NHPCO Facts and Figures

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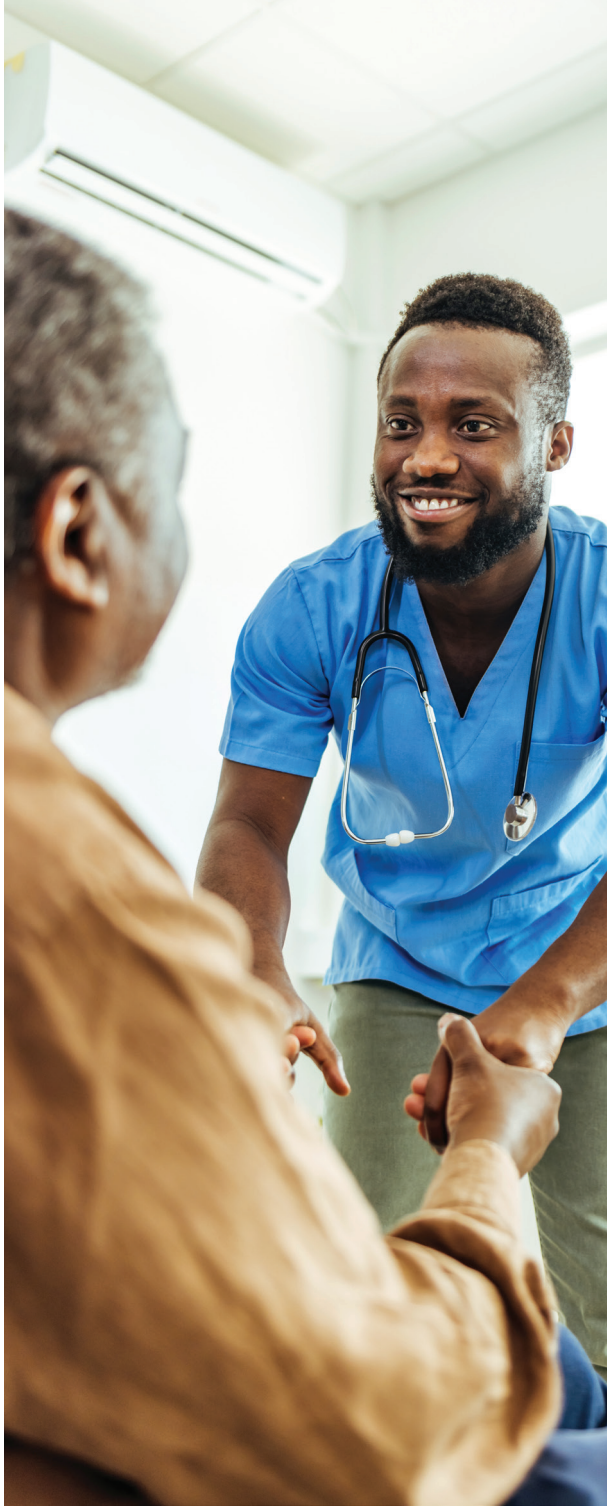

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The findings in this report reflect only those patients who received care through 2021, provided by the hospices certified by the Centers for Medicare and Medicaid Services (CMS) and reimbursed under the Medicare Hospice Benefit.

Section 1: Introduction

About this Report

NHPCO Facts and Figures provides an annual overview of hospice care delivery in the United States. 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 continues to see the impact of COVID-19 on patient care and the effect of the COVID-19 waivers on the traditional delivery of hospice care. These waivers included increased telehealth services. 2020 saw decreases in hospice usage in many areas due to the number of deaths outpacing hospice use (see Section 3).

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. Hospices 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 hospice services.

How is hospice care delivered?

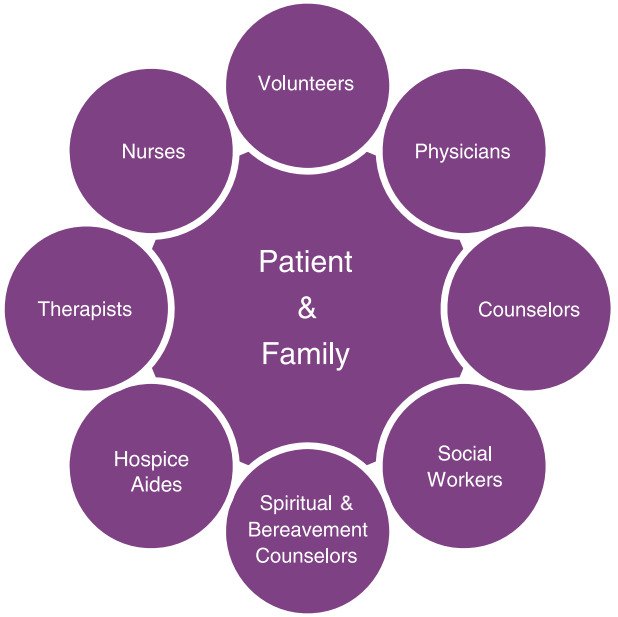
Typically, a loved one serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide

Introduction (continued)

additional care or other services. Hospice staff are on-call 24 hours a day, seven days a week.

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 physical, psychosocial, and spiritual needs of the beneficiary.

Figure 1: Structure of the interdisciplinary team



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 Levels 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.

Introduction (continued)

- **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.

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 provider 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.

Introduction (continued)

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.

Medicare Advantage Value-Based Insurance Design (VBID)

The Medicare Advantage (MA) value-based insurance design (VBID) is a model with the goal of providing innovation, more choices, and high-quality, person-centered care to Medicare beneficiaries. The hospice benefit component (sometimes referred to as the hospice carve-in) in MA plans participating in VBID must include palliative care and transitional concurrent care in addition to hospice services. The palliative and concurrent care eligibility and services are designed by each MA organization. The Hospice Benefit component began in 2021 and is currently set to end in 2030.

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, 1.71 million Medicare beneficiaries were enrolled in hospice care for one day or more in calendar year (CY) 2021. This is flat from 2020. This includes patients who:

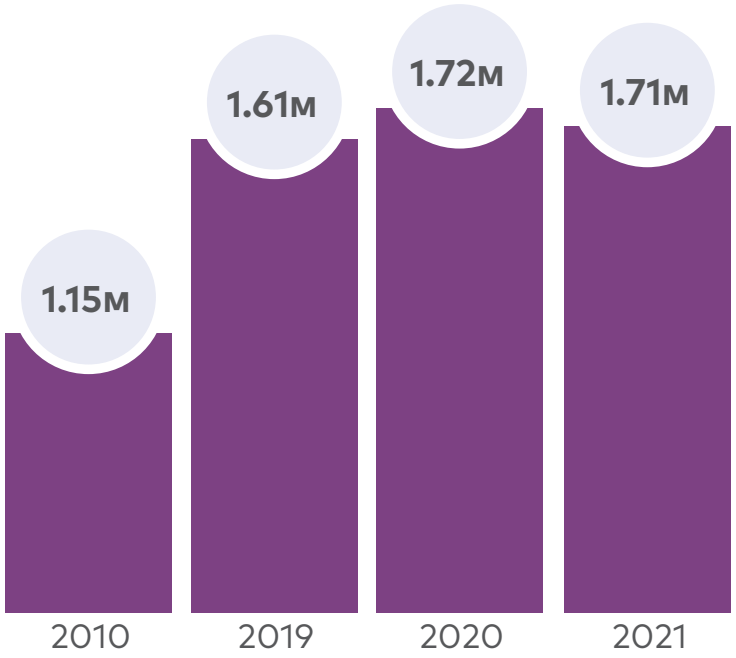
- Died while enrolled in hospice
- Were enrolled in hospice in 2020 and continued to receive care in 2021
- Left hospice care alive during 2021 (live discharges)

What proportion of Medicare decedents were served by hospice?

