HOSPICE FACTS & STATISTICS

February 2007

Although the concept of hospice dates to ancient times, the American hospice movement did not begin until the 1960s. The first hospice in the United States, the Connecticut Hospice, began providing services in March 1974. Providing palliative rather than curative care, hospice relies on the combined knowledge and skill of an interdisciplinary team of professionals—physicians, nurses, medical social workers, therapists, counselors, home care aides, and volunteers—who 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 to bring them 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

Medicare identified 3,078 hospices in January 2007. There are also an estimated 200 volunteer hospices in the United States. In 2002, 47 states had licensed hospices.[1] In 2005, hospices served 893,856 Medicare patients.[2] Less is known about hospices that do not participate in Medicare or Medicaid, as rules and regulations for licensure vary by state.

In 1982, Congress created a 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 continued to meet program eligibility requirements.

Beneficiaries must be re-certified as terminally ill at the beginning of each benefit period. The following covered hospice services are provided as necessary for palliative treatment for conditions related to the terminal illness: nursing care, medical social worker services, physician services, counseling (including dietary, pastoral, and other), inpatient care (including both respite care and short-term inpatient care for procedures necessary for pain control and acute and chronic symptom management), home care aide

Table 1. Number of Medicare-certified Hospices, by Auspice, 1984-2004

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

Source: Centers for Medicare & Medicaid Services (CMS), Health Standards and Quality Bureau (February 2007).
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.

and homemaker services, medical appliances and supplies (including drugs and biologicals), physical and occupational therapies, and speech-language pathology services. Bereavement services for families are provided for up to 13 months following a patient's death.

Table 2. Number of Medicare-certified Hospices and Program Payments, by State, 2005

State	Number of Hospices	Number of Persons	Number of Hospice Days	Program Payments ($thousands)
AL	111	24,990	2,685,120	306,047
AK	3	361	20,168	2,997
AZ	50	26,822	1,968,386	286,650
AR	51	8,916	696,300	80,554
CA	186	78,434	4,750,050	736,989
CO	45	13,567	773,216	112,365
CT	29	8,300	330,358	66,374
DE	7	2,950	179,384	24,775
DC	2	808	35,078	5,650
FL	41	84,820	5,583,732	891,919
GA	94	25,402	1,744,480	239,631
HI	7	1,816	92,992	14,915
ID	31	3,728	262,887	32,355
IL	102	33,629	1,794,403	259,560
IN	78	19,768	1,399,419	176,559
IA	68	12,397	708,118	84,761
KS	48	8,943	591,675	73,103
KY	27	11,177	656,515	83,956
LA	86	13,945	902,943	110,978
ME	17	3,197	184,568	24,305
MD	27	11,672	555,964	76,595
MA	60	16,755	927,960	138,049
MI	89	33,486	1,820,628	234,412
MN	63	12,221	758,113	100,864
MS	94	14,194	1,615,669	185,845
MO	85	23,164	1,576,933	183,451
MT	26	2,486	133,460	16,410
NE	32	5,009	321,818	32,666
NV	12	6,955	389,936	63,900
NH	21	3,016	146,168	22,934
NJ	49	21,882	1,103,907	167,156
NM	41	7,139	688,709	76,774
NY	50	32,688	1,637,474	261,147
NC	130	25,883	1,867,203	240,571
ND	15	1,705	99,673	12,016
OH	98	42,755	2,438,710	342,982
OK	143	20,186	2,085,053	240,991
OR	48	14,037	819,236	103,411
PA	138	44,635	2,609,167	332,516
PR	35	7,283	747,722	60,420
RI	8	3,766	184,785	29,368
SC	52	12,669	990,601	117,967
SD	15	1,770	80,545	9,939
TN	54	16,374	1,007,286	132,229
TX	218	64,768	4,498,768	593,810
UT	50	8,355	690,664	89,950
VT	10	1,179	62,462	7,957
VI	2	86	8,206	881
VA	65	16,360	972,604	121,563
WA	32	15,272	808,181	116,955
WV	19	5,254	344,385	42,295
WI	53	16,080	925,391	124,842
WY	18	802	77,582	6,057

Source: Centers for Medicare & Medicaid Services, Health Care Information System (HCIS). February 2007.
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.

