ethnicities has increased between 2000 and 2008 (Figure 3). White beneficiaries tend to use the hospice benefit more than other ethnicities. Several factors are believed to play a role in the lower rate of hospice election by minority populations, including differences in culture and heritage affecting views of death, differences in religion, education, and socialization, as well as disparities in access to health care services in general.[15] The share of beneficiaries aged 85 or older who died while in hospice care rose from 21 percent to 45 percent between 2000 and 2008 (Figure 4).

The number of Medicare hospice clients increased to 1,055,000 in 2008, and the average length of stay increased from 80 days in 2007 to 83 days in 2008.[16]

Stays in hospice tended to be longer for noncancer patients. The Commission has noted a steady increase in length of stay since 2000. The dramatic increase in noncancer patients partially accounts for this (Table 21).

The 2009-2010 HCS Report broke the average visits, patients, FTEs and revenue down into two income categories, $0 to $4,999,999, and over $5 million which shows that the average revenue per visit is slightly higher for the larger agencies (Table 22).

The March 2009 MedPAC Report to Congress examined the Medicare hospice population in 2006, based on institutionalized (in a nursing facility) versus noninstitutionalized. Of 730,000 beneficiaries in this analysis, just over 50 percent of the institutionalized beneficiaries were dually eligible for Medicare and Medicaid, in comparison with 17 percent of the noninstitutionalized population being dually eligible. In addition, institutionalized beneficiaries were significantly more likely than community-dwelling beneficiaries to have one of the terminal diagnoses that typically incur long hospice stays (Table 23).[17]

The Cost-Effectiveness of Hospice

Compared to hospital and skilled nursing facilities, hospice is a cost-effective service. Table 24 compares the average costs for a Medicare patient to stay one day in a hospital, a skilled nursing facility, and a hospice. Hospice charges per day are substantially lower than hospitals and skilled nursing facilities.

A study conducted by Duke University (using data from the 1993-2003 National Long Term Care Survey) showed reduced Medicare expenditures in the last year of life. These savings averaged $2309 per hospice user, with a maximum for $7000 for cancer and $3500 for other primary conditions. These savings were greatest for a cancer diagnosis when hospice was used for the last 58-103 days of life, and for other primary conditions, the last 50-108 days of life. The study directors estimate that increasing the length of hospice use for 7 in 10

[13] Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy. March 2009.
[14] Ibid.
[15] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy. March 2010.
[16] Medicare Payment Advisory Commission, A Data Book: Healthcare spending and the Medicare Program, June 2010. June 2010
[17] Medicare Payment Advisory Commission, A Data Book: Healthcare spending and the Medicare program, June 2010. June 2010

Medicare hospice users would increase savings.[18]

Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, also provide strong evidence that hospice is a less costly approach to care for the terminally ill. A 1988 study conducted by Abt Associates for HCFA (now CMS) concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care.[19] The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days during this period.

Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting that more savings and more appropriate treatment could be achieved through earlier enrollment.

The June 2006 MedPAC Report to Congress states that more than 25 percent of hospice patients are on the benefit less than a week. Using CMS Medicare claims data, MedPAC found the median length of stay for hospice patients was only 15 days.[20] Hospice use grew from 22 percent of eligible dying in 2000 to 31 percent in 2004.[21] The total number of covered days of hospice care doubled during that same period. The reluctance of caregivers, patients, and families to accept a terminal prognosis, along with the difficulty of predicting death may account for part of the delay. Education about hospice and its benefits may help broaden its use and improve end-of-life care.

A study published in the Aug. 19, 2010, *New England Journal of Medicine* ("Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer") indicates that severely ill patients introduced to palliative care early on had improved quality of life, less depression, longer life and reduced use of aggressive care at the end of life than their counterparts who were not provided access to palliative care. This study strongly supports the concurrent use of both palliative and curative services. In 2012, CMS is expected to begin study of the merits of providing concurrent hospice and curative care under a demonstration program authorized by P.L. 111-148.

The Demand for Hospice

Hospice is a humane and compassionate way to deliver health care and supportive services. Based largely on interviews with family members, a study of the non-hospice end-of-life experience of 3,357 older decedents and seriously ill patients who died reported that 40 percent were in severe pain prior to their death, and 25 percent experienced moderate to great anxiety or depression before they died.[22] The researchers found that very few patients received hospice care prior to their deaths, and they suggested that encouraging hospice might alleviate some of the distress that patients typically face at the end of life. Hospice care allows terminally ill patients and their families to remain together in the comfort and dignity of their homes, preserving one of our country's most important social values by keeping families together. In addition, hospice care allows family members to take an active role in providing or supplementing the care given by formal caregivers.