Of all Medicare decedents[1] in CY 2021, 47.3% received one day or more of hospice care and were enrolled in hospice at the time of death. This continues the downward trend from 2020. This decrease was likely due to death continuing to outpace the growth in hospice due to COVID-19.

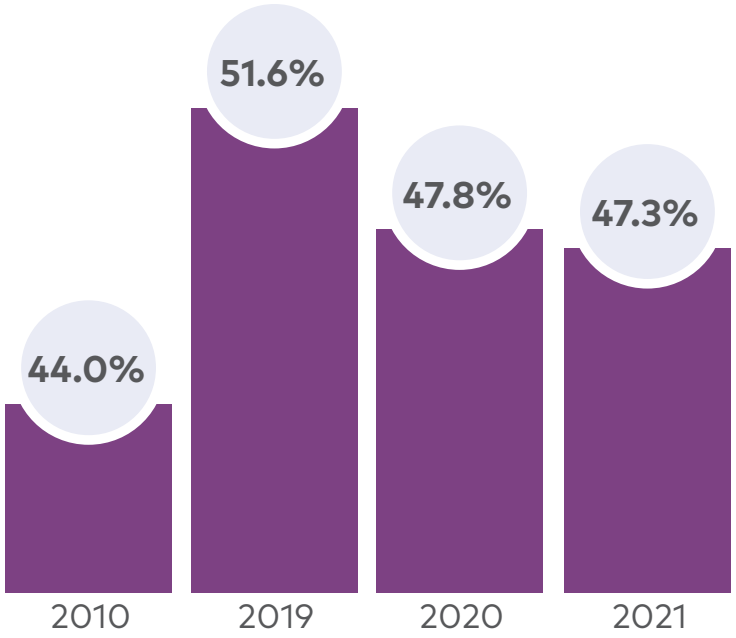
1. Decedents refers to Medicare beneficiaries who have died.

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



Source: *MedPAC March 2023 Report to Congress, 10-4*

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



Source: *MedPac March 2023 Report to Congress, Table 10-3*

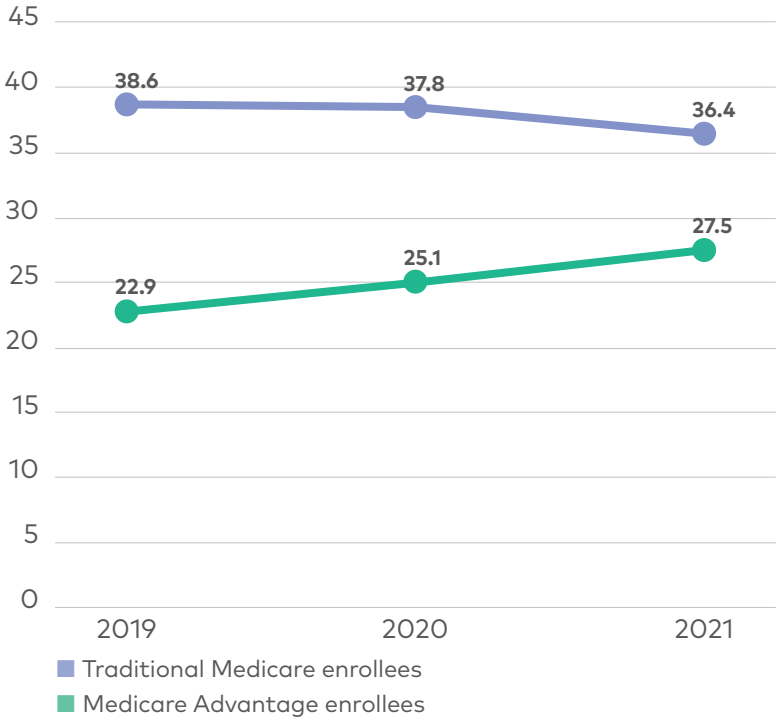
Who Receives Hospice Care? (continued)

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

In CY 2021, Medicare Advantage (MA) continued growing into a larger portion of the Medicare population as seen in Figure 4. To access hospice, MA beneficiaries must be in a value-based insurance design (VBID) plan or shift to Traditional Medicare to utilize the Medicare Hospice Benefit. Most beneficiaries switch to Traditional Medicare.

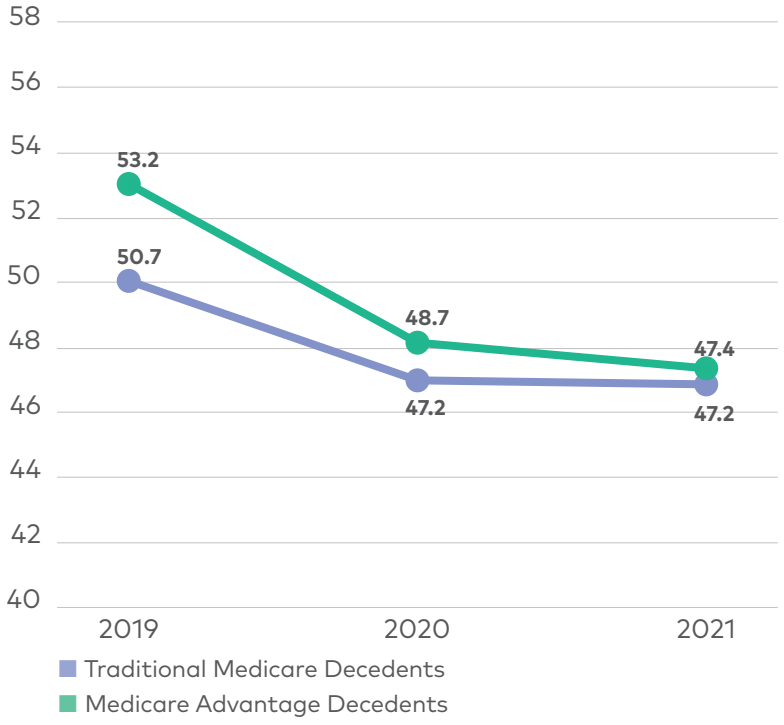
As demonstrated in Figure 5, utilization of the hospice benefit remains slightly higher among decedents originally enrolled in MA plans than among Traditional Medicare users. However, the percentage of MA beneficiaries utilizing hospice decreased (-1.3 percentage point) while Traditional Medicare beneficiaries were flat from CY 2020.