The number of people enrolled in Medicare hospice has grown at a dramatic rate, largely as the result of a 1989 Congressional mandate that increased reimbursement rates by 20 percent and tied future increases to the annual increase in the hospital market basket. From 1984 to January 2007, the total number of hospices participating in Medicare rose from 31 to 3,078—a more than 99-fold increase (Table 1). Of these hospices, 1,851 are freestanding, 650 are home health agency-based, 563 are hospital-based, and 14 are skilled nursing facility-based. Table 2 shows the calendar year 2005 distribution of Medicare-certified hospices by state as well as each state's number of patients, total charges, and program payments.

WHO PAYS? HOW MUCH?

National health care expenditures for 2006 are projected at $2,122.5 billion.[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 unreimbursed hospice services for patients with little or no insurance. Table 3 indicates the breakdown of 1998 and 2000 hospice expenditures by source of payment.

Table 3. Distribution of Hospice Primary Payment Source, 1998 & 2000

Source of Payment	1998 Percent	2000 Percent
Medicare	72.4	70.2
Medicaid/MediCal	4.9	4.4
Private Insurance	14.2	9.9
Out of Pocket	3.4	0.2
Other	5.1	0.9
Unknown	n/a	14.4

Source: US Department of Health & Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 2000 National Home and Hospice Care Survey, CD-ROM Series 13, No. 31. July 2002.

According to a June 2006 report from the Medicare Payment Advisory Commission (MedPAC), Medicare spent $6.7 billion on hospice care in 2004. The CMS Office of the Actuary estimates that the Medicare program will spend $9.8 billion on hospice care in 2006. Spending is projected to increase at an average rate of 9 percent per year from 2004 to 2015. During that same period, the number of Medicare beneficiaries is expected to grow at an average annual rate of approximately 2 percent per year.

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In the same June 2006 report, MedPAC states that changes in the use and provision of hospice care suggest that the hospice payment system should be re-evaluated. Such an evaluation would assess whether changes to the benefit structure and payment rates, which were developed 25 years ago, would improve the accuracy of the payment rate. 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. Type of services provided, type of personnel providing the care, and frequency and duration of patient visits are not collected on Medicare claims. Only payment category billed and number of days for each category are currently available. Medicare would have to collect additional data in order to make a comprehensive evaluation of patient costs and service use by hospice patients.

Table 4. Medicare Benefit Payments, FY2006 and FY2007

	2006 (Estimated)		2007 (Projected)	
	Amount ($millions)	Percent of Total	Amount ($millions)	Percent of Total
Total Medicare Benefit Payments*	339,483	100.0	376,441	100.0
Part A				
Hospital care	119,121	35.1	125,510	33.3
Skilled nursing facility	19,236	5.7	20,665	5.5
Home health	5,922	1.7	6,442	1.7
Hospice	8,515	2.5	9,694	2.6
Managed Care	28,668	8.4	39,934	10.6
TOTAL	181,462	53.5	202,545	53.8
Part B				
Physician	57,984	17.1	59,503	15.8
Durable medical equipment	8,191	2.4	8,563	2.3
Carrier lab	3,682	1.1	3,848	1.0
Other carrier	15,269	4.5	16,809	4.5
Hospital	22,119	6.5	23,626	6.3
Home health	7,096	2.1	7,709	2.0
Intermediary lab	3,182	0.9	3,287	0.9
Other intermediary	13,291	3.9	14,141	3.8
Managed care	27,207	8.0	36,409	9.7
TOTAL	158,021	46.5	173,895	46.2

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, FY 2008 President's budget (February 2007).
*Part A total does not include peer review organization payments. Figures may not add to totals due to rounding.

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. Beneficiary copayment for respite care may not exceed the Part A inpatient deductible, which was $952 per year in 2006.

A 2004 Government Accountability Office (GAO) report estimated that the Medicare per diem rate for all hospice care in freestanding 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 was, 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, using 2003 freestanding hospice cost report data, total margins of freestanding hospices varied by agency size and for-profit/nonprofit status. This analysis showed that the median profit margin for large for-profit agencies was 18 percent, but the median for large nonprofits was 2 percent. These total margins were calculated using all payers' payments and all patients' costs, so they may differ from Medicare margins.

