NHPCO
National Hospice and Palliative Care Organization

National Alliance for Care at Home

NHPCO Facts and Figures

2024 EDITION

Published September 2024

NHPCO

National Hospice and Palliative Care Organization

For over two decades, the National Hospice and Palliative Care Organization (NHPCO) has published its annual NHPCO Facts and Figures report, providing an overview of hospice care delivery.

At time of this report's publication, NHPCO is in the process of forming a new, joint organization with the National Association for Home Care & Hospice, the National Alliance for Care at Home.

National Alliance for Care at Home

The National Alliance for Care at Home will bring the important work of Facts and Figures forward with an increased focus on data and research representing the broader care-at-home community.

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Please see the Data Sources Section at the end of this report for details on the data sources used within this publication.

The findings in this report reflect only those patients who received care through 2022, provided by the hospices certified by the Centers for Medicare and Medicaid Services (CMS) and reimbursed under the Medicare Hospice Benefit.

Section 1: Introduction

About this Report

NHPCO Facts and Figures provides an annual overview of hospice care delivery. This overview provides specific information on:

- Hospice patient characteristics
- Location and level of care
- Medicare hospice spending
- Hospice provider characteristics
- Quality of care

Currently, most hospice patients have their costs covered by Medicare through the Medicare Hospice Benefit.

Impact of COVID-19

This year, COVID-19 continued to impact patient care as COVID-19 waivers were still in place through May 2023. These waivers included increased telehealth services. Utilization of hospice has not returned to pre-pandemic rates but has increased since 2020 (see Section 3). Due to the impact of COVID-19 on data from 2020, 2020 data is not included in many of the charts this year.

What is hospice care?

Considered the model for quality, compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's private residence, but may also be provided in freestanding hospice facilities, hospitals, nursing homes, assisted living facilities, or other long-term care facilities. Hospice services are available to patients with any terminal illness. Hospice providers promote inclusivity in the community by ensuring all people regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease, or other characteristics have access to high-quality, end-of-life care.

How is hospice care delivered?

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally-ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff are on-call 24 hours a day, seven days a week.

Introduction (continued)

The hospice team develops a care plan to meet each patient's individual needs for pain management and symptom control. This interdisciplinary team (IDT), as illustrated in Figure 1, usually consists of the patient's personal physician; hospice physician or medical director; nurses; hospice aides; social workers; bereavement counselors; spiritual care providers; and trained volunteers. In addition to the IDT, the hospice will support the physical, psychosocial, and spiritual needs of the beneficiary.

What services are provided?

The hospice interdisciplinary team:

- Manages the patient's pain and other symptoms
- Assists the patient and loved ones with the emotional, psychosocial, and spiritual aspects of dying
- Provides medications and medical equipment
- Instructs the informal caregivers on how to care for the patient
- Provides grief support and counseling to the patient as well as the surviving family and friends for up to 13 months after death
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time
- Delivers special services like speech and physical therapy, when needed

Location of Care

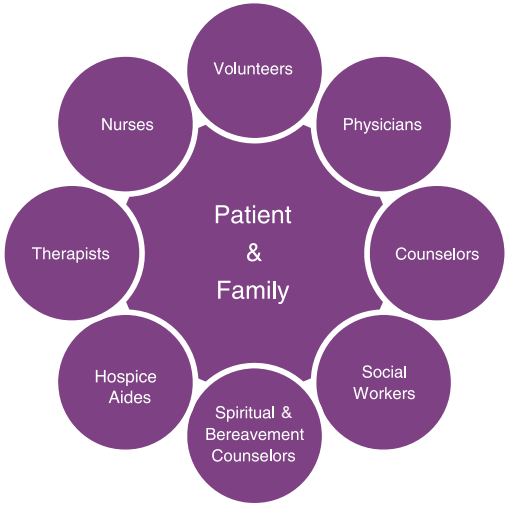
The majority of hospice care is provided in the place the patient calls home. In addition to private residences, this includes nursing homes, assisted living facilities, and residential facilities. Hospice care may also be provided in freestanding hospice facilities and hospitals (see Location of Care).

Levels of Care

Hospice patients may require differing intensities of care during the course of their illness. While hospice patients may be admitted at any level of care, changes in their status may require a change in their level of care.

The Medicare Hospice Benefit affords patients four levels of care to meet their clinical needs: routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the interdisciplinary team, medication, medical equipment, and supplies.

Figure 1: Structure of the interdisciplinary team



- **Routine Home Care (RHC)** is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care at their residence.
- **Continuous Home Care (CHC)** is care provided for between eight and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services intended to maintain the terminally-ill patient at home during a pain or symptom crisis.
- **Respite Care (also referred to as Inpatient Respite Care (IRC))** is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long-term care facility with enough 24-hour nursing personnel present.
- **General Inpatient Care (GIP)** is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility with a registered nursing available 24 hours a day to provide direct patient care.

Introduction (continued)

Volunteer Services

The U.S. hospice movement was founded by volunteers who continue to play an important and valuable role in hospice care and operations. Moreover, hospice is unique as it is the only Medicare benefit which requires volunteers to provide at least five percent of total patient care hours.

Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services to support patient care and clinical services ("clinical support")
- Engaging in a variety of activities such as fundraising, outreach and education, and serving on a hospice's board of directors (general support)

Bereavement Services

Counseling or grief support for the patient and their loved ones is an essential part of hospice care. After the patient's death, bereavement support is offered to families for at least one year. These services can take a variety of forms, including telephone calls, visits, written materials about grieving, phone or video calls, and support groups. Individual counseling may be offered by the hospice, or the hospice may make a referral to a community resource.

Some hospices also provide bereavement services to the community in addition to supporting patients and their families.

Quality of Care

In 2010, the Patient Protection and Affordable Care Act (ACA) mandated the initiation of a quality reporting program for hospices known as the Hospice Quality Reporting Program (HQRP). All Medicare-certified hospices must comply with HQRP reporting requirements; failure to comply results in a percentage point reduction to the Annual Payment Update (APU) for the corresponding fiscal year.

CMS determines the quality measures hospices must report and the processes they must use to submit data for those measures. In addition, data from HQRP measures are displayed on Care Compare, the official CMS website for publicly reported healthcare quality measures. Currently, the measures included in the HQRP are the Hospice Item Set Comprehensive Assessment Measure at Admission, Hospice Visits in Last Days of Life, the Hospice Care Index, and the CAHPS® Hospice Survey.

Veterans

The US Department of Veterans Affairs (VA) provides a hospice benefit as part of the VA Standard Medical Benefits Package. The hospice benefit can be delivered by VA or community providers wherever the enrolled Veteran calls home, including a personal residence, a nursing home, or an inpatient unit. Similar to the Medicare benefit, VA requires the Veteran to have a terminal condition with a prognosis of six months or less if the disease runs its normal course.

Introduction (continued)

Hospice care for Veterans can present unique challenges. Veterans may be facing illnesses intensified by health complications due to toxic exposures or traumatic events and experience a reemergence of traumatic life experiences due to end-of-life symptoms and may deny pain medication or other comfort measures. It is also common for Veterans to choose not to share their military experience with providers due to lack of identification as a Veteran, feelings of shame or guilt related to their service, and subscription to ideals of military stoicism. Each Veteran's experience varies greatly depending on the conflict they served in as well as their age, the location of their service, and their role in the conflict.

Hospice providers caring for Veterans can learn how to accompany and guide Veterans through their life stories towards a more peaceful ending through the We Honor Veterans program (WHV). WHV provides educational tools and resources to:

- Promote Veteran-centric educational activities
- Increase organizational capacity to serve Veterans
- Support development of strategic partnerships
- Increase access and improve quality of care for Veterans in the community

See appendix for details on methodology, limitations, and data sources, including cited references within the report.

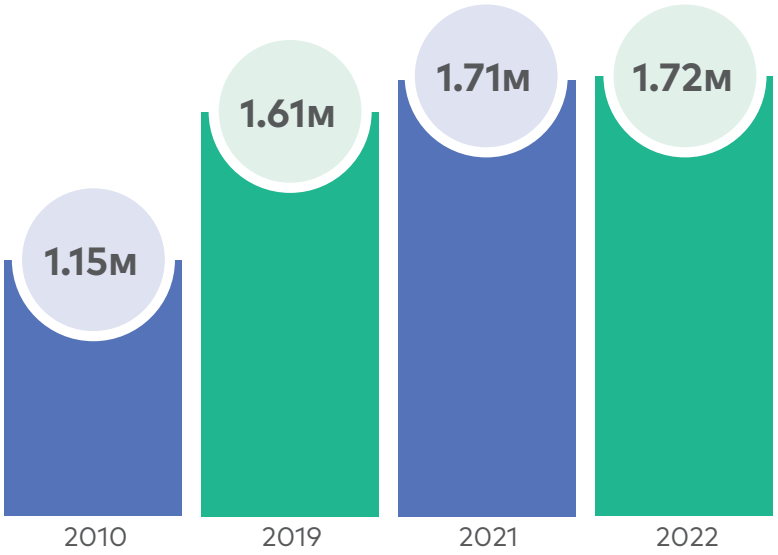
Section 2: Who Receives Hospice Care?