Figure 4: Medicare Advantage v. Traditional Medicare beneficiaries (in millions)



Source: *Medicare Enrollment, June 2023 (https://data.cms.gov/tools/medicare-enrollment-dashboard)*

Figure 5: Medicare Advantage v. Traditional Medicare hospice use (percentage)



Source: *MedPac March 2023 Report to Congress, Table 10-3*

Who Receives Hospice Care? (continued)

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

Medicare Beneficiary and Decedent Characteristics

In CY 2021, approximately 2.8 million Medicare (both Traditional and Medicare Advantage) beneficiaries died which includes both the 1.7 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 2021 Medicare beneficiaries and decedents, by characteristics

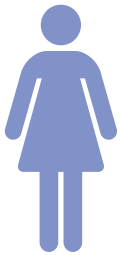
Demographic Characteristic	Total Medicare Enrollees	Decedents
Total	**63,892,626**	**2,750,141**
Age		
Under 65 Years	8,041,304	236,041
65-74 years	31,812,889	712,518
75-84 Years	17,379,347	843,160
85-94 years	5,908,242	765,942
95 years and Over	750,844	192,480
Sex		
Male	29,159,084	1,373,655
Female	34,733,542	1,376,486
Race		
Non-Hispanic White	46,504,697	2,088,893
Black (or African-American)	6,716,021	301,423
Asian/Pacific Islander	2,349,223	69,294
Hispanic	6,222,827	234,121
American Indian/Alaska Native	258,058	14,993
Other	546,619	19,574
Unknown	1,295,182	21,843

Source: *CMS Program Statistics - Medicare Deaths*

Beneficiary Gender

In CY 2021, when presented with a binary question, beneficiaries who identified as female and died in 2021, 52.5% used hospice. Among beneficiaries who identified as male and died in 2021, 42.1% used hospice. Both groups saw a drop in usage of less than one percentage point from 2020.

Figure 6: Share of Medicare decedents who use hospice, by gender



Among Medicare decedents who identified as female

52.5%
used hospice (2021)

Among Medicare decedents who identified as male

42.1%
used hospice (2021)

Source: *MedPac March 2023 Report to Congress, Table 10-3*

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

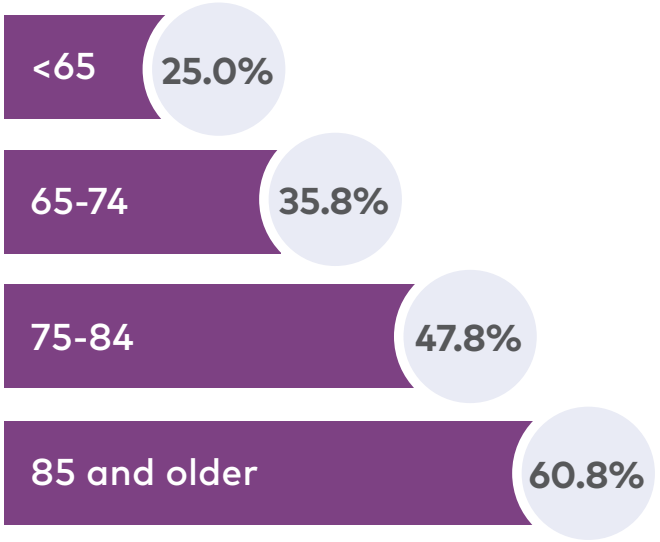
This calculation compares how each group accesses hospice but does not compare size of the groups or health disparities or inequities factors which can impact the those who access Medicare.

Who Receives Hospice Care? (continued)

Beneficiary Age

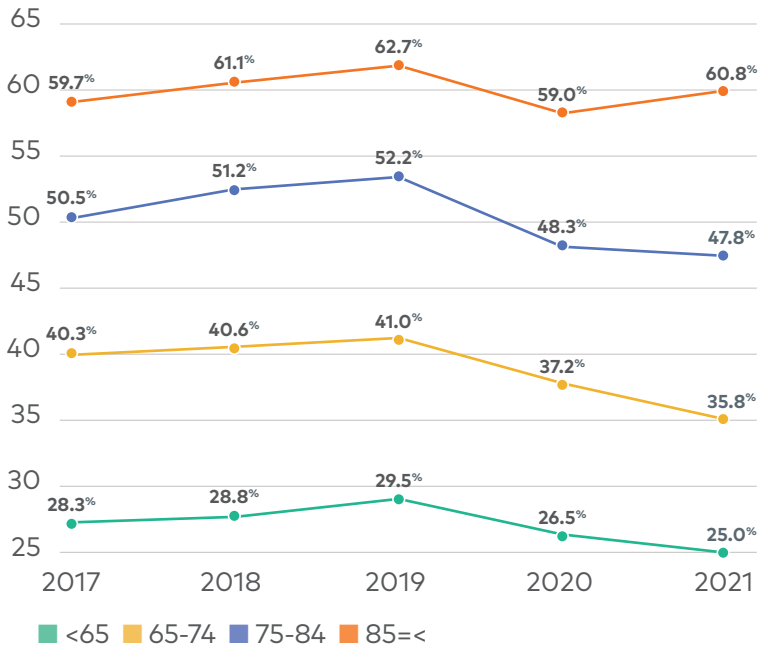
In CY 2021, as shown in Figure 7, 60.8% of Medicare decedents age 85 years and older utilized the Medicare Hospice Benefit, while progressively smaller percentages of decedents in younger age groups received hospice care. Figure 8 highlights beneficiaries over 85 were the only age group who saw an increase in usage in CY 2021, but no age group has returned to pre-COVID-19 levels.