The Medicare hospice benefit still represents a small proportion of total Medicare spending. In 2006, an estimated 2.5 percent of Medicare benefit payments were spent on hospice care (Table 4). 2007 projections indicate that hospice care will continue to be a small proportion of total Medicare spending. Approximately 42 percent of the estimated $339 billion in Medicare spending for FY 2006 and 40 percent of the projected $376 billion in spending for FY 2007 will go to hospitals. In FY 2006, approximately 17 percent of Medicare spending will go to physician services, and approximately 16 percent in FY 2007.

With the growth in Medicare-certified hospices, there are concomitant increases in Medicare's total reimbursement to hospices. Table 5 details Medicare-subsidized hospice utilization for FY 2003 by type of hospice. Freestanding hospices served the majority of hospice clients. In contrast,

Table 5. Medicare Hospice Outlays, Clients, and Days per Client, by Type of Agency, FY2003

Auspice	Percent of Outlays	Number of Clients	Average Days per Client
Freestanding	61.2	453,712	62.5
Hospital-based	13.3	107,206	49.7
Skilled nursing facility-based	0.5	3,581	50.7
Home health agency-based	19.0	148,901	48.5
TOTAL	100.0	713,400	57.6

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, Center for Health Plans and Providers (March 2005).
Note: The total for average days per client is weighted by the number of beneficiaries in each hospice type.

skilled nursing facility-based hospices served the fewest number of clients. In 2003, over 41 million aged and disabled persons were enrolled in the Medicare program. The *2006-2007 Hospice Salary & Benefits Report* conducted by the Hospital & Healthcare Compensation Service (HCS) in cooperation with the National Association for Home Care & Hospice (NAHC) is based on data collected in August of 2006 from Medicare certified hospices.

Table 6. Length of Stay

Average # of Days	Median # of Days
61.25	20.81

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

The data show that the average length of stay rose to 61.25 days in 2006 with a median stay of 20.81 days (Table 6). For calendar year (CY) 2005, 893,856 enrollees received hospice services, nearly 15 times the number of hospice recipients in federal fiscal year (FY) 1989 (Table 7; please note that the data on this table, for all years except 2004 and 2005, represent federal fiscal years).

Table 7. Medicare Hospice Outlays, Clients, Days per Client, and Dollar Amount Per Client, FY89-FY2003 and CY2004-CY2005

Fiscal Year	Outlays ($millions)	Number of Clients	Average Days per Client	Average Dollar Amount 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**	*6,717.1*	*797,117*	*65.0*	*8,405*
*2005**	*7,904.4*	*893,856*	*65.3*	*8,843*

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

Medicare hospice expenditures climbed from $205.4 million in 1989 to more than $7.9 billion in CY 2005 (Table 7). Per above, the number of hospice clients increased to 893,856 in CY 2005, and the average length of stay increased slightly from 65.0 days in CY 2004 to 65.3 days in CY 2005. The 2006-2007 HCS Report broke the average visits, patients, FTEs and revenue down into two income categories, $0 to $2,999,999, and over $3 million which shows that the average revenue per visit is higher for the larger agencies (Table 8).

Table 8. Average Visits, Patients, FTEs, and Revenue

	Average Visits	# Unduplicated Patients	# FTEs	Average Revenue	Revenue Per Visit
$0-$2,999,999	24,870	515	22.40	1,543,810	62.06
Over $3,000,000	46,624	1,292	80.30	8,108,287	173.91
All Revenues Combined	38,020	1,080	52.40	4,661,997	122.62

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

Due to an aging population, an increasing interest and concern about end-of-life care, and rising health care costs, the need for Medicare-certified hospices will continue to rise. More important, both medical professionals and the general public are slowly beginning to choose hospice care over other forms of health care delivery because of its holistic, patient-family, in-home-centered philosophy.

MEDICARE'S FUNDING MECHANISMS

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 payment of higher rates in areas with high wage levels, and proportionately lower rates in areas with wage levels below the national average. Industry representatives, including the Hospice Association of America, participated in a negotiated process for rulemaking with the Health Care Financing Administration (HCFA—now CMS—the Centers for Medicare & Medicaid Services) 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 still based on hospital wage data. Medicare hospice rates also vary according to the level of care received by the beneficiary. The FY 2006 published payment rates—adjusted by the hospital market basket index—are as follows. Section 321 of the Benefits Improvement and Protection Act of 2000 included a provision mandating a five percent increase in hospice rates for FY 2001. This increase continues as part of the hospice base rate. Current rates, effective October 1, 2006, are listed below:

Routine Home Care Day: $130.79. This category is for individuals receiving hospice care at home. The rate does not vary by volume or intensity of services

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Continuous Home Care Day: $763.36 for 24 hours, or $31.81 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.