How many Medicare beneficiaries received care?

As seen in Figure 2, 1.72 million Medicare beneficiaries were enrolled in hospice care for one day or more in calendar year (CY) 2022. This is a slight increase from 2021 but approximately equal to 2020. This includes patients who:

- Died while enrolled in hospice
- Were enrolled in hospice in 2021 and continued to receive care in 2022
- Left hospice care alive during 2022 (live discharges)

Figure 2: Number of Medicare hospice users (millions of beneficiaries)



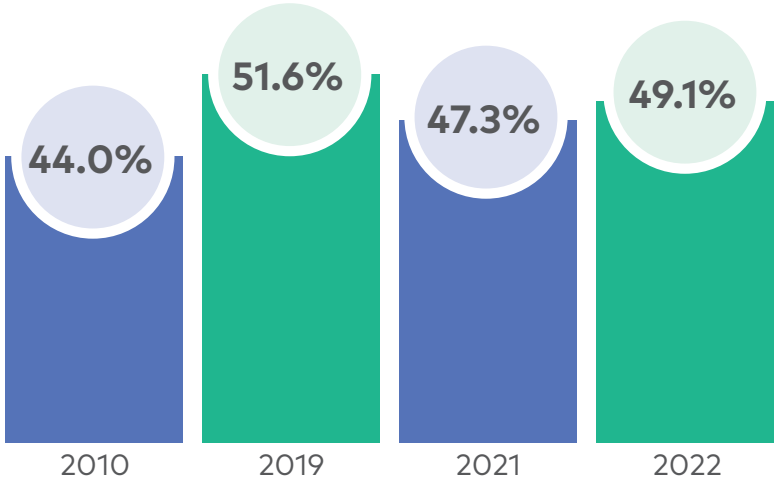
Source: *MedPAC July Data Book, 11-8*

What proportion of Medicare decedents were served by hospice?

Of all Medicare decedents[1] in CY 2022, 49.1% received one day or more of hospice care and were enrolled in hospice at the time of death. This is the first increase in utilization since 2019. Utah had the highest hospice utilization by Medicare decedents (59.61%) and Puerto Rico had the lowest utilization (21.36%

1. Decedents refers to Medicare beneficiaries who have died.

Figure 3: Share of Medicare decedents who used hospice (percentage)



Source: *MedPac March 2024 Report to Congress, Table 9-2*

Who Receives Hospice Care? (continued)

Figure 4: Share of Medicare decedents who used hospice, by state

State	Hospice Beneficiaries	Hospice Utilization
UT	15,126	59.61%
FL	150,304	55.97%
RI	6,528	55.14%
WI	36,900	54.31%
IA	20,029	54.24%
AZ	45,760	54.08%
DE	6,656	54.02%
OH	78,330	52.87%
TX	145,160	52.23%
MN	29,696	52.09%
ID	10,152	51.83%
SC	35,137	51.81%
KS	17,968	51.78%
ME	9,375	50.62%
MI	60,241	49.74%
IN	38,740	49.47%
OR	23,325	49.28%
CO	24,528	49.03%
GA	55,622	48.70%
AL	37,003	48.59%
NC	58,146	48.57%
NE	9,560	48.43%
LA	27,533	48.19%
MO	36,933	47.79%
OK	26,620	47.77%
NH	7,663	47.18%
AR	19,659	47.09%
IL	58,605	46.62%
NV	16,332	46.25%
TN	40,753	46.09%
MA	32,395	46.05%
VA	40,524	45.74%
PA	72,087	45.41%
NM	11,339	45.08%
MD	25,195	44.88%
CT	16,100	44.58%
NJ	37,709	43.99%
CA	176,754	43.98%
HI	6,692	43.77%
VT	3,359	43.36%
SD	3,927	42.85%
MS	19,010	42.56%
WV	11,914	42.15%
KY	22,823	41.44%
WA	29,761	40.96%
MT	4,937	39.43%
WY	2,222	37.71%
ND	2,642	36.24%
VI	384	33.11%
AK	1,299	30.34%
DC	1,561	27.15%
NY	48,618	26.34%
PR	10,278	21.36%

Source: *Hospice Analytics*

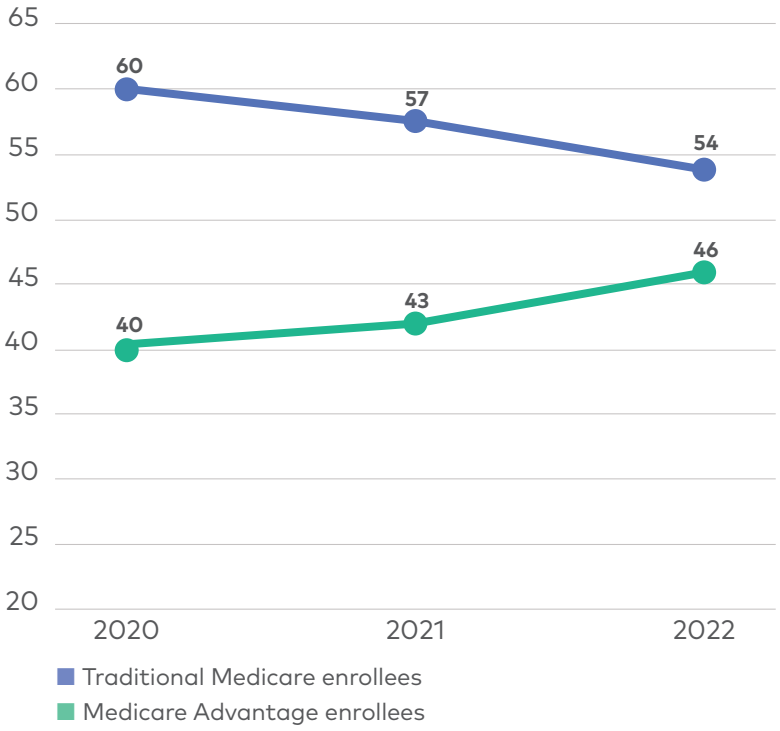
Who Receives Hospice Care? (continued)

What percent of hospice patients were enrolled in Medicare Advantage within the year?

In CY 2022, Medicare Advantage (MA) continued growing into a larger portion of the Medicare population, as seen in Figure 5. A vast majority of MA beneficiaries shift to Traditional Medicare to utilize the Medicare Hospice Benefit. A small sect of beneficiaries who stay with MA for hospice care have value-based insurance design (VBID) plans.

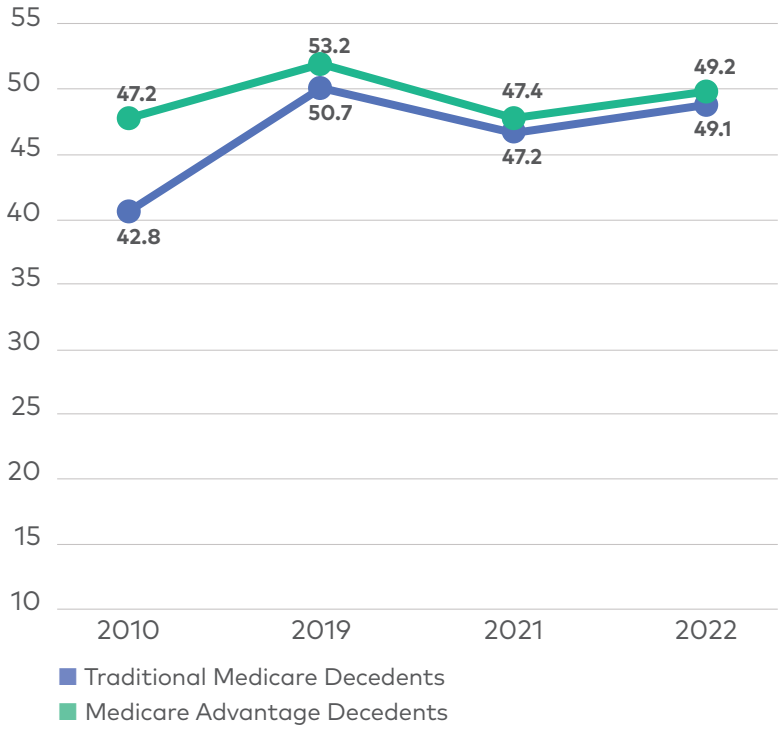
As demonstrated in Figure 6, utilization of the hospice benefit remains slightly higher among decedents enrolled in MA plans than among Traditional Medicare users. Both MA and Traditional Medicare utilization increased from CY 2021 but have yet to return to pre-COVID-19 utilization rates.