Figure 7: Share of Medicare decedents who used hospice, by age 2021 (percentage)



Source: *MedPAC March 2023 Report to Congress, Table 10-3*

Figure 8: Share of Medicare decedents who used hospice, by age 2017-21 (percentage)



Source: *MedPAC March 2023 Report to Congress, Table 10-3 & MedPAC March 2022 Report to Congress, Table 11-3*

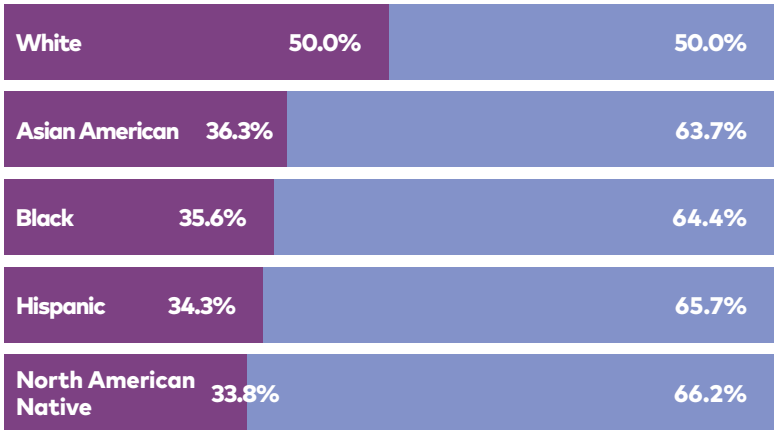
Who Receives Hospice Care? (continued)

Patient Race/Ethnicity

In CY 2021, 50.0% of White Medicare decedent beneficiaries used the Medicare Hospice Benefit. 36.3% of Asian American Medicare decedent beneficiaries and 35.6% of Black Medicare decedent beneficiaries enrolled in hospice in 2021. 34.3% of Hispanic and 33.8% of North American Native Medicare decedents used hospice in 2021.

2. North American Native is an updated term for the previously used American Indian/ Alaska Native.

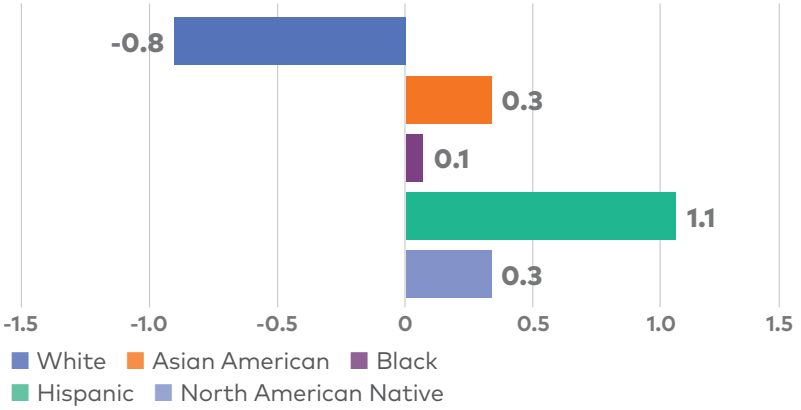
Figure 9: Share of Medicare decedents who used hospice, by race



Source: *MedPAC March 2023 Report to Congress, Table 10-3*

CY 2021 saw an increase in hospice utilizations by all race/ethnicity groups except White beneficiaries which saw a -0.8 percentage point decrease. Despite this rebound from the 2020 decrease, no group has returned to pre-COVID-19 utilization percentages.

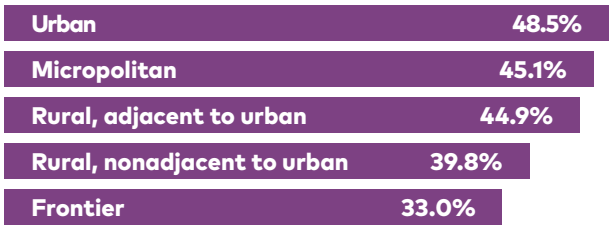
Figure 10: Percentage point change of decedents who use hospice, by race



Beneficiary Location

In CY 2021, a higher percentage of decedent beneficiaries located in an urban area (48.5%) utilized hospice compared to rural (44.9%, 39.8%) or frontier (33.0%) decedent beneficiaries. 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, micropolitan decedents saw the largest decrease from 2020 to 2021 (-1.7 percentage points).

Figure 11: Share of Medicare decedents who use hospice, by location



Source: *MedPAC March 2023 Report to Congress, Table 10-3*

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. While cancer is in the top 20 diagnoses twice, it is tied with Alzheimer's/nervous system disorders/organic psychosis as the top category of diagnosis (24%). Although COVID-19 accounts for only 2% of primary diagnoses, it may still have been a secondary or contributory diagnosis.

Table 2: FY 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	G30.9-Alzheimer disease, unspecified	135,910	7.4%
2	G31.1-Senile degeneration of brain, not elsewhere classified	124,365	6.8%
3	J44.9-Chronic obstructive pulmonary disease, unspecified	78,630	4.3%
4	G30.1-Alzheimer disease with late onset	63,980	3.5%
5	I50.9-Heart failure, unspecified	52,375	2.8%
6	G20-Parkinson disease	52,155	2.8%
7	"I25.10-Atherosclerotic heart disease of native coronary artery withoutangina pectoris"	47,117	2.6%
8	"C34.90-Malignant neoplasm of unspecified part of unspecified bronchus or lung"	44,093	2.4%
9	U07.1-Emergency use of U07.1	43,505	2.4%
10	I67.2-Cerebral atherosclerosis	38,543	2.1%
11	I11.0-Hypertensive heart disease with (congestive) heart failure	36,860	2.0%
12	I67.9-Cerebrovascular disease, unspecified	35,120	1.9%
13	E43-Unspecified severe protein-energy malnutrition	33,111	1.8%
14	I63.9-Cerebral infarction, unspecified	29,291	1.6%
15	"I13.0-Hypertensive heart and renal disease with (congestive) heart failure"	27,455	1.5%
16	C61-Malignant neoplasm of prostate	24,806	1.3%
17	N18.6-End stage renal disease	24,565	1.3%
18	J96.01-Acute respiratory failure with hypoxia	23,329	1.3%
19	C25.9-Malignant neoplasm: Pancreas, unspecified	22,128	1.2%
20	"J44.1-Chronic obstructive pulmonary disease with acute exacerbation, unspecified"	20,928	1.1%

Source: *FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule, Table 2*

Who Receives Hospice Care? (continued)

As seen in Figure 13, patients with a neurological primary diagnosis have the longest average length of stay (155 days) followed by chronic obstructive pulmonary disease (COP) with 140 days. While cancer is in the top 20 diagnoses twice, it is tied with Alzheimer's/nervous system disorders/organic psychosis as the top category of diagnosis (24%). Although COVID-19 accounts for only 2% of primary diagnoses, it may still have been a secondary or contributory diagnosis.