Table 9. 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	Percent of 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).

Inpatient Respite Care Day: $135.30. Care may be provided for no more than five days at a time in an inpatient facility.

General Inpatient Care Day: $581.82. Care may be provided in a Medicare-certified hospital, skilled nursing facility, or inpatient unit of a hospice.

Table 9 illustrates Medicare hospice expenditures and utilization by type of care for FY 2002-FY 2005. Table 10 reveals average Medicare reimbursements per unit of care for the four categories of hospice care and hospice-related physician services for FY 2002-FY 2007.

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, 2006, the cap amount was $20,585.39.

Table 10. Average Medicare Reimbursements for Hospice Care, Selected Years FY2002-FY2007

	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
Routine home care (per day)	$110.06	$114.20	$118.08	$121.98	$126.49	$130.79
Continuous home care (per hour)	26.85	27.77	28.72	29.66	30.76	31.81
Inpatient respite (per day)	114.22	118.13	122.15	126.18	130.85	135.30
General inpatient care (per day)	491.19	508.01	525.28	542.61	562.69	581.82

Source: 2002 data from Health Care Financing Administration (HCFA) Program Memorandum Intermediaries Transmittal #A-01-81 (June 29, 2001). All other data from Centers for Medicare & Medicaid Services (CMS), Center for Health Plans and Providers, 2003 & 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).
Note: Average reimbursements based on total outlays and total units of care.

MEDICAID-FUNDED HOSPICE

As is true for Medicare, hospice services represent a relatively small part of total Medicaid payments. Table 11 shows that, in FY 2003, of the over $234 billion in Medicaid vendor payments, 34.8 percent went to hospital and skilled nursing facility services. Hospice is an optional Medicaid service, currently not available in two states and all five U.S. territories (Table 12). In FY 2003, hospice services comprised only 0.4 percent of total Medicaid payments. Medicaid hospice expenditures totaled $898 million in FY 2003, an increase of 27.2 percent from the $706 million spent in FY 2002 (Table 13).

Table 11. Medicaid Payments, by Type of Service, FY 2002 & FY 2003

	2002 ($millions)	Percent of Total	2003 ($millions)	Percent of Total
Inpatient hospital	29,127.1	13.6	31,549.2	13.5
Nursing home	39,282.2	18.3	40,381.0	17.2
Physician	8,354.6	3.9	9,209.9	3.9
Outpatient hospital	8,470.6	4.0	9,251.9	4.0
Home health[d]	19,287.8	9.0	21,649.3	9.2
Hospice[b]	706.2	0.3	897.6	0.4
Prescription drugs	28,408.2	13.3	33,714.3	14.4
ICF (MR) services[c]	10,681.3	5.0	10,861.2	4.6
Other	69,879.5	32.6	76,589.1	32.7
Total payments[a]	214,197.5	100.0	234,103.5	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, February 2007).
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 2001 was $314.6 million, or 57.6%of the total. In FY 2002, it was $404.7 million, or 57.3%. In FY 2003, it was $534.7 million, or 59.6% 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.

MANAGED CARE AND HOSPICE

Increasingly, health care services in the United States are 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

Table 12. U.S. States and Territories that DO NOT Provide the Medicaid Hospice Benefit, 2006	
States	**Territories**
Connecticut New Hampshire	American Samoa Guam Northern Mariana Islands Puerto Rico Virgin Islands
Sources: Kaiser Family Foundation online (www.kff.org) and state and territory Medicaid offices.	

cover all care provided through the plan. An enrollee's choice of provider and access to specialty care vary under managed care arrangements, but there tend to be incentives for consumers to use certain providers who are part of