The number of patients accessing the Medicare Hospice benefit has increased in recent years. The largest growth has been in residents of nursing facilities. Hospice use by beneficiaries in nursing facilities grew from 11

[18] Traylor, D. H. Jr., et al. "What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program?" *Social Science & Medicine* (2007), doi:10.1016/j.socscimed.2007.05.028.
[19] Kidder, D., "The Effects of Hospice Coverage on Medicare Expenditures." Health Services Research 117 (1992): 599-606.
[20] Medicare Payment Advisory Commission, A Data Book: Healthcare spending and the Medicare program, June 2006. June 2006.
[21] Medicare Payment Advisory Commission, Report to Congress: Increasing the Value of Medicare. June 2006.
[22] Lynn, J., J. Teno, R. Phillips, A. Wu, N. Desbiens, et al. "Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients." Annals of Internal Medicine 126, no. 2 (January 15, 1997: 97-106).

percent to 35 percent from 1992 to 2000.[23] Another study performed by the Office of Inspector General (OIG) of the Department of Health & Human Services (HHS) in September 2009 indicated that in 2006, 31 percent of hospice patients resided in nursing homes.[24] Brown University researchers, in a study entitled, "Hospice enrollment and hospitalization of dying nursing home patients," revealed that when hospice care is integrated into nursing home care, there are decreased hospitalizations for the SNF patients. Table 25 shows the percent of hospice caseload residing in a SNF or LTC facility.

Inpatient and Resident Hospices

The 2009-2010 HCS Report revealed that 6.46 percent of responding hospices have their own residence. The average number of residential beds was 13.93 (see Table 26 for how hospices are staffing the residence). Some additional employees included chaplain, volunteers, therapists and bereavement counselors. Table 27 shows how these residences are funded. Some other responses included donations and insurance.

The Future of Hospice

Trends indicate that as more patients and families are educated about its many benefits, hospice is growing as an attractive alternative to facing death in a clinical setting. Nevertheless, only a fraction of those who have the option of hospice care choose to participate in it. Physicians and nurses caring for patients with terminal illnesses in clinical facilities need to open the dialogue with families about the option of hospice and its possible benefits to patients and their caregivers. Until clinicians, patients, and families become more comfortable talking about death and the dying process, hospice will remain marginalized as an excellent option for accessing supportive services during an extremely difficult time.

[23] Medicare Payment Advisory Commission, Report to Congress: Increasing the Value of Medicare. June 2006.
[24] Office of Inspector General (OIG), Health & Human Services (HHS), *Medicare Hospice Care For Beneficiaries In Nursing Facilities: Compliance With Medicare Coverage Requirements*. OEI-02-06-00221, September 2009. http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf

Table 1: Number of Medicare-certified Hospices, by Auspice, 1984-2009

Year	HHA	HOSP	SNF	FSTG	TOTAL
1984	n/a	n/a	n/a	n/a	31
1985	n/a	n/a	n/a	n/a	158
1986	113	54	10	68	245
1987	155	101	11	122	389
1988	213	138	11	191	553
1989	286	182	13	220	701
1990	313	221	12	260	806
1991	325	282	10	394	1,011
1992	334	291	10	404	1,039
1993	438	341	10	499	1,288
1994	583	401	12	608	1,604
1995	699	460	19	679	1,857
1996	815	526	22	791	2,154
1997	823	561	22	868	2,274
1998	763	553	21	878	2,215
1999	762	562	22	928	2,274
2000	739	554	20	960	2,273
2001	690	552	20	1003	2,265
2002	676	557	17	1,072	2,322
2003	653	561	16	1,214	2,444
2004	656	562	14	1,438	2,670
2005	672	551	13	1,648	2,884
2006	650	563	14	1,851	3,078
2007	627	562	18	2,050	3,257
2008	606	552	19	2,169	3,346
2009	578	531	20	2,278	3,407

Source: Centers for Medicare & Medicaid Services (CMS), Health Standards and Quality Bureau (February 2010).
Notes: Home health agency-based (HHA) hospices are owned and operated by freestanding proprietary and nonprofit home care agencies. Hospital-based (HOSP) hospices are operating units or departments of a Hospital.

Table 2: Number of Medicare-certified Hospices and Program Payments, by State, 2008

State	# of Hospices	# of Persons	#of Hospice Days	Average LOS	Program Payments ($thousands)
AL	127	25,832	2,657,562	104	339,259
AK	5	495	26,615	55	4,234
AZ	58	29,580	2,474,796	86	397,848
AR	51	10,324	661,395	65	93,058
CA	222	87,548	5,608,689	65	979,340
CO	51	15,010	990,172	67	159,231
CT	31	10,591	505,731	48	100,557
DE	8	4,130	335,978	82	52,457
DC	3	1,231	83,937	69	13,934
FL	41	96,262	7,048,713	74	1,204,362
GA	140	31,624	2,375,152	76	354,005
HI	8	2,506	142,729	58	24,957
ID	37	5,084	444,874	88	60,188
IL	106	39,273	2,236,055	57	352,542
IN	84	22,255	1,479,591	67	211,988
IA	75	15,218	913,623	61	132,137
KS	56	11,855	816,806	70	112,185
KY	27	13,140	795,294	64	112,993
LA	129	16,937	1,326,621	79	174,646
ME	21	4,873	308,828	64	45,791
MD	28	14,233	761,402	54	120,876
MA	69	20,766	1,308,325	63	211,976
MI	95	40,167	2,425,404	61	364,816
MN	64	15,208	905,619	61	136,387
MS	118	14,382	1,581,129	111	201,575
MO	105	24,651	1,820,509	74	242,808
MT	28	3,052	198,408	65	26,866
NE	33	6,326	347,314	55	48,243
NV	19	7,578	464,621	62	81,634
NH	21	4,385	246,507	57	39,628
NJ	55	27,481	1,649,138	61	278,862
NM	40	7,689	643,948	85	91,225
NY	51	38,007	2,079,802	55	358,425
NC	81	32,147	2,358,641	74	345,206
ND	14	1,677	102,010	61	12,816
OH	111	49,833	3,226,162	66	723,787
OK	139	18,955	1,875,304	100	235,227
OR	47	16,062	995,296	62	153,491
PA	167	56,090	3,715,385	67	545,629
RI	8	4,822	295,699	62	50,162
SC	75	19,452	1,708,932	89	244,260
SD	15	2,102	111,444	53	16,362
TN	56	21,014	1,371,335	66	197,582
TX	298	75,766	5,868,325	78	849,104
UT	70	8,878	835,996	96	115,107
VT	10	1,407	80,394	57	12,139
VA	75	21,380	1,473,916	70	209,362
WA	32	19,260	1,174,075	61	188,746
WV	20	7,371	549,573	75	74,777
WI	65	19,944	1,358,776	69	205,330
WY	17	976	54,493	57	7,932