Figure 5: Medicare Advantage v. Traditional Medicare beneficiaries (in millions)



Source: *Medicare Enrollment, March 2024 (https://data.cms.gov/tools/medicare-enrollment-dashboard)*

Figure 6: Medicare Advantage v. Traditional Medicare hospice use (percentage)



Source: *MedPac March 2024 Report to Congress, Table 19-2*

Who Receives Hospice Care? (continued)

What are the characteristics of Medicare beneficiaries who received hospice care?

Medicare Beneficiary and Decedent Characteristics

In CY 2022, approximately 2.6 million Medicare (both Traditional and Medicare Advantage) beneficiaries died which includes both the 1.72 million who elected hospice care and those who did not use hospice. When reviewing hospice specific demographic information, it is necessary to understand the larger population of Medicare beneficiaries and decedents as detailed in Table 1 below.

Table 1: CY 2022 Medicare beneficiaries and decedents, by characteristics

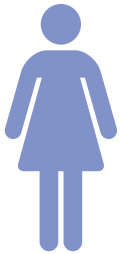
Demographic Characteristic	Total Medicare Enrollees	Decedents
Total	**67,990,335**	**2,649,240**
Age		
Under 65 Years	11,718,703	234,301
65-74 years	33,199,315	672,663
75-84 Years	16,930,722	834,527
85-94 years	5,497,522	735,523
95 years and Over	644,073	172,226
Sex		
Male	31,087,927	1,310,409
Female	36,902,396	1,338,831
Race		
Non-Hispanic White	52,870,608	2,162,178
Black (or African-American)	7,333,277	285,289
Asian/Pacific Islander	1,930,681	50,400
Hispanic	2,346,723	66,708
American Indian/Alaska Native	266,193	13,047
Other	1,425,135	42,852
Unknown	1,817,718	28,766

Source: *Hospice Analytics*

Beneficiary Gender

In CY 2022, when presented with a binary question, beneficiaries who identified as female and died in 2022, 54.3% used hospice. Among beneficiaries who identified as male and died in 2022, 43.8% used hospice. Both groups saw an increase of utilization from 2021 to 2022 greater than the average change from 2010 to 2021.

Figure 7: Share of Medicare decedents who use hospice, by gender



Among Medicare decedents who identified as female

54.3%
used hospice (2022)

Among Medicare decedents who identified as male

43.8%
used hospice (2022)

Source: *MedPac March 2024 Report to Congress, Table 9-2*

This section refers to shares of decedents which is calculated as:

number of beneficiaries in the group who both died and received hospice

total number of beneficiaries in the group who died

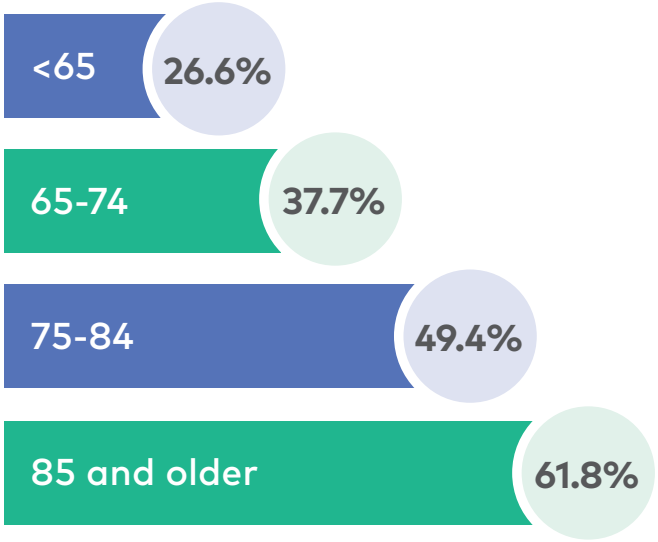
This calculation compares how each group accesses hospice but does not compare size of the groups or health disparities or inequities factors which can impact the those who access Medicare.

Who Receives Hospice Care? (continued)

Beneficiary Age

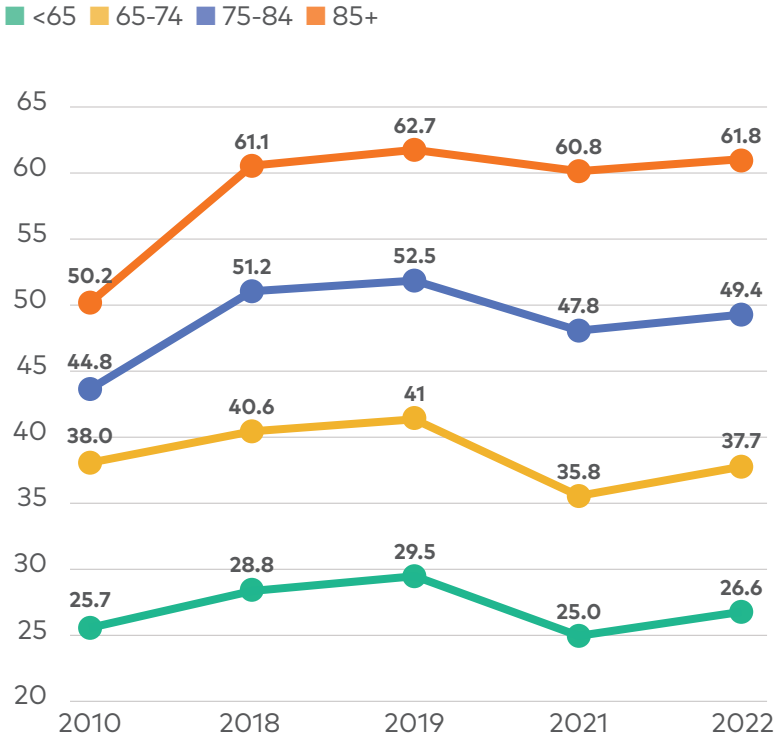
In CY 2022, as shown in Figure 8, 61.8% of Medicare decedents age 85 years and older utilized the Medicare Hospice Benefit, while progressively smaller percentages of decedents in younger age groups received hospice care. Figure 9 highlights the overall increase for all ages groups from CY 2021 to 2022, but utilization has yet to return to pre-COVID-19 rates.

Figure 8: Share of Medicare decedents who used hospice, by age 2022 (percentage)



Source: *MedPAC March 2024 Report to Congress, Table 9-2*

Figure 9: Share of Medicare decedents who used hospice, by age 2010-22 (percentage)



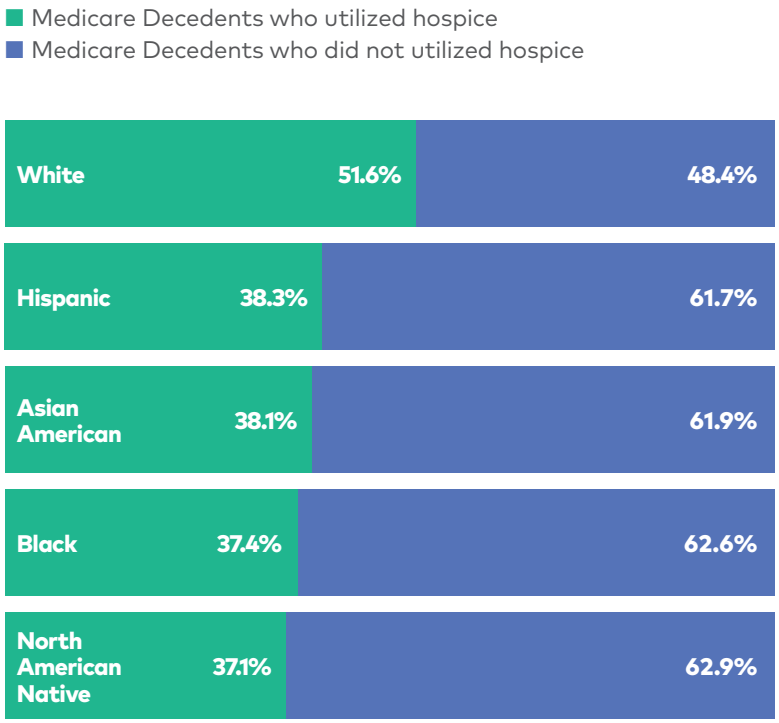
Source: *MedPAC March 2024 Report to Congress, Table 9-2*

Who Receives Hospice Care? (continued)

Beneficiary Race/Ethnicity

In CY 2022, 51.6% of White Medicare decedents used the Medicare Hospice Benefit. 38.1% of Asian American Medicare decedents, and 37.4% of Black Medicare decedents enrolled in hospice. 38.3% of Hispanic and 37.1% of North American Native Medicare decedents used hospice in 2022.