Table 13. Medicaid Hospice Outlays, FY87-2002

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

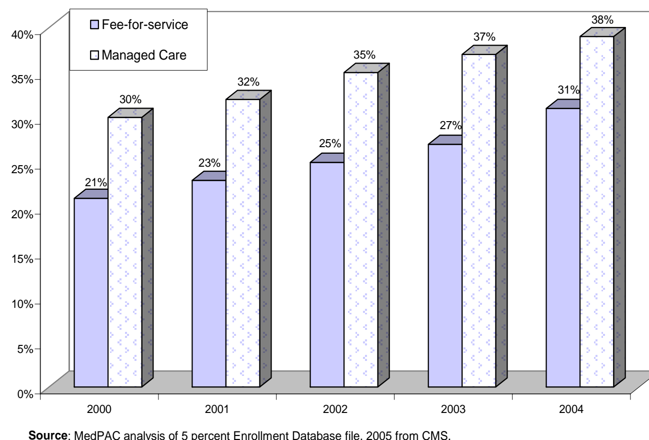
Source: Centers for Medicare & Medicaid Services (Form CMS-64), www.cms.gov, (February 2007).
Note: FY96 totals exclude data for Florida and Hawaii. FY97 totals exclude data for Hawaii. FY99 and FY 2000 totals exclude Medicaid SCHIP.

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 Medicare Payment Advisory Commission (MedPAC) report released in June 2006 revealed that about 38 percent of the individuals in Medicare's managed care plan, Medicare+Choice, chose hospice as opposed to 31 percent of those enrolled in the traditional Medicare benefit at their time of death.[4] (Figure 1)

Managed care is most prevalent in the employer-based health insurance market. In 2002, ninety-five percent of insured workers received health benefits through a managed care plan.[5] 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

Figure 1. Hospice Use for Medicare Decedents, 2000-2004

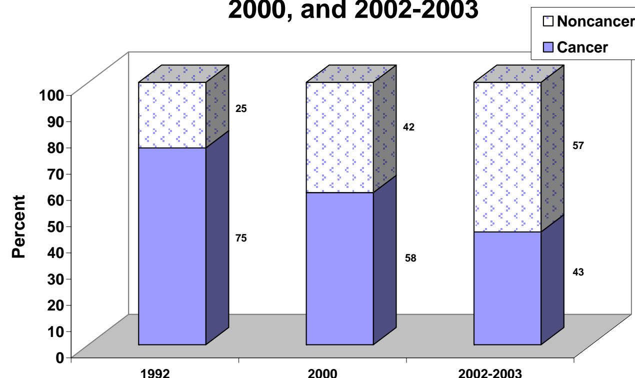


Source: MedPAC analysis of 5 percent Enrollment Database file, 2005 from CMS.

December 31, 2005, 64.07 percent of all Medicaid beneficiaries were enrolled in managed care.[6] Medicare managed care enrollment has increased at a slower pace. As of January 2007, 17.6 percent of Medicare beneficiaries were enrolled in Medicare Advantage.[7]

When a Medicare-eligible patient who is an enrollee of a Medicare participating managed care organization (MCO) 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 MCO, and is not required to disenroll from the MCO. Medicare pays the hospice for its services and the MCO for attending physician services and services not related to the patient's terminal illness. In addition, MCOs are required to inform enrollees about the availability of hospice care if: 1) a Medicare-certified hospice is located in the MCO's service area; or 2) it is common practice to refer patients to hospice programs outside their service area.

Figure 2. Hospice Patients by Diagnosis, 1992, 2000, and 2002-2003



Source: Medicare Payment Advisory Commission, "Report to Congress: Increasing the Value of Medicare," June 2006.

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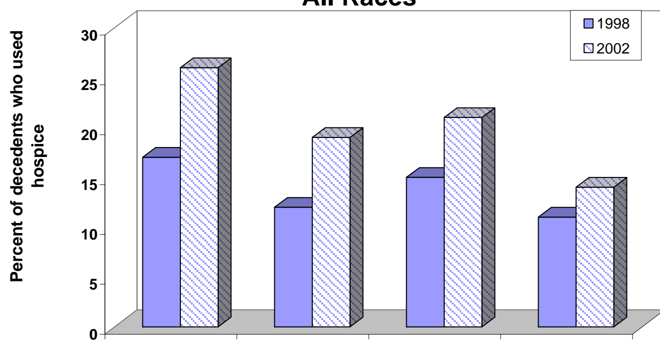
The increasingly competitive health care market has created incentives for hospices to enter managed care provider networks. Hospices have considerable experience managing payments under the Medicare prospective reimbursement system's per-patient cap. Little is known about the extent to which hospices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

WHO ARE HOSPICE PATIENTS?