Source: Centers for Medicare & Medicaid Services, Office of Information Systems. March 2010.

Notes: Medicare program payments represent fee-for-service only; that is, program payments exclude amounts paid for managed care services. Numbers may not add to totals because of rounding.

Table 3: Distribution of Hospice Primary Payment Source, 2007 & 2008

Source of Payment	2007 Percent	2008 Percent
Medicare	83.6	84.3
Medicaid	5.0	5.1
Private Insurance	8.5	7.8
Other	2.9	2.8

Source: National Hospice and Palliative Care Organization, "NHCPO Facts and Figures: Hospice Care In America." October 2009.

Table 4: Medicare Benefit Payments, FY2009 and FY2010

	2009 (Estimated)		2010 (Projected)	
	Amount ($millions)	**% of Total**	**Amount ($millions)**	**% of Total**
Total Medicare Benefit Payments*	**434,473**	**100.0**	**452,741**	**100.0**
Part A				
Hospital care	132,648	30.5	136,787	30.2
Skilled nursing facility	25,760	5.9	26,268	5.8
Home health	7,152	1.6	7,484	1.7
Hospice	11,953	2.8	12,580	2.8
Managed Care	56,789	13.1	60,393	13.3
TOTAL	234,302	53.9	243,512	53.8
Part B				
Physician	62,508	14.4	58,295	12.9
Durable medical equipment	8,265	1.9	8,295	1.8
Carrier lab	4,639	1.1	5,043	1.1
Other carrier	17,168	4.0	17,614	3.9
Hospital	26,546	6.1	34,968	7.7
Home health	11,176	2.6	11,721	2.6
Intermediary lab	3,287	0.8	3,387	0.7
Other intermediary	14,414	3.3	15,023	3.3
Managed care	52,168	12.0	54,885	12.1
TOTAL	200,170	46.1	209,229	46.2

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, FY 2011 President's budget (February 2010).
* Figures may not add to totals due to rounding.

Table 5: Medicare Hospice Outlays, Clients, Days per Client, and Dollar Amount Per Client, FY89-FY2003 and CY2004-CY2008

FY	Outlays ($millions)	#of Clients	Avg. Days (per client)	Avg. $ (per client)
1989	205.4	60,802	44.8	$3,020
1990	308.8	76,491	48.4	4,037
1991	445.4	108,413	44.5	4,108
1992	853.6	156,583	56.1	5,452
1993	1,151.9	202,768	57.2	5,681
1994	1,316.7	221,849	58.9	5,935
1995	1,830.5	302,608	58.8	6,049
1996	1,944.0	338,273	54.5	5,747
1997	2,024.5	374,723	50.1	5,402
1998	2,171.0	401,140	47.6	5,412
1999	2,435.1	445,146	44.5	5,471
2000	2,895.5	513,840	47.3	5,635
2001	3,610.7	579,801	49.9	6,228
2002	4,516.6	643,303	53.0	7,021
2003	5,682.3	713,400	57.6	7,965
*2004**	*6,716.0*	*799,715*	*64.0*	*8,428*
*2005**	*7,902.2*	*873,909*	*66.0*	*9,118*
*2006**	*9,235.6*	*942,375*	*70.0*	*9,837*
*2007**	*10,343.3*	*999,803*	*71.0*	*10,385*
*2008**	*11,195.8*	*1,054,722*	*71.0*	*10,662*

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, Center for Health Plans and Providers (March 2005).
*Data for 2004, 2005, 2006, 2007 and 2008 represent calendar year (CY) data and is from CMS/OIS/HCIS (March 2010).

Table 6: Medicare Hospice Outlays, Clients, and Days per Client, by Type of Agency, FY2005

Auspice	% of Outlays	#of Clients	Avg. Days (per client)
Freestanding	70.8	583,821	69.0
Hospital-based	11.9	117,597	52.6
Skilled nursing facility-based	0.4	3,854	54.9
Home health agency-based	17.0	161,777	53.6
TOTAL	100.0	791,568	63.8

Source: Centers for Medicare & Medicaid Services, Standard Analytical Files – 100% Final Action Claims (Nov. 2006).
Note: The total for average days per client is weighted by the number of beneficiaries in each hospice type.