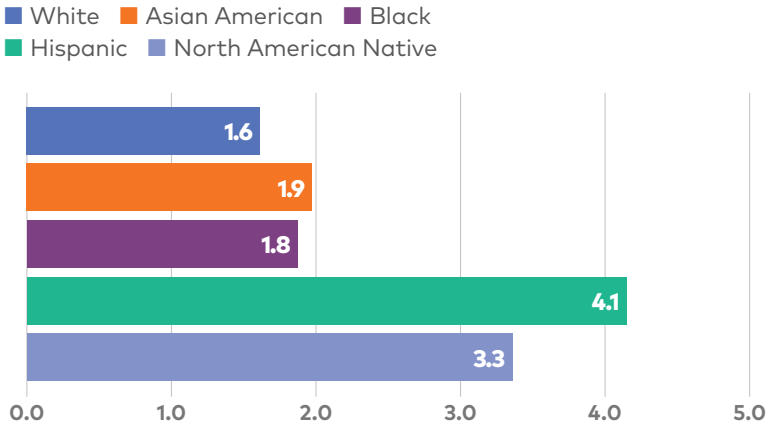
Figure 10: Share of Medicare decedents who used hospice, by race



Source: *MedPAC March 2024 Report to Congress, Table 9-3*

CY 2022 saw an increase in hospice utilizations by all race/ethnicity groups with Hispanic beneficiaries seeing the largest increase. No group has returned to pre-COVID-19 utilization.

Figure 11: Percentage change of decedents who use hospice from 2021 to 2022, by race

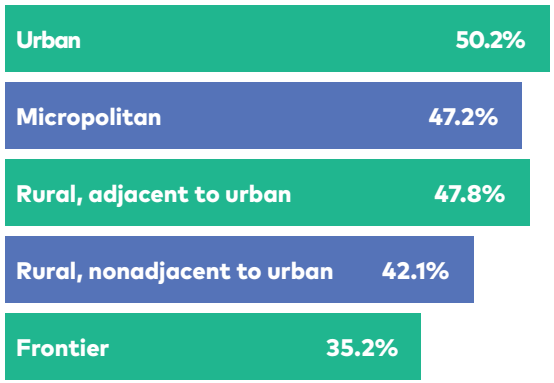


Source: *MedPAC March 2024 Report to Congress, Table 9-3*

Beneficiary Location

In CY 2022, decedent beneficiaries located in an urban area were the only group with over half of decedents using hospice (50.2%); whereas, rural (44.9%, 39.8%) and frontier (33.0%) decedent beneficiaries have much lower rates of utilization. Despite multiple rural classifications, rural decedents near an urban community are more similar to urban decedents, whereas rural decedents not near an urban community have a utilization rate more similar to frontier decedents. However, all groups saw a similar percentage point change from 2021 to 2022 (1.7% to 2.9%).

Figure 12: Share of Medicare decedents who use hospice, by location



Source: *MedPAC March 2024 Report to Congress, Table 9-2*

Who Receives Hospice Care? (continued)

Principal Diagnosis

The principal hospice diagnosis is the diagnosis (based on ICD-10 codes) determined to be the most contributory to the patient's terminal prognosis. Alzheimer's/nervous system disorders/organic psychosis (25%) is the top category of diagnosis for hospice beneficiaries and appears multiple times in the top diagnoses by, ICD-10 code. Cancer and circulatory diseases round out the top three diagnoses groups which account for nearly three-fourths of all hospice beneficiary diagnoses. Although COVID-19 accounts for only 1% of primary diagnoses, it may still have been a secondary or contributory diagnosis.

Table 2: CY 2022 Top 20 Principal Hospice Diagnoses, by ICD-10 code

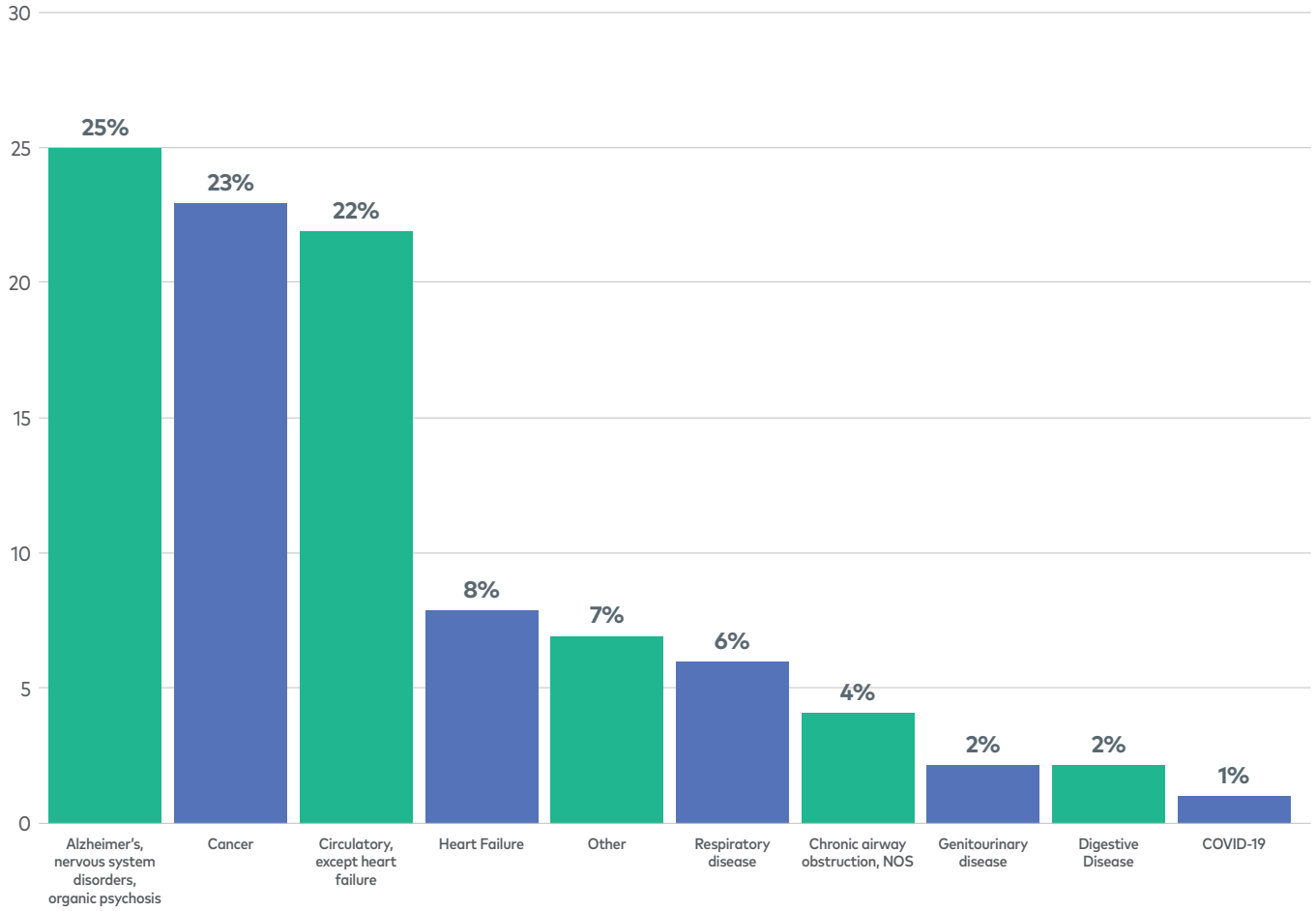
Rank	International Classification of Diseases, Tenth Revision (ICD-10)/ Reported Principal Diagnosis"		Number of Beneficiaries	Percentage of all Reported Principal Diagnoses
1	G311	Senile degeneration of brain, not elsewhere classified	132,665	7.7
2	G309	Alzheimer's disease, unspecified	115,336	6.7
3	J449	Chronic obstructive pulmonary disease, unspecified	74,178	4.3
4	G301	Alzheimer's disease with late onset	61,097	3.5
5	G20	Parkinson's disease	50,977	2.9
6	I509	Heart failure, unspecified	46,806	2.7
7	I2510	Atherosclerotic heart disease of native coronary artery w/o angina pectoris	43,159	2.5
8	I672	Cerebral atherosclerosis	42,583	2.5
9	C3490	Malignant neoplasm of unspecified part of unspecified bronchus or lung	40,948	2.4
10	I110	Hypertensive heart disease with heart failure	36,776	2.1
11	I679	Cerebrovascular disease, unspecified	35,699	2.1
12	E43	Unspecified severe protein-calorie malnutrition	32,976	1.9
13	I130	Hypertensive heart & chronic kidney disease with heart failure and stage 1-4 or unspecified chronic kidney disease	32,194	1.9
14	I639	Cerebral infarction, unspecified	27,188	1.6
15	C61	Malignant neoplasm of prostate	26,676	1.5
16	N186	End stage renal disease	23,695	1.4
17	J9601	Acute respiratory failure with hypoxia	22,129	1.3
18	C259	Malignant neoplasm of pancreas, unspecified	21,678	1.3
19	J441	Chronic obstructive pulmonary disease w (acute) exacerbation	18,992	1.1
20	C189	Malignant neoplasm of colon, unspecified	18,372	1.1

Source: *Hospice Analytics*

Who Receives Hospice Care? (continued)

As seen in Figure 13, patients with a neurological primary diagnosis have the longest average length of stay (159 days) followed by chronic obstructive pulmonary disease (COP) with 135 days. All diagnoses saw increases from 2021 except for COP with a decrease of five days.