Figure 12: CY 2021 Hospice cases by primary diagnosis (percentage)

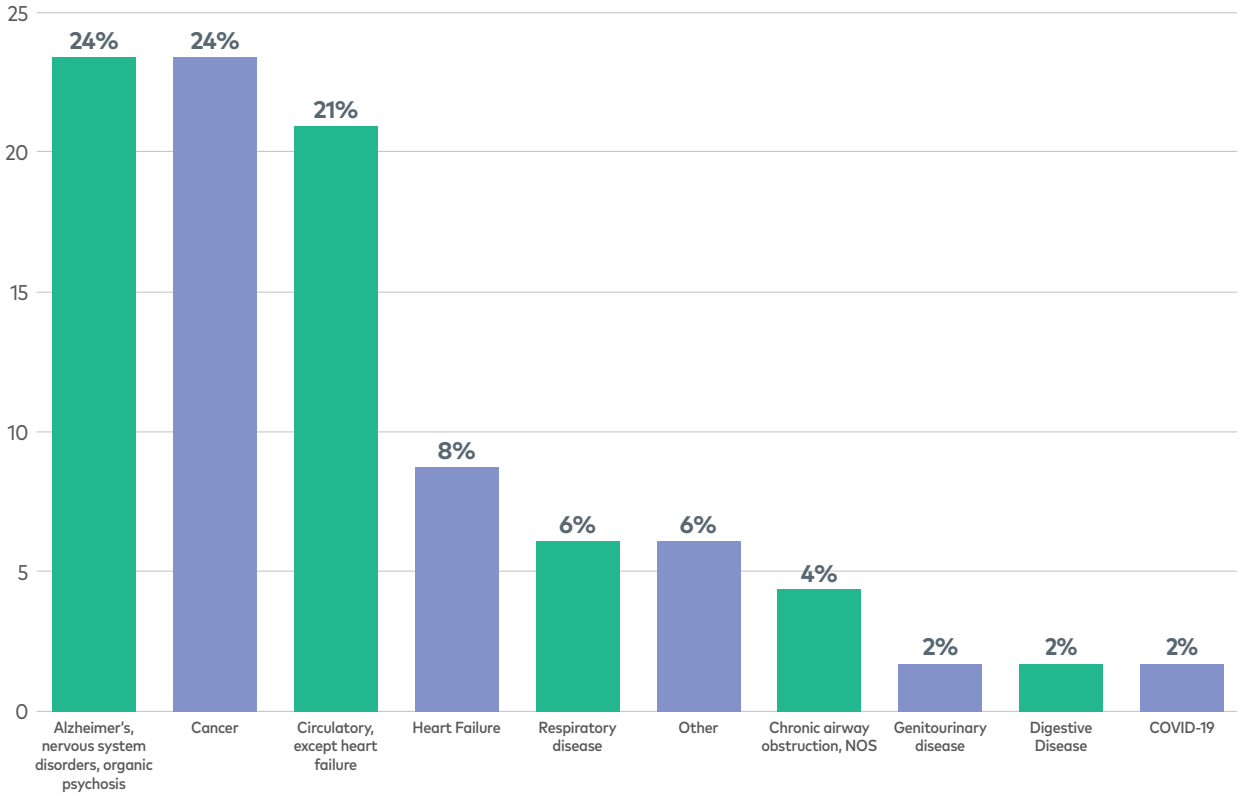
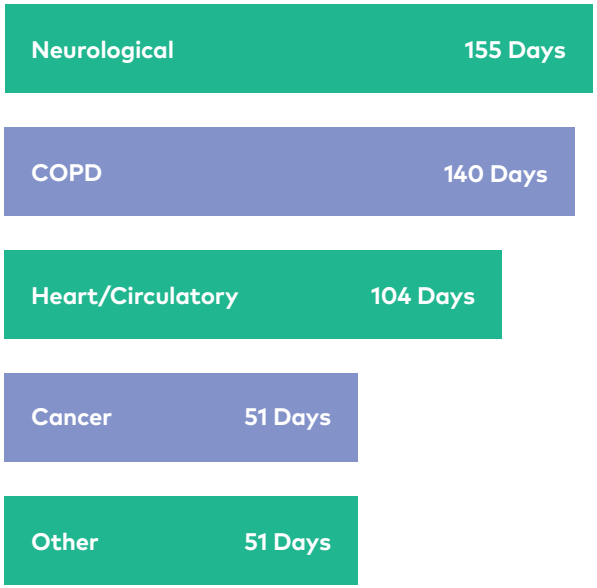


Figure 13: CY 2021 Average length of stay, in days, by diagnosis



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

Note: Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2021, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2021. Subgroups may not sum to 100 percent due to rounding.

Source: *FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule, Table 2*

Section 3: How Much Care Is Received?

Length of Stay

The average lifetime length of stay (LOS) for Medicare decedents enrolled in hospice in 2021 was 92.1 days; a decrease from 2020 which saw the highest increase in five years. The median lifetime length of stay (MLOS) was 17 days which is a decrease from the consistent 18 days over the last five years.

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	87.8	18	0.87
2019	92.5	18	1.20
2020	97.0	18	1.31
2021	92.1	17	1.29

Note: 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 2023 Report to Congress, Table 10-4*

Days of Care by Lifetime Length of Stay in 2020

- 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 17 days or less.
- 75% of patients were enrolled for 79 days or less.
- The top 10% of patients were enrolled for more than 264 days.

Figure 14 CY 2021 days of care by length of stay, in days

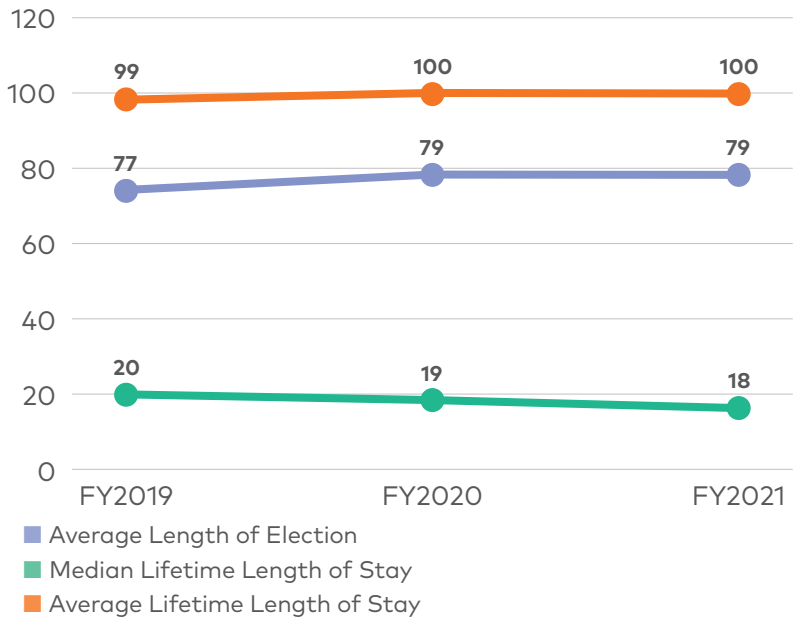
Source: *MedPAC July 2023 Data Book, Chart 11-13*

How Much Care Is Received? (continued)

Days of Care

Figure 15 depicts the variation in length of stay between median and average lifetime (includes all elections of hospices) and election (a patient may be included twice if they had multiple elections). 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 15: Average lifetime lengths of stay, average length elections, and median lifetime lengths of stay, in days



Source: *FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule, Table 4*

Discharges

In CY 2021, 17.2% percent of all Medicare hospice discharges were live, which was a return to pre-pandemic level. All hospice discharges saw an increase in 2021 except for discharges for cause which did not change.