Table 7: Medicare Hospice Utilization by Type of Care, FY2002-FY2005

Type of Care	Units of Care FY2002	Units of Care FY2003	Units of Care FY2004	Units of Care FY2005	% Care by Type, FY2005
Routine days	33,028,464	39,898,744	47,054,341	53,999,676	96.5
Continuous hours	2,510,587	3,212,941	4,048,2277	4,748,147	1.1
Inpatient respite days	67,620	75,481	85,389	96,646	0.2
General inpatient days	885,337	1,045,845	1,138,866	1,250,678	2.2
Physician procedures	478,272	573,545	639,872	778,906	n/a

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, Center for Health Plans and Providers (November 2006).

Table 8: Average Medicare Reimbursements for Hospice Care, Selected Years FY2004-FY2010

	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
Routine home care (per day)	$118.08	$121.98	$126.49	$130.79	$135.11	$139.97	$142.91
Continuous home care (per hour)	28.72	29.66	30.76	31.81	32.86	34.04	34.75
Inpatient respite (per day)	122.15	126.18	130.85	135.30	139.76	144.79	147.83
General inpatient care (per day)	525.28	542.61	562.69	581.82	601.02	622.66	635.74

Source: 2004 data from CMS Program Memorandum Intermediaries Transmittal A-03-057 (July 3, 2003), 2005 data from CMS Hospice Wage Index, CMS Reference #CMS-1264-N (July 2004). 2006 data from CMS Transmittal #R655CP (August 2005), 2007 data from CMS Manual System Transmittal 1094 (October 27, 2006), 2008 data from CMS Manual System Transmittal 1280 (June 29, 2007), 2009 data from CMS Provider Inquiry Assistance JA6155 (August 26, 2008), 2010 data from CMS Transmittal 1796 (August 14, 2009).
Note: Average reimbursements based on total outlays and total units of care.

Table 9: U.S. States and Territories that DO NOT Provide the Medicaid Hospice Benefit, 2009

States	Territories
New Hampshire Oklahoma	American Samoa Guam Northern Mariana Islands Puerto Rico Virgin Islands

Sources: Kaiser Family Foundation online (www.kff.org) and state and territory Medicaid offices.

Table 10: Medicaid Hospice Outlays, FY87-2006

Fiscal Year	Outlays ($millions)	Annual Percent Change
1987	1.5	n/a
1988	3.9	165.4
1989	18.9	385.4
1990	20.2	7.0
1991	44.1	117.9
1992	84.2	90.9
1993	128.9	53.1
1994	197.6	53.3
1995	283.5	43.5
1996	318.7	12.4
1997	327.3	2.7
1998	325.0	-0.7
1999	344.9	6.1
2000	402.6	16.7
2001	546.1	35.6
2002	706.2	29.3
2003	897.6	27.2
2004	1,129.1	25.8
2005	1,333.2	18.1
2006	1,638.8	22.9

Source: Centers for Medicare & Medicaid Services (Form CMS-64), www.cms.gov, (May 2010).
Note: FY96 totals exclude data for Florida and Hawaii. FY97 totals exclude data for Hawaii. FY99 and FY 2000 totals exclude Medicaid SCHIP.

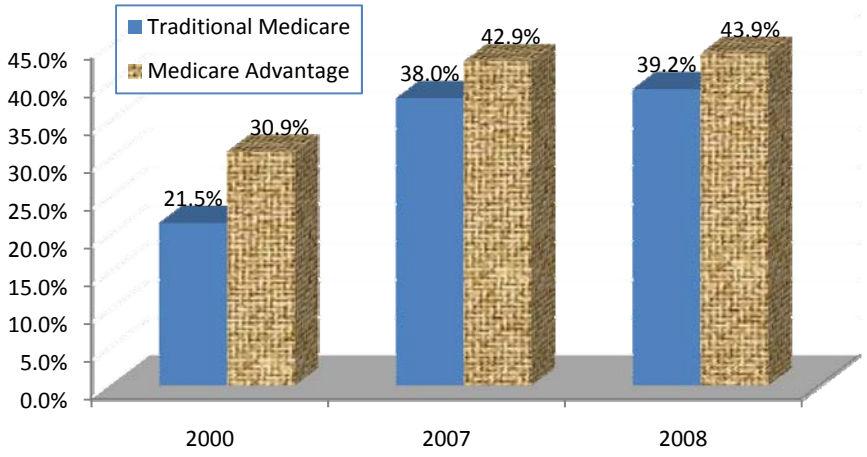
Table 11: Medicaid Payments, by Type of Service, FY 2005 & FY 2006

	2005 ($millions)	% of Total	2006 ($millions)	% of Total
Inpatient hospital	35,131.5	12.8	36,268.9	13.5
Nursing home	44,790.3	16.3	45,669.7	17.0
Physician	11,268.9	4.1	10,578.7	3.9
Outpatient hospital	10,011.9	3.6	10,165.7	3.8
Home health[d]	26,019.2	9.5	27,480.4	10.2
Hospice[b]	1,333.2	0.5	1,638.8	0.6
Prescription drugs	42,848.5	15.6	28,128.7	10.5
ICF (MR) services[c]	11,708.7	4.3	11,850.7	4.4
Other	91,739.3	33.4	97,169.8	36.1
Total payments[a]	274,851.4	100.0	268,954.2	100.0

Source: Centers for Medicare & Medicaid Services, Division of Medical Statistics, Data are from MSIS (formerly Form HCFA-2082), with the exception of hospice data, which are from Form CMS-64. (www.cms.hhs.gov, April 2010).