In a June 2006 MedPAC report, NCHS 2003 data was cited that cancer as the primary hospice diagnosis decreased from 75 percent in 1992 to 58 percent in 2000 and to 43 percent in 2002-2003 (Figure 2). The balance between hospice patients with cancer diagnoses and those with non-cancer diagnoses has shifted dramatically in that 10 year period.

Figure 3. Hospice Use Has Increased Among All Races



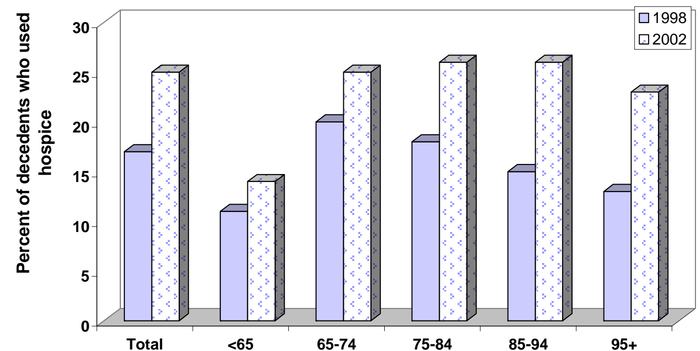
Note: Excludes beneficiaries in managed care. Figure does not show "other" or unidentified race.
Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

MedPAC's June 2004 Report to Congress showed that hospice use among all ethnicities has increased between 1998 and 2002 (Figure 3). White beneficiaries tend to use the hospice benefit more than other ethnicities. Differences in culture and heritage affecting views of death, differences in religion, education, and socialization are also factors that lower minority use of hospice is attributed to, as well as disparities in access to health care services in general.[8]

The median length of enrollment for a beneficiary in hospice decreased from 16 days to 15 days between 2000 and 2004 (Table 14). While short stays remained consistent, the number of days for longer stays increased.[9]

The share of beneficiaries aged 95 or older who died while in hospice care rose from 12 percent to 23 percent between 1998 and 2002 (Figure 4).

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



Note: Excludes beneficiaries in managed care.
Source: MedPAC analysis of 5 percent enrollee database from CMS, 2003.

Hospice use by beneficiaries in nursing facilities grew from 11 percent to 35 percent from 1992 to 2000.[10]

HOW COST-EFFECTIVE IS HOSPICE?

Compared to hospital and skilled nursing facilities, hospice is a cost-effective service. Table 15 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.

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 concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care.[11] 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.

Table 14. Long Stays in Hospice Getting Longer, but Short Stays Persist

	Length of stay (in days)				
	10th percentile	25th percentile	Median	75th percentile	90th percentile
2000	3	6	16	51	130
2004	2	5	15	56	168

Source: MedPAC analysis of 5 percent Enrollment Database file, 2005, from CMS.

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

Table 15. Comparison of Hospital, SNF, and Hospice Medicare Charges, 1998-2006[1]

	1998	1999	2000	2001	2002	2003	2004	2005[1]	2006[1]
Hospital inpatient charges per day	$2,177	$2583	$2762	$3069	$3574	$4,117	$4559	$4,773	$5,036
Skilled nursing facility charges per day	482	424	413	422	475	487	493	521	535
Hospice charges per covered day of care	113	113	118	120	125	129	132	134	136

Sources: The hospital and SNF Medicare charge data for 1998-2004 are from the Annual Statistical Supplement, 2005, to the Social Security Bulletin, Social Security Administration. The hospice charge data for 1998-2004 are from the Health Care Financing Review, Statistical Supplement, Centers for Medicare & Medicaid Services, 2005.
Notes: 1Hospital data for 2005 and 2006 are updated using the Bureau of Labor Statistics' (BLS) General medical and surgical hospitals Producer Price Index (PPI). SNF data for 2005 and 2006 are updated using the BLS Nursing care facilities PPI. Hospice data for 2005 and 2006 are updated using the BLS Home health care services PPI.

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.[12] Hospice use grew from 22 percent of eligible dying in 2000 to 31 percent in 2004.[13] 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.

Table 16. Average Percent of Hospice Caseload in SNF or LTC Facility

Region	Avg. %	Region	Avg. %
1	33.40	6	27.33
2	24.51	7	37.00
3	21.56	8	18.18
4	22.90	9	24.98
5	15.00	National	24.23

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.
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.