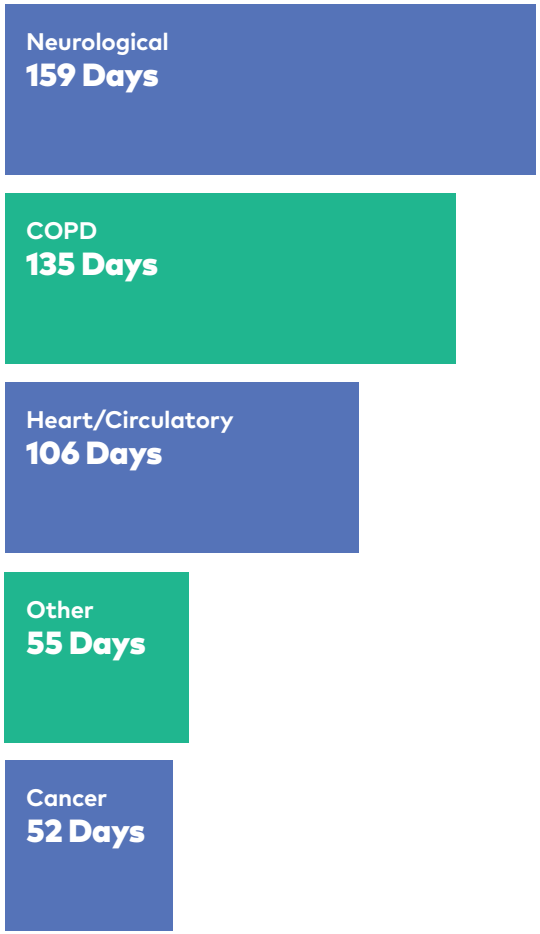
Figure 13: CY 2021 Hospice cases by primary diagnosis (percentage)



Note: *NOS (not otherwise specified). Cases include all patients who received hospice care in 2022, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2022. Subgroups may not sum to 100 percent due to rounding.*

Source: *MedPAC July 2024 Data Book, Chart 11-13*

Figure 14: CY 2021-2022 Average length of stay, in days, by diagnosis



Source: *MedPAC July 2024 Data Book, Chart 11-15; MedPAC July 2023 Data Book, Chart 11-14*

Section 3: How Much Care Is Received?

Length of Stay

The average lifetime length of stay (LOS) for Medicare decedents enrolled in hospice in 2022 was 95.3 days; an increase from 2021 which saw a decrease after a large increase in 2020. The median lifetime length of stay (MLOS) was 18 days which is a return to the norm.

Table 3: Average lifetime length of stay, in days

Year	Average lifetime length of stay among decedents (in days)	Median lifetime length of stay among decedents (in days)	Number of Medicare decedents who used hospice (in millions)
2010	87.0	18	0.87
2019	92.5	18	1.20
2021	92.1	17	1.29
2022	95.3	18	1.30

Note: *"Lifetime length of stay" is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.*

Source: *MedPAC March 2024 Report to Congress, Table 9-3*

Days of Care by Length of Stay in 2022

- 10% of patients were enrolled in hospice for two days or less.
- 25% of patients were enrolled in hospice for five days or less.
- 50% of patients were enrolled for 18 days or less.
- 75% of patients were enrolled for 84 days or less.
- The top 10% of patients were enrolled for more than 275 days.

Figure 15: CY 2021 days of care by length of stay, in days

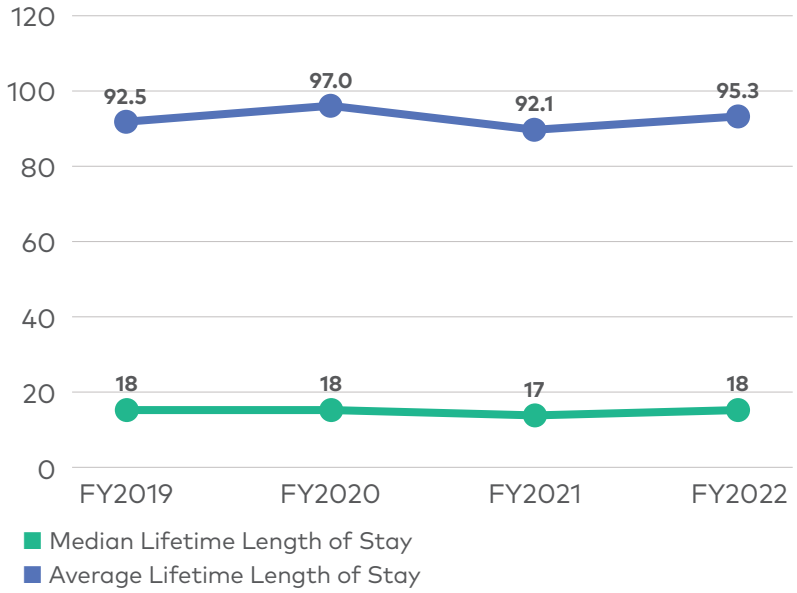
Source: *MedPAC July 2024 Data Book, Chart 11-15*

How Much Care Is Received? (continued)

Days of Care

Figure 16 depicts the variation in length of stay between median and average lifetime (includes all elections of hospices). The difference in the median and the average shows how despite some patients having very long lengths of stay (due to a variety of factors), most patients have a short length of stay on hospice.

Figure 16: Average lifetime lengths of stay and median lifetime lengths of stay, in days, FY 2019 - 2022



Source: *MedPAC July 2024 Data Book, Chart 11-14*

Discharges

In CY 2022, 17.3% of all Medicare hospice discharges were live, which was flat from 2021 and at the pre-COVID-19 level. Only discharges for moving out of services saw an increase in 2022.

Table 4: Rates of hospice live discharge and reported reason for discharge, CY 2020–2022 (percentage)

Reason for Discharge	2020	2021	2022
All live discharges	15.4%	17.2%	17.3%
Patient-Initiated Live Discharges			
Revocation	5.7	6.3	6.1
Transferred hospice providers	2.2	2.4	2.4
Hospice-Initiated Live Discharges			
No longer terminally ill	5.6	6.3	6.1
Moved out of service area	1.6	2.0	2.3
Discharged for cause	0.3	0.3	0.3

Source: *MedPAC July 2024 Data Book, Chart 11-19*

How Much Care Is Received? (continued)

Location of Care

Average length of stay by location of care, as shown in Figure 17, was 98 days at a private residence, 109 days in nursing facilities, and 165 days in assisted living facilities. Median length of stay by location of care, shown in Figure 18, was 25 days at a private residence, 22 days in nursing facilities, and 55 days in assisted living facilities. The variance between average and median lengths of stay indicates that although some patients have long lengths of stay, most patients have short hospice stays.