Notes: [a]Total outlays include hospice outlays from the Form CMS-64 plus payments for all service types included in the MSIS, not just the eight service types listed. For data anomalies, see *MSIS/State Anomalies/Issues: All States* at http://www.cms.hhs.gov/medicaid/msis/anomalies.pdf, [b]Hospice outlays come from Form CMS-64 and do not include Medicaid SCHIP. All other expenditures come from the MSIS. The federal share of Medicaid's hospice spending in FY 2005 was $779.2 million, or 58.5% of total Medicaid hospice payments. In FY 2006, it was $958.4 million, or 58.5% of total Medicaid hospice payments. [c]ICF is intermediate care facilities. [d]Home health includes both home health and personal support services. Figures may not add to totals due to rounding.

Figure 1. Hospice Use for Medicare Decedents, 2000-2008



Source: Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March 2010.
MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

Table 12: Hospice Benefit Offered by Plan Type

	Indemnity	POS[a]	PPO[b]
Hospice Benefit Offered	84.4%	90.0%	100.0%
Hospice Benefit Not Offered	15.6%	10.0%	00.0%
Total	**100.0%**	**100.0%**	**100.0%**

Source: Jackson B, Gibson T, Staeheli, J. *Hospice Benefits and Utilization in the Large Employer Market*. Washington, DC: The MEDSTAT GROUP, Office of the Assistant Secretary for Planning and Evaluation; March 2000.
Note: Findings based on results from 32 Indemnity plans, 10 Point of Service (POS) plans, and 10 Preferred Provider Organization (PPO) plans.

Table 13: Characteristics of Hospice Benefit Package by Plan Type

Characteristic	Indemnity	POS	PPO	Total
Definition of Hospice Provided	92.6%	88.9%	70.0%	87.0%
Definition of Terminal Illness Specified	55.6%	66.7%	20.0%	50.0%
Other Benefits Reduced if Hospice Elected	7.4%	0.0%	0.0%	4.3%
Precertification Required	92.6%	88.9%	80.0%	89.1%
Deductible for Hospice Benefits	48.1%	22.2%	20.0%	37.0%
Coinsurance for Hospice Benefits (in network)	40.7%	44.4%	30.0%	39.1%
Coinsurance for Hospice Benefits (out of network)	7.4%	100.0%	50.0%	34.8%
Lifetime Limit – Days	11.1%	22.1%	0.0%	10.9%
Lifetime Limit – Dollars	44.4%	22.2%	30.0%	37.0%

Source: Jackson B, Gibson T, Staeheli, J. *Hospice Benefits and Utilization in the Large Employer Market*. Washington, DC: The MEDSTAT GROUP, Office of the Assistant Secretary for Planning and Evaluation; March 2000.
Note: Findings based on results from 27 Indemnity plans, 9 Point of Service (POS) plans, and 10 Preferred Provider Organization (PPO) plans.

Table 14: Services Covered Under the Hospice Benefit by Plan Type

Service	Indemnity	POS	PPO
Hospice in Hospital	81.5%	77.8%	40.0%
In-Patient Hospice Facility	77.8%	88.9%	20.0%
Hospice in an Extended Care Facility/SNF	48.1%	33.3%	20.0%
In-Home Hospice	77.8%	66.7%	70.0%
Case Management	44.4%	66.7%	50.0%
Respite	40.7%	11.1%	20.0%
Homemaker	55.6%	44.4%	10.0%
Home Health Aide	42.3%	44.4%	50.0%
Individual Counseling	70.4%	88.9%	30.0%
Family Counseling	7.8%	66.7%	40.0%
Equipment	66.7%	44.4%	10.0%
Other Therapies	88.9%	55.6%	30.0%

Source: Jackson B, Gibson T, Staeheli, J. *Hospice Benefits and Utilization in the Large Employer Market*. Washington, DC: The MEDSTAT GROUP, Office of the Assistant Secretary for Planning and Evaluation; March 2000.
Note: Findings based on results from 27 Indemnity plans, 9 Point of Service (POS) plans, and 10 Preferred Provider Organization (PPO) plans.

Table 15: Number of Full-time Equivalent (FTE) Employees and Volunteers Working in Medicare-certified Hospice, 2008 & 2009

Caregiver Type	Employees		Volunteers	
	2008	2009	2008	2009
Counselors	5,064	5,447	1,420	1,447
RNs	29,411	31,548	450	380
LPNs/LVNs	6,107	6,664	127	93
Physicians	3,610	3,830	564	756
MSWs	7,482	7,992	233	224
Homemakers	2,926	3,171	2,584	2,079
HHAs	19,666	21,386	417	333
Other	20,738	22,021	44,010	43,260
TOTAL	**95,004**	**102,058**	**49,805**	**48,571**

Source: CMS, Centers for Medicare & Medicaid Services, Online Survey Certification and Reporting data through December of each year listed.