IS HOSPICE IN DEMAND?

But more compelling than its cost-effectiveness as a rationale for hospice care is the fact that 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 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.[14] 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. MedPAC's 2004 Report to the Congress noted that the number of hospice patients residing in nursing facilities increased from 11 percent to 36 percent from 1992-2000. 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 16 shows the percent of hospice caseload residing in a SNF or LTC facility.

Table 17. Hospice Inpatient Unit Staffing Ratios

	National Average
RNs to Patients	1 : 8.58
LPNs to Patients	1 : 8.13
HCAs to Patients	1 : 7.60
Social Worker to Patients	1 : 15.49
Chaplains to Patients	1 : 21.36

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

HOSPICES WITH OWN INPATIENT UNITS AND RESIDENCES

The 2006-2007 HCS Report revealed that 33.14 percent of responding hospices have their

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own inpatient unit. The national average bed-size was 18.96 beds (see Table 17 for staff-to-patient ratios). Nearly 27 percent of hospices had their own residence. The average number of residential beds was 14.84 (see Table 18 for how hospices are staffing the residence). Some additional comments included chaplain, volunteers, therapists and bereavement counselors. Table 19 shows how these residences are funded. Some other responses included donations and insurance.

Table 18. Hospice Residence Staffing, by Percent

RN	LPN	HCA	SW
27.06	26.47	25.88	20.59

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

Table 19. Hospice Residence Funding, by Percent

Private Pay	Fundraising	Medicaid
41.94%	29.03%	29.03%

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

HOW ACCESSIBLE IS HOSPICE THROUGH PRIVATE INSURANCE?

Tables 20-23 are from a study sponsored by the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. This study is part of a larger project exploring the use of hospice benefits and services provided through the Medicare program and through private insurance. The MEDSTAT Group's contribution to the larger study is an examination of hospice benefits in commercial plans and the use of hospice benefits by persons commercially insured. In particular, this part of the report focuses on hospice benefits in plans offered by large employers in the U.S. and the utilization of hospice benefits by the employees of these large companies, their dependents, and in some cases early retirees. MEDSTAT's proprietary MarketScan® database is used for all of the analyses in this study. MarketScan includes about 70 employers and 200 insurance carriers/claims administrators. It is a database that represents the health care experience of about four million privately insured individuals annually.

Three complementary approaches to the study of commercially insured hospice patients were taken in this study: an analysis of hospice benefits offered by large employers through an examination of their Summary Plan Description (SPDs) booklets; discussions with selected large employers about their hospice benefits; and a quantitative analysis of hospice use and expenditures of commercially insured individuals.

Of the 52 SPDs selected for analysis, hospice was identified as a covered benefit in 46. Table 20 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.

Table 20. 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.

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 21 represent the proportion of plan types with certain hospice benefit-related criteria. As this table shows, the vast majority of plans provide a definition of hospice and require precertification from a physician to prove terminal illness. All SPDs providing a description of the hospice benefit identified the terminally ill as its

Table 21. 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 22. 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.

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 22 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. The low percentage of point-of-service plans offering hospice services other than in-home hospice care is perplexing.

Table 23. Characteristics of Plans Selected for Study (N=9)				
Plans	**Plan Type**	**Number of Covered Lives**	**Number of Persons Accessing Hospice Benefit 1995**	**Hospice Model**
Employer Plan A	POS	19,533	104	Unbundled
Employer Plan B	PPO	36,805	100	Comprehensive
Employer Plan C	Indemnity	213,922	38	Unbundled
Employer Plan D	Indemnity	114,825	57	Comprehensive
Employer Plan E	Indemnity	36,871	57	Comprehensive
Employer Plan F	Indemnity	40,508	55	Medicare
Employer Plan G	Indemnity	184,115	45	Medicare
Employer Plan H	Indemnity	6,965	19	Comprehensive
Employer Plan I	POS	45,167	0	Unbundled

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.

WHO PROVIDES HOSPICE CARE?

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.

However, CMS collects information on Medicare-certified hospice staff (Table 24). Table 24 demonstrates that the number of volunteers slightly decreased from 2004 to 2005, while the number of employees increased nearly nine percent over the same period of time. A closer look at each caregiver type shows that there tend to be more employees than volunteers in most categories. All Medicare hospice volunteers must participate in intensive volunteer training programs.