Figure 17: Average length of stay by location of care, in days

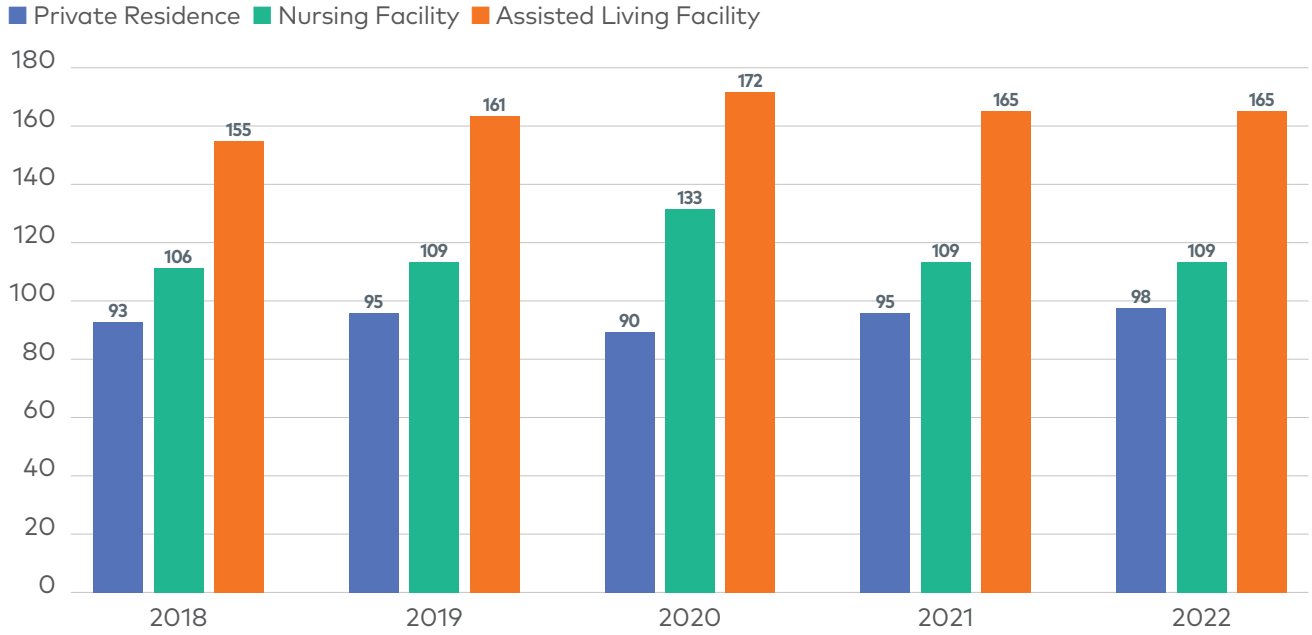
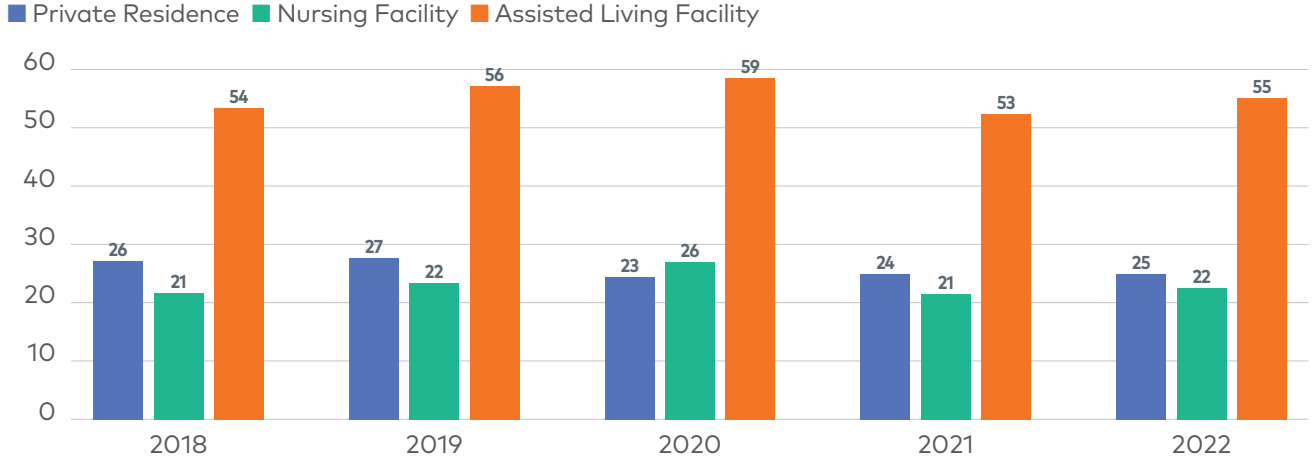


Figure 18: Median days by location of care, in days

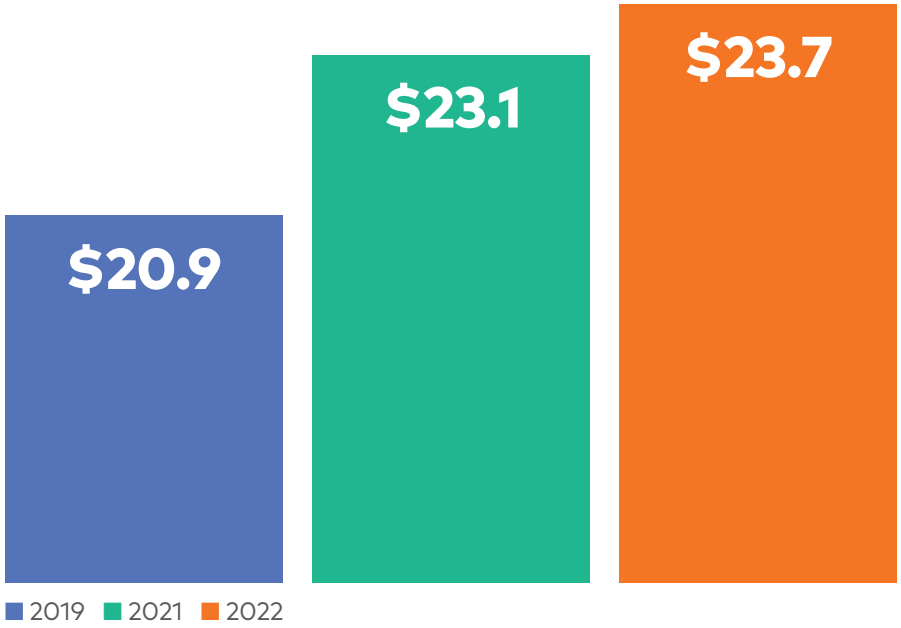


Source: *MedPAC July 2024 Data Book, Chart 11-15; MedPAC March 2022 Report to Congress, Table 11-7*

Section 4: How Does Medicare Pay for Hospice?

Medicare paid hospice providers a total of $23.7 billion dollars for care provided in CY 2022, representing an increase of 2.7% over the previous year. This is slower growth compared to 2019-2021 but similar growth from 2020-2021.

Figure 19: Medicare spending (billions of US dollars)



Source: *MedPAC March 2024 Report to Congress, Table 9-3*

Spending by Level of Care

In CY 2022, the vast majority of Medicare days of care were at the routine home care (RHC) level of care for both payments made and days of care provided.

Table 5: Percent of payment, by level of care

Percent of Payment by Level of Care	Total payment (in billions)	Percentage of payment
Routine home care	21.55	93.78%
General inpatient care	1.14	4.96%
Inpatient respite care	0.15	0.67%
Continuous home care	0.14	0.60%

Table 6: Percent of days, by level of care

Percent of Days by Level of Care	Total number of days (in millions)	Percentage of day
Routine home care	128.32	98.78%
General inpatient care	1.14	0.88%
Inpatient respite care	0.35	0.27%
Continuous home care	0.09	0.07%

Source: *Hospice Analytics*

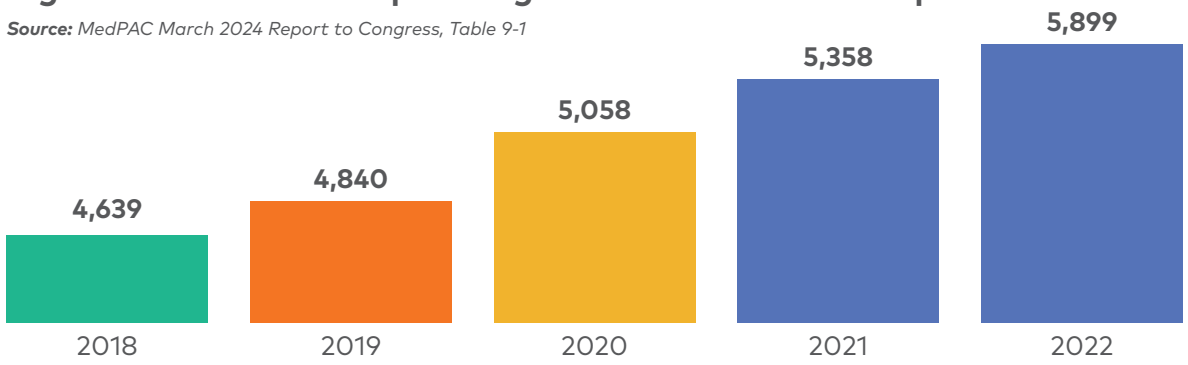
Section 5: Who Provides Care?

How many hospices were in operation in 2021?

In CY 2022, there were 5,899 Medicare certified hospices in operation based on claims submitted. This is an increase of over 500 hospices since 2021 and outpaced the average annual percent change since 2018.