Table 16: Staff Productivity in Hospice, 2008 & 2009

Job Title	Average Visits per 8-hour Day	
	2008	2009
RN	5.13	5.06
LPN	6.11	5.75
HCA	5.30	5.34
Physical Therapist	5.47	5.49
Occupational Therapist	5.37	5.36
Social Worker	3.30	3.65

Source: *Hospice Salary & Benefits Report 2008-2009* and *Hospice Salary & Benefits Report 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2008 and October 2009.

Table 17: Average Caseload	
Job Title	**National Average**
RN	12.42
LPN	13.02
HCA	12.05
Physical Therapist	8.75
Occupational Therapist	6.75
Social Worker	26.34
Chaplain	13.02

Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.

Table 18: Average Compensation of Hospice Executives, October 2009

	Salary by Percentile		
	25th	50th	75th
Director of Hospice	$95,000	$116,6997	$150,850
Top-Level Financial Executive	$75,057	$90,850	$110,008
Director of Clinical Services	$68,751	$75,000	$85,000
Director of Social Work and Counseling	$55,000	$62,450	$70,000
QI/Utilization Review Manager	$57,100	$67,600	$78,900

Source: *Hospice Salary & Benefits Report 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.

Notes: **Director of Hospice** is the top level position for the hospice and can be the owner**. Top Level Financial Executive** is responsible for direction and coordination activities concerned with financial administration. **Director of Clinical Services** plans and implements, and directs nurses/clinical services. **Director of Social Work and Counseling** is responsible for planning and administering social work and counseling programs and may include supervision of Bereavement Coordinator and Chaplain**.** **QI/Utilization Review Manager** is responsible for coordination of interdepartmental quality improvement activities.

Table 19: Average Hourly and Per Visit Compensation of Selected Hospice Caregivers, October 2009

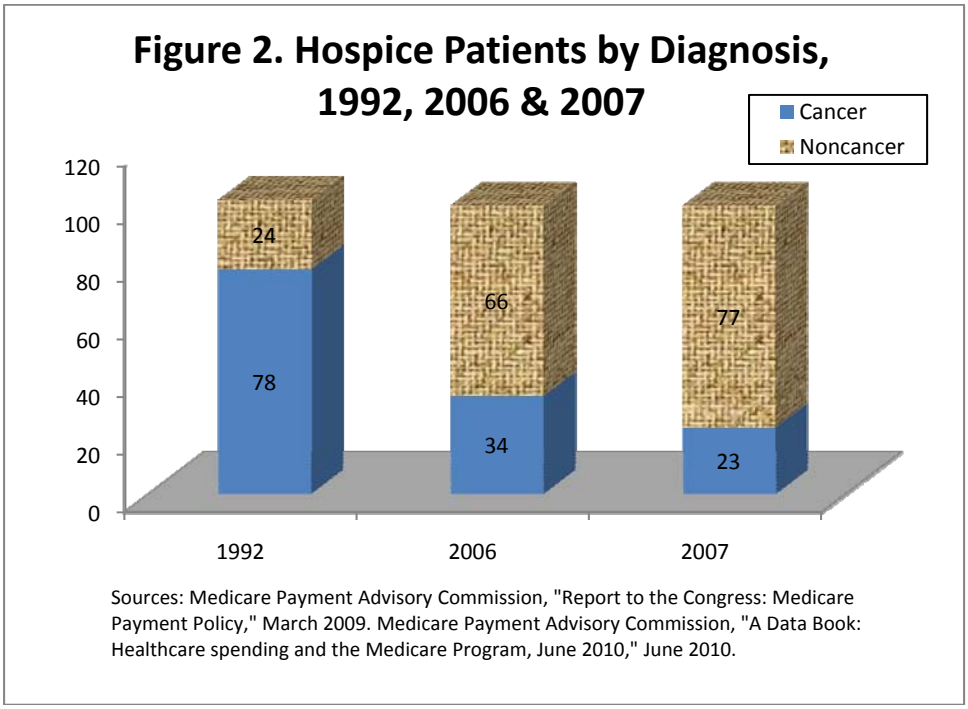
	Per-Hour Rate Range			Per-Visit Rate Range		
	Average Minimum ($)	Average ($)	Average Maximum ($)	Average Minimum ($)	Average ($)	Average Maximum ($)
Registered Nurse (RN)	25.77	28.56	30.64	35.00	38.65	41.15
Practical Nurse (LPN)	17.99	20.36	22.00	23.47	26.27	29.42
Physical Therapist	33.54	36.32	37.94	49.00	54.47	62.00
Social Worker (MSW)	21.87	24.22	26.31	41.50	46.47	53.75
Dir. of Volunteer Services	17.00	20.67	23.80	n/a	n/a	n/a

Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.
Notes: The average rate is based on the reported weighted average of workers with the same job title in an agency. Similarly, the minimum and maximum averages are weighted by agency. **Physical Therapist** organizes and conducts medically prescribed therapy programs involving exercise and other treatments. **Social Worker** identifies and analyzes the social and emotional factors underlying client illness. **Director of Volunteer Services** organizes and directs a program for recruiting and training volunteer workers. **Practical Nurse** is a Licensed Practical Nurse.