Table 4: Rates of hospice live discharge and reported reason for discharge, CY 2019–2021 (percentage)

Reason for Discharge	2019	2020	2021
All live discharges	17.4%	15.4%	17.2%
Patient-Initiated Live Discharges			
Revocation	6.5	5.7	6.3
Transferred hospice providers	2.3	2.2	2.4
Hospice-Initiated Live Discharges			
No longer terminally ill	6.5	5.6	6.3
Moved out of service area	1.7	1.6	2
Discharge for cause	0.3	0.3	0.3

Source: *MedPAC July 2023 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 16 was 95 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 17, were 24 days at a private residence, 21 days in nursing facilities, and 53 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 16: Average length of stay by location of care, in days

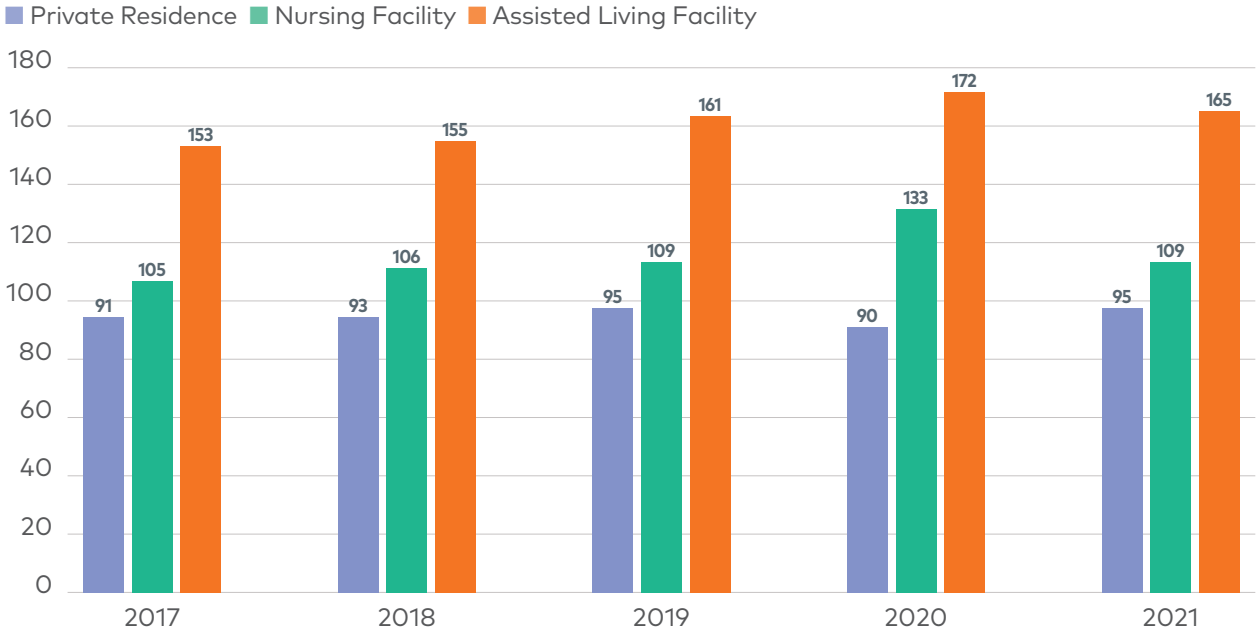
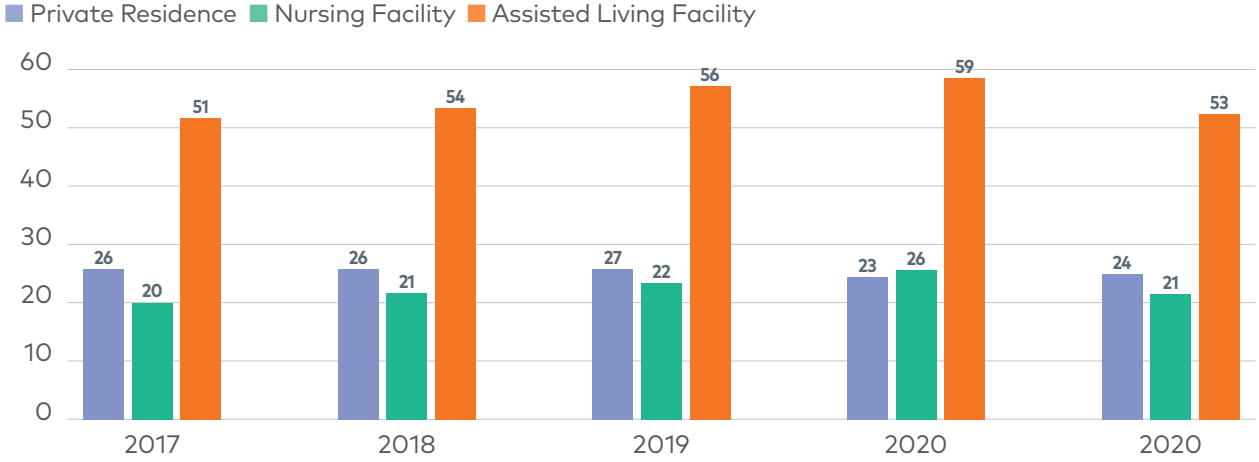


Figure 17: Median days by location of care, in days

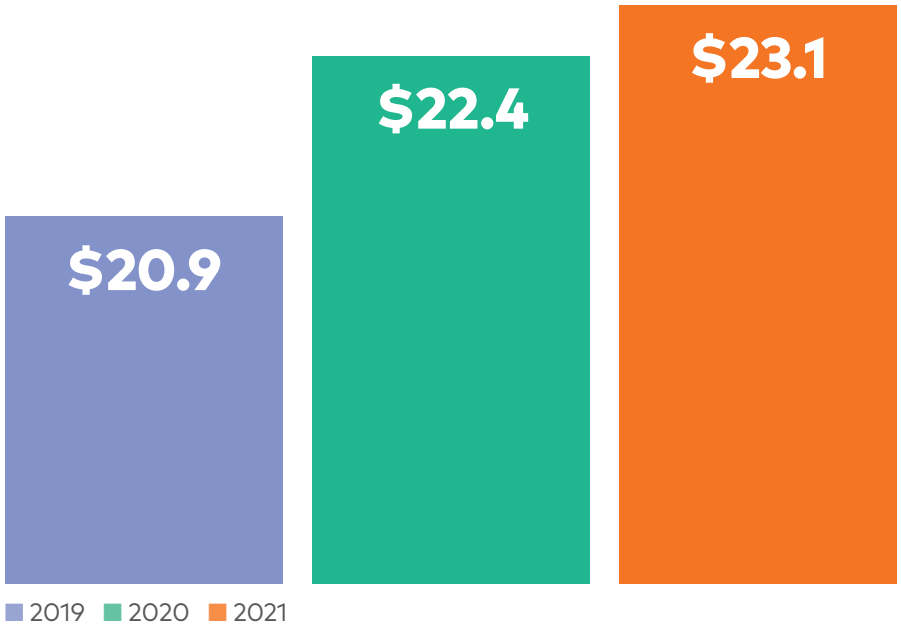


Source: *MedPAC July 2023 Data Book, Chart 11-14; MedPAC March 2022 Report to Congress, Table 11-7*

Section 4: How Does Medicare Pay for Hospice?