Figure 20: Number of operating Medicare certified hospices

Source: *MedPAC March 2024 Report to Congress, Table 9-1*



What are the characteristics of Medicare certified hospices?

As shown in Table 7, the growth in hospice ownership in CY 2022 is being driven by the growth in for-profit (10.1%), freestanding (9.0%), and urban providers (11.1%). The largest decreases were with nonprofit (-2.2%), hospital based (-3.3%), and rural providers (-2.1%).

Table 7: Characteristics of Medicare certified hospices

Category	2020	2021	2022	Percent change 2018–2021	Percent change 2021–2022
For profit	3691	4008	4414	7.4%	10.1%
Nonprofit	1220	1195	1169	-1.4%	-2.2%
Government	146	143	141	-3.5%	-1.4%
Freestanding	4189	4511	4919	6.8%	9.0%
Hospital based	413	396	383	-4.4%	-3.3%
Home health based	437	434	421	-2.1%	-3.0%
SNF based	19	17	17	-8.2%	0.0%
Urban	4196	4505	5006	6.2%	11.1%
Rural	853	845	827	-1.0%	-2.1%

Source: *MedPAC March 2024 Report to Congress, Table 9-1*

Figure 21: Tax status

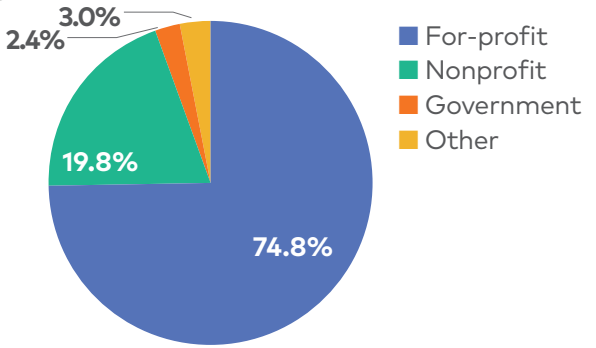


Figure 22: Hospice structure

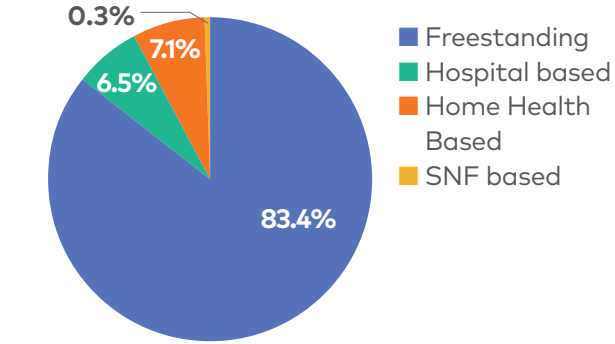
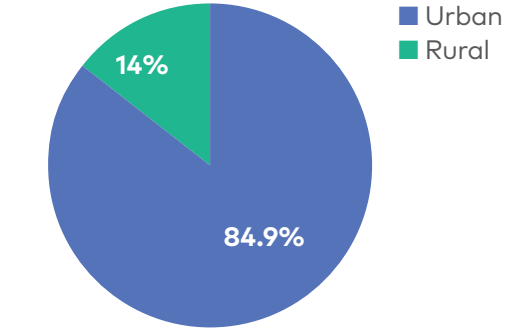


Figure 23: Hospice location



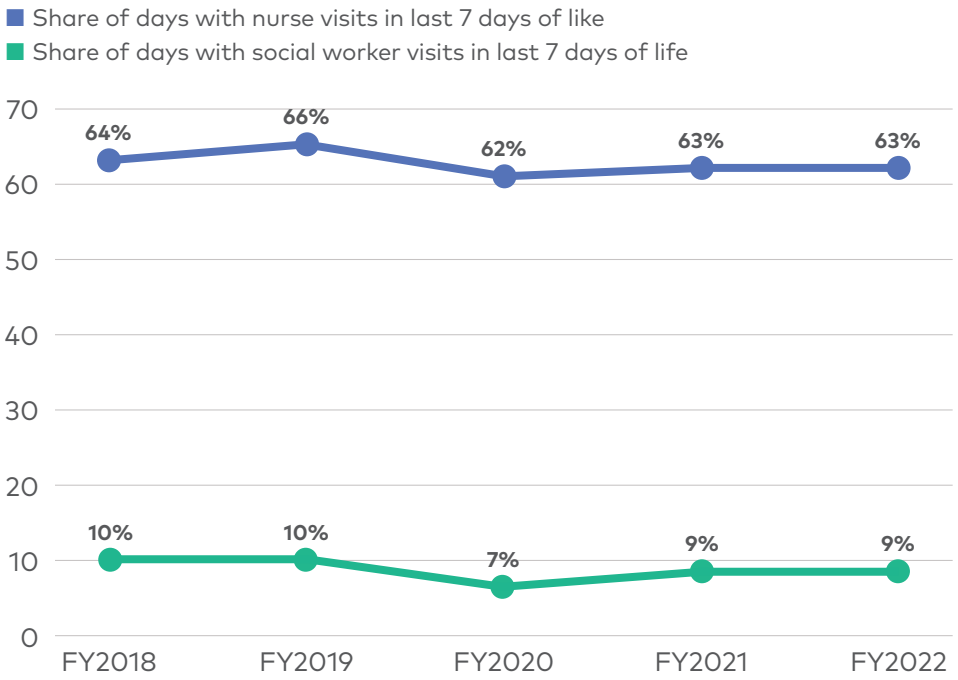
Source: *MedPAC March 2023 Report to Congress, Table 10-2*

Section 6: What is the Quality of Hospice Care?

Scores on publicly reported quality measures were generally stable in the most recent reporting period. Scores for the Hospice Item Set Comprehensive Assessment Measure increased slightly, while scores for the ten components of the composite Hospice Care Index show 15% of providers with publicly available data were outliers on three or more measures, and 2% were outliers on five or more.

Visits in the last days of life by both nurses and social workers were steady in CY 2022 but continue to remain below pre-COVID-19 levels, and performance continues to vary widely among providers. Hospice Visits in Last Days of Life measures the percentage of patients who received a visit from a registered nurse or social worker on at least two of the last three days of life. Scores from providers who met criteria for public reporting of the measure vary from a 25th percentile of 40% to a 75th percentile of 75%.

Figure 24: Share of days with visits in last seven days of life (percentage)

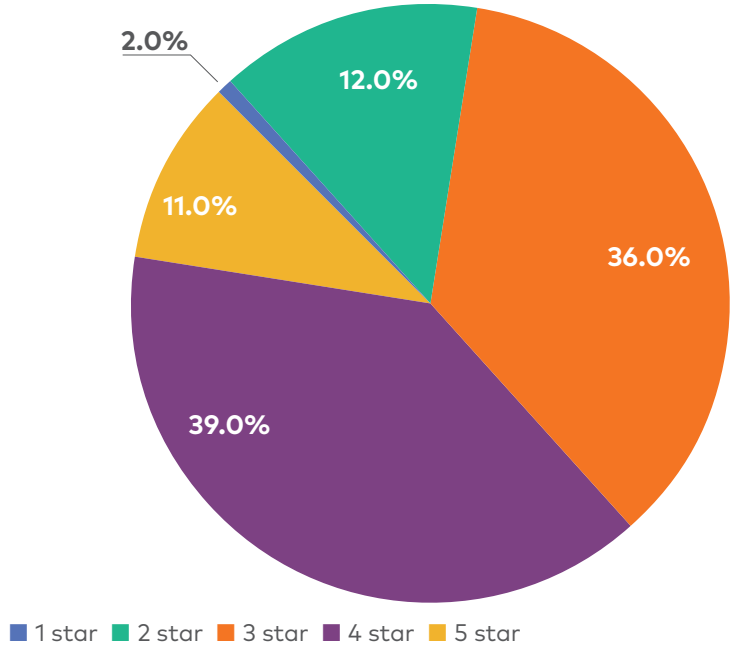


Source: *MedPAC March 2024 Report to Congress, Table 9-8*

The CAHPS® survey assesses the experiences of patients who died while receiving hospice care and their primary informal caregivers. The CAHPS Hospice Survey provides Hospice Survey Star Ratings for hospices with at least 75 survey responses in a reporting period.

In the most recently available data (January 2021 – December 2022), 50.0% of participating providers received four or five stars on the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey, which represents a 1% increase over the prior reporting period. However, Star Ratings were available for fewer than half of providers (2,046). Survey data from the same reporting period shows that 81% of caregivers rated the hospice as a 9 or 10 out of 10, and 84% said they would definitely recommend the hospice.