Table 20. Characteristics of hospice providers with few institutionalized beneficiaries compared to providers with a large proportion of institutionalized patients

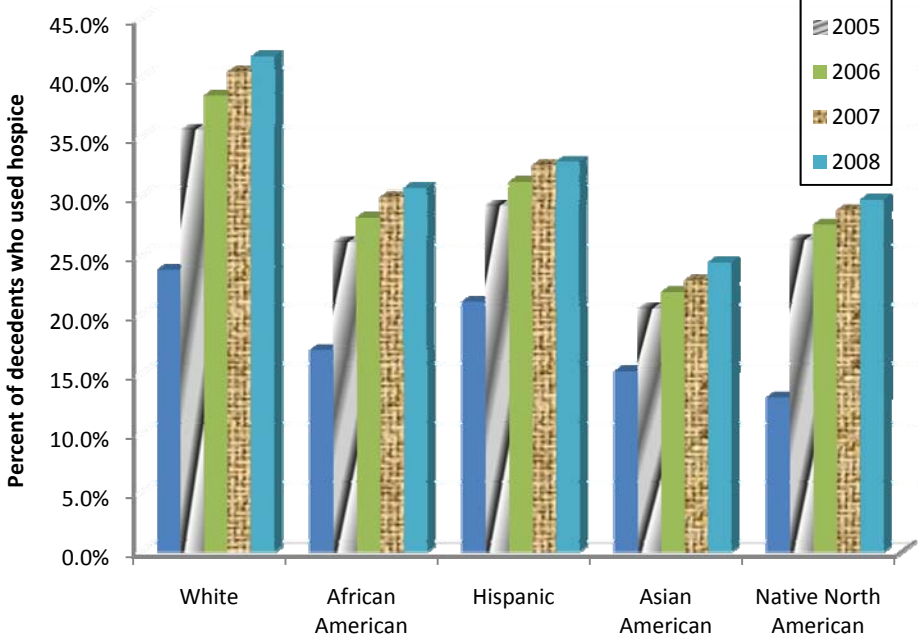
	Low-institutionalized hospices (less than 15 percent institutionalized)	High-institutionalized hospices (more than 40 percent institutionalized)
Number of providers serving institutionalized beneficiaries, 2006	1,329	290
Average percent of institutionalized beneficiaries as proportion of caseload, 2006	9%	52%
Percent, 2006		
Freestanding	57	80
For profit	45	72
Urban	68	74
Average length of episode (in days), 2005	79	117
Percent of stays above 180 days, 2005	14%	24%

Note: Low- and high-institutionalized hospices are defined based on the percent of Medicare patients institutionalized—less than 15 percent and more than 40 percent, respectively. Patients are considered institutionalized if they spent at least 90 days in a nursing facility leading up to or during their hospice stay.
Source: MedPAC analysis of hospice claims and beneficiary data from CMS for 2004, 2005, and 2006.



Sources: Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009. Medicare Payment Advisory Commission, "A Data Book: Healthcare spending and the Medicare Program, June 2010," June 2010.

Hospice Use Has Increased Among All Races



Source: Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*. March 2010. MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

Table 21. Hospice length of stay by diagnosis, 2007		
	Diagnosis share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	23%	10%
Circulatory, except heart failure	11	19
Lung cancer	9	8
Debility, NOS	9	23
Heart failure	8	22
Alzheimer's and similar disease	6	33
Unspecific symptoms/signs	6	23
Chronic airway obstruction, NOS	6	26
Dementia	5	29
Organic psychoses	4	29
Genitourinary disease	3	5
Nervous system, except Alzheimer's	3	31
Respiratory disease	3	12
Other	2	12
Digestive disease	1	9
All	100	19
Source: Medicare Payment Advisory Commission, "A Data Book: Healthcare Spending and the Medicare program, June 2010." June 2010. MedPAC analysis of 100 percent hospice claims Standard Analytical File from CMS. Note: NOS (not otherwise specified). Percent of cases by diagnosis does not sum to 100 due to the exclusion of patients with multiple diagnoses.		