Table 24. Number of Full-time Employees and Volunteers Working in Medicare-certified Hospice, 2005 & 2006				
Caregiver Type	**Employees**		**Volunteers**	
	2005	**2006**	**2005**	**2006**
Counselors	3,750	4,171	1,327	1,293
RNs	23,416	26,029	428	417
LPNs/LVNs	4,952	5,826	97	100
Physicians	2,620	3,070	899	877
MSWs	6,013	6,574	164	211
Homemakers	2,332	2,656	2,186	2,343
HHAs	14,755	16,591	753	616
Other	16,111	17,581	36,348	39,937
TOTAL	**73,947**	**82,498**	**42,201**	**45,793**

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

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 2006 survey conducted by the Hospital and Healthcare Compensation Service (HCS), in cooperation with the Hospice Association of America (HAA), collected information from 450 hospices on staff productivity (measured as the number of visits per 8-hour day). Hospice staff conducted from 3.53 visits per day on average for social workers to 6.02 visits per day on average for licensed practical nurses

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(Table 25). Registered nurses provided an average of 5.02 visits per day; physical therapists provided a 5.47 visit average.

Table 25. Staff Productivity in Hospice, 2005 & 2006		
Job Title	**Average Visits per 8-hour Day**	
	2005	**2006**
RN	5.05	5.02
LPN	5.92	6.02
HCA	5.12	5.30
Physical Therapist	5.51	5.47
Occupational Therapist	5.31	5.33
Social Worker	3.36	3.53

Source: *Hospice Salary & Benefits Report 2005-2006* and *Hospice Salary & Benefits Report 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2005 and October 2006.

Social work visits are generally more time-intensive, which may account for the differences by discipline. Table 26 addresses average caseload for visit staff.

Table 26. Average Caseload

Job Title	National Average
RN	12.41
LPN	13.04
HCA	11.16
Physical Therapist	10.14
Occupational Therapist	8.24
Social Worker	25.75
Chaplain	13.04

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.

In the 2006 survey mentioned above, information on salary and benefits provided to employees in 66 job categories, including both administrative and non-supervisory positions, was collected. Summary results for administrators are shared in Table 27. Table 28 provides summary data on the hourly and per-visit compensation rates for hospice caregivers.[15] Table 26 from the 2006-2007 Hospice Salary & Benefits Report gives us the national average caseload for basic hospice caregivers.

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 the death and dying process, hospice will remain marginalized as an excellent option for accessing supportive services during an extremely difficult time.

Table 27. Average Compensation of Hospice Executives, October 2006

	Salary by Percentile		
	25th	50th	75th
Director of Hospice	$70,346	$78,417	$92,700
Top-Level Financial Executive	$63,960	$78,500	$100,880
Director of Clinical Services	$60,320	$67,030	$78,000
Director of Social Work and Counseling	$48,014	$53,600	$60,719
QI/Utilization Review Manager	$54,150	$62,000	$70,000

Source: *Hospice Salary & Benefits Report 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.
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 28. Average Hourly and Per Visit Compensation of Selected Hospice Caregivers, October 2006

	Per-Hour Rate Range			Per-Visit Rate Range		
	Average Minimum ($)	Average ($)	Average Maximum ($)	Average Minimum ($)	Average ($)	Average Maximum ($)
Registered Nurse (RN)	23.15	25.97	28.00	30.00	35.29	38.00
Practical Nurse (LPN)	16.40	18.48	20.42	23.00	26.16	28.00
Physical Therapist	30.02	31.72	34.13	45.00	51.14	55.00
Social Worker (MSW)	19.90	22.33	24.01	40.00	42.37	44.22
Dir. of Volunteer Services	15.00	18.29	20.51	n/a	n/a	n/a

Source: *Hospice Salary & Benefits Report, 2006-2007*, Hospital & Healthcare Compensation Service in cooperation with Hospice Association of America, October 2006.
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.

[1] Hospice Association of America. October 2002.
[2] Centers for Medicare & Medicaid Services, Health Care Information Service, February 2007.
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[14] 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.
[15] To order a copy of the 2006-2007 Hospice Salary & Benefits Report, contact the Hospice Association of America's Publications Department, 228 Seventh Street, SE, Washington, DC 20003-4306; 202/546/4759.

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