Figure 25: Breakdown of hospice star ratings (percentage)

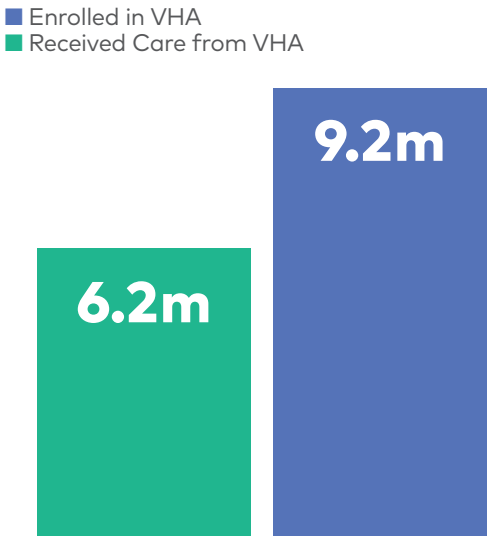


Source: *MedPAC March 2024 Report to Congress*

Special Focus: Veterans

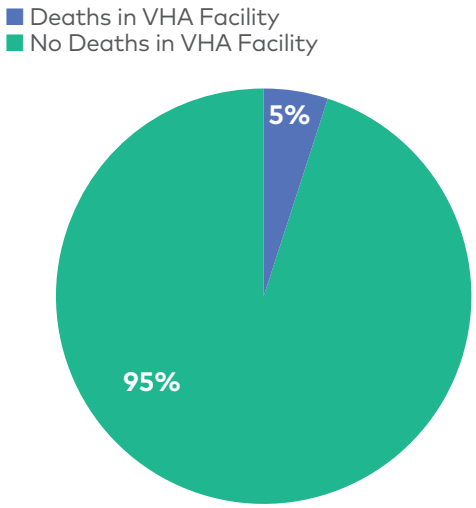
In FY 2023, the Veterans Administration (VA) paid for 48,194 Veterans to receive home hospice care from VA contracted providers compared to 13,316 from community providers. This was a substantial decrease for both VA and community providers since FY 2022. With roughly half of all living US Veterans enrolled in the Veterans Health Administration (VHA) and only 5% of Veteran deaths occurring in VHA facilities, this figure is limited in summarizing the full breadth of US Veterans receiving end-of-life care.

Figure 26: Veterans' Use of VHA (in millions)



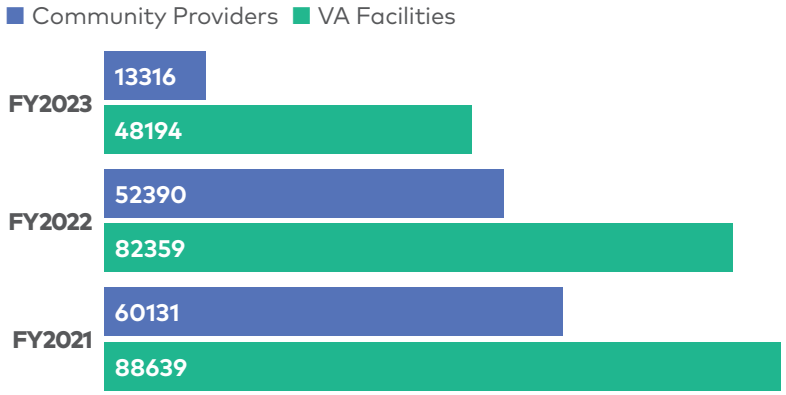
Source: *Congressional Budget Office. The Veterans Community Care Program: Background and Early Effects. October 2021. Washington, D.C.*

Figure 27: Deaths in VHA facilities



Source: *O'Malley, Kelly A. PhD; Baird, Lola MSW; Kaiser, Anica Pless PhD; Bashian, Hannah M. PhD, MEd; Etchin, Anna G. PhD, RN; Sager, Zachary S. MD; Heintz, Hannah BA; Korsun, Lynn BA; Kemp, Katherine; Moye, Jennifer PhD. Maximizing Veterans Health Affairs Community Hospice Collaborations: Review of Perceived Resource Needs to Support Veterans at End of Life. Journal of Hospice & Palliative Nursing 26(1):p 21-28, February 2024.*

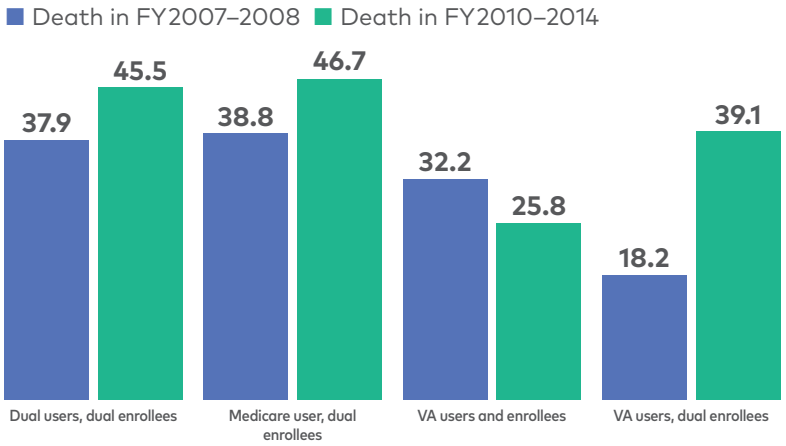
Figure 28: VA funded hospice patients, by location



Source: *U.S. Department of Veterans Affairs FY 2023, FY 2024, and FY 2025 Budget Submissions*

Veterans can be eligible for both Medicare and VA health benefits; dually eligible Veterans have the right to elect either Medicare or VA as the payer to cover hospice care, and can use both or just one. Between FY 2010 and FY 2014, Veteran decedents who were enrolled in both but used only Medicare had the highest utilization rate, followed by Veteran decedents who were enrolled in both and used both.

Figure 29: Hospice utilization, by type of enrollee



Source: *U.S. Department of Veterans Affairs FY 2023, FY 2024, and FY 2025 Budget Submissions*

Special Focus: Veterans (continued)

In FY 2023, the VA paid $165.80 million for home hospice care, a substantial increase from FY 2022 ($21.52 million). The number of visits and cost per visit increased in FY 2023 as well.

Table 8: VA payments for Hospice

	FY 21	FY 22	FY 23
Payments	$30,977,000	$21,521,000	$165,795,000
Clinical encounter/visit	577,064	460,876	727,350
Cost per clinic stops/procedures	$53.62	$46.70	$227.94

Source: *U.S. Department of Veterans Affairs FY 2023, FY 2024, and FY 2025 Budget Submissions*

Figure 30 VA hospice funding, by location

Note: *The reason for the large increase in funding and clinical encounter is unclear based on the VA budget documents.*

Source: *U.S. Department of Veterans Affairs FY 2023, FY 2024, and FY 2025 Budget Submissions*

Appendix

Citations

CMS Program Statistics – Medicare Deaths

Congressional Budget Office. The Veterans Community Care Program: Background and Early Effects. October 2021. Washington, D.C.

Hospice Analytics

MedPAC March 2024 Report to Congress, Chapter 9: Hospice services

MedPAC July 2024 Data Book, Section 11: Other services

Miller SC, Intrator O, Scott W, Shreve ST, Phibbs CS, Kinosian B, Allman RM, Edes TE. Increasing Veterans' Hospice Use: The Veterans Health Administration's Focus On Improving End-Of-Life Care. Health Aff (Millwood). 2017 Jul 1;36(7):1274-1282. doi: 10.1377/hlthaff.2017.0173. PMID: 28679815.

O'Malley, Kelly A. PhD; Baird, Lola MSW; Kaiser, Anica Pless PhD; Bashian, Hannah M. PhD, MEd; Etchin, Anna G. PhD, RN; Sager, Zachary S. MD; Heintz, Hannah BA; Korsun, Lynn BA; Kemp, Katherine; Moye, Jennifer PhD. Maximizing Veterans Health Affairs Community Hospice Collaborations: Review of Perceived Resource Needs to Support Veterans at End of Life. Journal of Hospice & Palliative Nursing 26(1):p 21-28, February 2024. | DOI: 10.1097/NJH.0000000000000980

VA President's Budget Request – FY 2023, 2024, and 2025 Budget Submissions

Limitations

For this report, only sources with comprehensive national level claims data were utilized. More detailed information may be available but did not include all Medicare hospice claims for the time period of this report's review.

In addition, data reported may be in calendar year (January through December) or fiscal year (October through September).

Finally, the data utilized is limited by the format of data collected by the Centers for Medicare and Medicaid Services; specifically, the limited language describing gender and race/ethnicity.

Questions May Be Directed To:

National Alliance for Care at Home
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Web: www.AllianceForCareAtHome.org

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Suggested Citation:

2024 Edition: Hospice Facts and Figures. Alexandria, VA: National Alliance for Care at Home.

SEPTEMBER 2024

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