Table 22: Average Visits, Patients, FTEs, and Revenue

	Average Visits	# Unduplicated Patients	# FTEs	Average Revenue	Revenue Per Visit
$0-$4,999,999	12,687	299	24.7	2,035,385	160.43
Over $5,000,000	77,183	1,202	126.8	16,083,967	208.39
All Revenues Combined	38,711	891	56.4	6,291,390	162.52

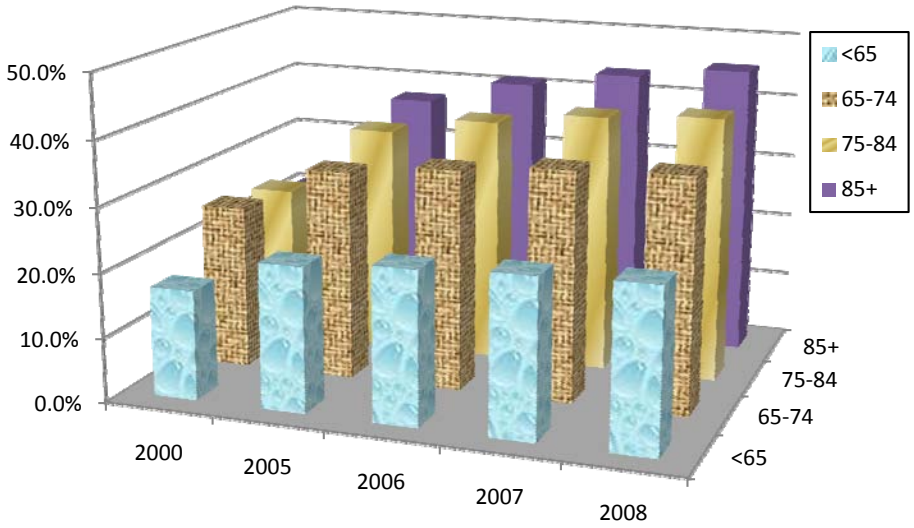
Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.

Table 23. Characteristics of institutionalized and noninstitutionalized Medicare hospice patients, 2006

	Hospice beneficiaries	
Beneficiary characteristics	Institutionalized	Noninstitutionalized
Percent of all hospice beneficiaries	18.0%	82.0%
Percent eligible for Medicare and Medicaid	51.1	16.6
Average age (in years)	84.6	80.0
Percent female	72.5	54.9
Percent of all beneficiaries by diagnosis		
Ill-defined debility	12.7	6.2
Alzheimer's disease	11.8	4.1
Circulatory diseases	11.1	10.7
Dementia	10.5	2.7
Cancer (lung and other)	10.2	41.9
Unspecific symptoms/signs	9.6	4.4
Heart failure	7.2	8.1
Organic psychosis	7.2	2.3
Chronic airway obstruction, not otherwise specified	4.1	5.7
Multiple diagnoses during episode	3.6	2.7
Genitourinary diseases	3.6	3.4
Nervous system	3.4	2.2
Respiratory disease	2.1	2.8
Other	2.0	1.8
Digestive diseases	0.9	1.7

Note: Institutionalized beneficiaries are defined as beneficiaries who spent at least 90 days in a nursing facility leading up to or during their hospice stay.
Source: Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy. March 2009.
MedPAC analysis of hospice claims and beneficiary data from CMS for 2006.

Figure 4. Growth in Hospice Use is Greatest Among Older Decedents



Source: Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy." March 2010.
MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

Table 24: Comparison of Hospital, SNF, and Hospice Medicare Charges, 1999-2009[1]

	1999	2000	2001	2002	2003	2004	2005	2006[1]	2007[1]	2008[1]	2009[1]
Hospital inpatient charges per day	$2583	$2762	$3069	$3574	$4,117	$4559	$4,999	$5,475	$5,895	$6,196	$6,200
Skilled nursing facility charges per day	424	413	422	475	487	493	504	519	558	590	622
Hospice charges per covered day of care	113	112	119	125	129	132	138	141	146	150	153

Sources: The hospital Medicare charge data for 1999-2007 are from the Annual Statistical Supplement, 2008, to the Social Security Bulletin, Social Security Administration. The SNF Medicare charge data for 1999-2005 are from the Annual Statistical Supplement, 2006, to the Social Security Bulletin, Social Security Administration. The hospice charge data for 1999-2007 are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2008.
Notes: [1]Hospital data for 2008 & 2009 are updated using the Bureau of Labor Statistics' (BLS) General medical and surgical hospitals Producer Price Index (PPI). SNF data for 2006- 2009 are updated using the BLS Nursing care facilities PPI. Hospice data for 2008 & 2009 are updated using the BLS Home health care services PPI.

Table 25: Average Percent of Hospice Caseload in SNF or LTC Facility

Region	Avg. %	Region	Avg. %
1	36.80	6	46.43
2	25.12	7	52.43
3	30.31	8	9.01
4	34.55	9	26.45
5	34.25	National	32.83

Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.
Note: Regions used in the survey do not match the regions used by CMS. Region 1: CT, ME, MA, NH, RI, VT. Region 2: NY, NJ, PA. Region 3: DE, DC, FL, GA, MD, NC, SC, VA, WV. Region 4: IL, IN, MI, OH, WI. Region 5: AL, KY, MI, TN. Region 6: IA, KS, MN, MO, NE, ND, SD. Region 7. AR, LA, OK, TX. Region 8: AZ, CO, ID, MT, NV, NM, UT, WY. Region 9: AK, CA, HI, OR, WA.

Table 26: Hospice Residence Staffing, by Percent

RN	LPN	HCA	SW
29.52	23.81	28.57	18.10

Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.

Table 27: Hospice Residence Funding, by Percent

Private Pay	Fundraising	Medicaid
38.96%	37.66%	23.38%

Source: *Hospice Salary & Benefits Report, 2009-2010*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2009.