Medicare paid hospice providers a total of $23.1 billion dollars for care provided in CY 2021, representing an increase of 2.8% over the previous year. This is slower growth compared to 2019-2020.

Figure 18 Medicare spending (billions of US dollars)



Source: *MedPAC March 2023 Report to Congress, table 10-4*

Spending by Level of Care

In FY 2022, the vast majority of Medicare days of care were at the routine home care (RHC) level of care for both percent of payments made and percent of days of care provided. The greatest change since FY 2013 is the decrease in both payments and days of continuous home care (CHC) and general inpatient (GIP); whereas, days and payments were stable for inpatient respite care.

Table 5: Percent of payment, by level of care

Percent of Payment by Level of Care	2013	2022
Routine home care	90.6%	93.7%
Continuous home care	1.8%	0.6%
Inpatient respite care	0.3%	0.7%
General inpatient care	7.3%	5.0%

Table 6: Percent of days, by level of care

Percent of Days by Level of Care	2013	2022
Routine home care	97.5%	98.8%
Continuous home care	0.4%	0.1%
Inpatient respite care	0.3%	0.3%
General inpatient care	1.8%	0.9%

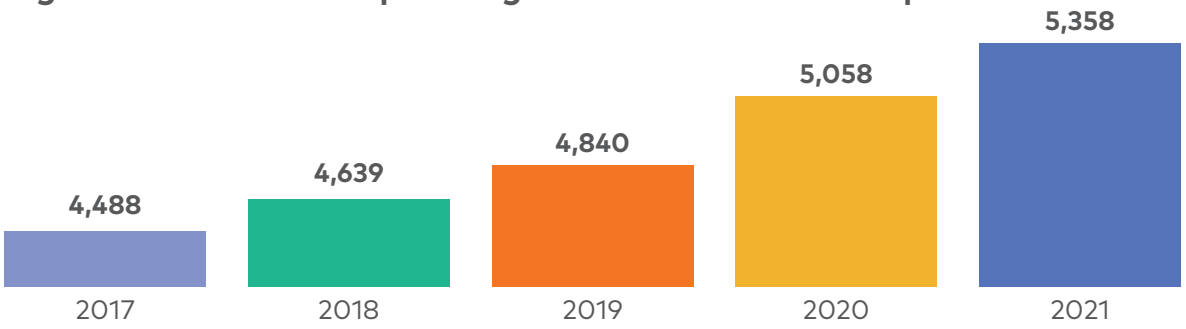
Source: *FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule, Table 3*

Section 5: Who Provides Care?

How many hospices were in operation in 2021?

In CY 2021, there were 5,358 Medicare certified hospices in operation based on claims submitted. This is an increase of 300 hospices from 2020 and outpaced the average annual percent change since 2017.

Figure 19: Number of operating Medicare certified hospices



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

What are the characteristics of Medicare certified hospices?

As shown in Table 7, the growth in hospice ownership in CY 2021 is being driven by the growth in for-profit (8.6%), freestanding (7.7%), and urban providers (7.4%). The largest decreases were with government (-2.1%), skilled nursing facility (SNF) based (-10.5%), and rural providers (-0.9%).

Table 7: Characteristics of Medicare certified hospices

Category	2020	2021	Percent change 2020–2021
For profit	3691	4008	8.6%
Nonprofit	1220	1195	-2.0%
Government	146	143	-2.1%
Freestanding	4189	4511	7.7%
Hospital based	413	396	-4.1%
Home health based	437	434	-0.7%
SNF based	19	17	-10.5%
Urban	4196	4505	7.4%
Rural	853	845	-0.9%

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

Figure 20: Tax status

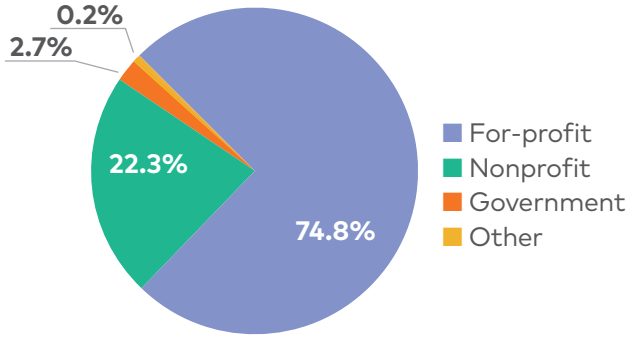


Figure 21: Hospice structure

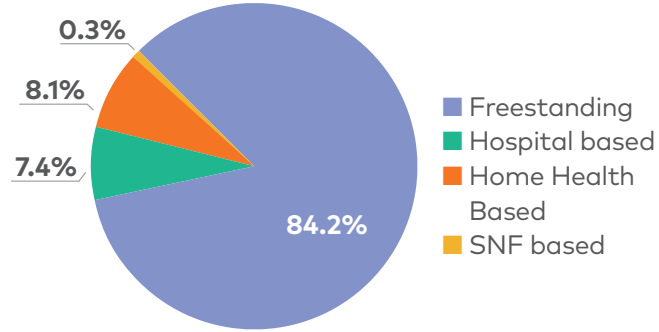
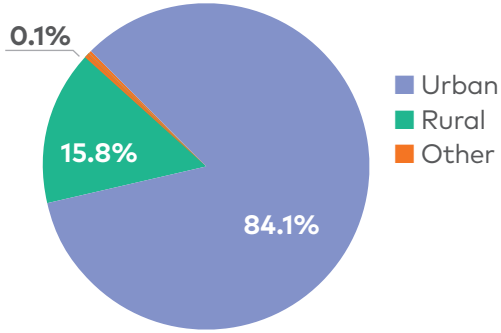


Figure 22: Hospice location

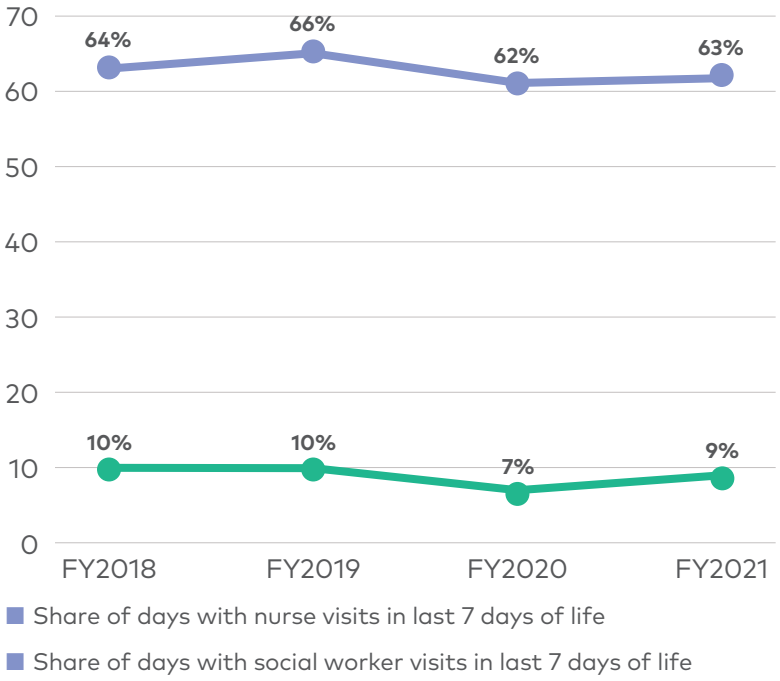


Source: *MedPAC March 2023 Report to Congress, Table 10-2*

Section 6: What is the Quality of Hospice Care?

CY 2021 saw an increase in visits in the last days of life by both nurses and social workers after a decline in 2020.

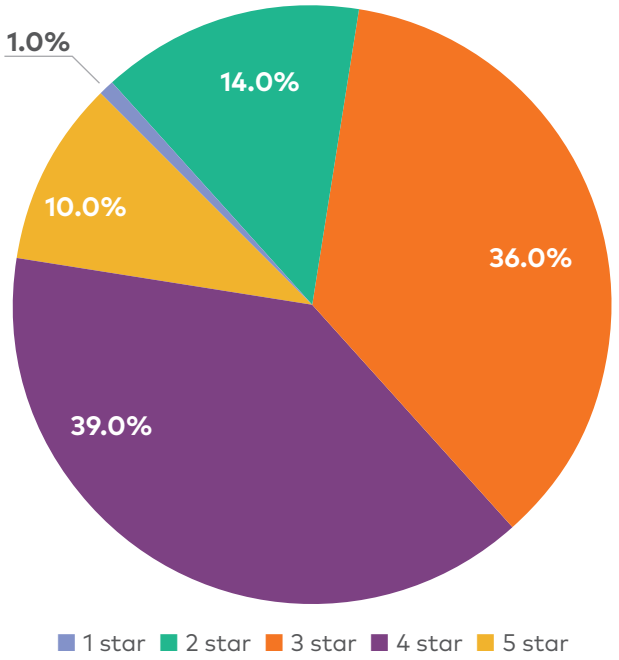
Figure 23: Share of days with visits in last seven days of life (percentage)



Source: *MedPAC March 2023 Report to Congress, Table 10-9*

In the most recently available data (April 2019-December 2019, July 2020-September 2021), 49.0% of participating providers received four or five stars on the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey. The CAHPS® survey assesses the experiences of patients who died while receiving hospice care and their primary informal caregivers.

Figure 24: Breakdown of hospice star ratings (percentage)



Source: *MedPAC March 2023 Report to Congress, Table 10-8*

Special Focus: Value-Based Insurance Design (VBID)

Value-based insurance design (VBID) is a CMS Innovation Center (CMMI) model with the goal of providing innovation, more choices, and high-quality, person-centered care to Medicare beneficiaries through Medicare Advantage (MA). Starting in 2021, MA plans could voluntarily add a hospice benefit to their VBID plans. VBID beneficiaries are not included in the data on beneficiaries who utilize the Traditional Medicare Hospice Benefit.

From CY 2021 to 2022, there was an increase in both participating providers and beneficiaries as well as an increase in the percentage of use of in-network providers.

Table 8: Participating hospice providers

Participating hospice providers	2021	2022
In network hospice providers	17%	22%
Out of network hospice providers	83%	78%
Total providers	**596**	**1,168**
VBID hospice beneficiaries	**2021**	**2022**
Beneficiaries who utilized in network hospices	37%	48%
Beneficiaries who utilized out of network hospices	63%	52%
Total beneficiaries	**9,630**	**19,065**

Source: *CMS Value-Based Insurance Desgin Model, Findings at a Glance, 2021-2022*

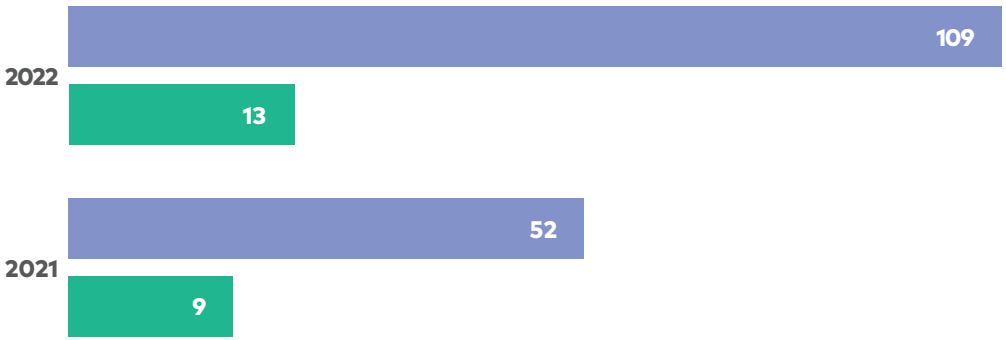
Table 9: VBID hospice beneficiaries

Characteristics	In Network Providers #	In Network Providers %	Out of Network #	Out of Network %
For-profit	177	68.1%	655	68.1%
Nonprofit	58	22.3%	195	20.3%
Other	25	9.6%	93	9.7%
Rural	22	8.5%	83	8.6%
Non-rural	238	91.5%	879	91.4%

Source: *CMS Value-Based Insurance Desgin Model, Findings at a Glance, 2021-2022*

From CY 2021 to CY 2022, there was also an increase in the number insurers (MA parent organizations) and plans participating in VBID. However, some participating insurers and plans did not continue after 2021.

Figure 25: Medicare Advantage plan participation, CY 2021-2022



Source: *CMS Value-Based Insurance Desgin Model, Findings at a Glance, 2021-2022*

Appendix

Citations

MedPAC March 2023 Report to Congress, Chapter 10: Hospice services

MedPAC July 2023 Data Book, Section 11: Other services

FY 2024 Hospice Wage Index and Quality proposed rule (CMS-17787-9)

MA VBID Model Phase II: Second Annual Evaluation Hospice At-A-Glance Report

CMS Program Statistics – Medicare Deaths

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:

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Attention: Communications
Phone: 703.837.1500
Web: www.nhpco.org/hospice-care-overview/hospice-facts-figures/
Email: Communications@nhpco.org

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