HOSPICE ANALYTICS

Hospice Utilization Report
Oregon

2024 Medicare Information

11/14/25

Data & graphs provided by: Cordt Kassner, PhD, Hospice Analytics
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Hospice Utilization & Regulation

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Oregon State Capitol
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Phone: 503-986-1743
Email: shc.exhibits@oregonlegislature.gov

TUESDAY

Date: **November 18, 2025**
Time: **11:30 AM**
Room: **HR C**

Informational Meeting

Invited Speakers Only

Hospice Regulation in Oregon

Dana Selover, Section Manager, Health Care Regulation and Quality Improvement, Oregon Health Authority
Robert Tyler Braun, Assistant Professor, Weill Cornell Medical College
Brandon Novick, Policy Coordinator, Center for Economic and Policy Research
Barb Hansen, CEO, Oregon Hospice & Palliative Care Association

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Oregon

MEDICARE HOSPICE BENEFICIARIES SERVED IN CALENDAR YEAR 2024

65

Number of Hospices

23,756

Number of Medicare Patients

25,073

Number of Medicare Admissions

Hospice Utilization

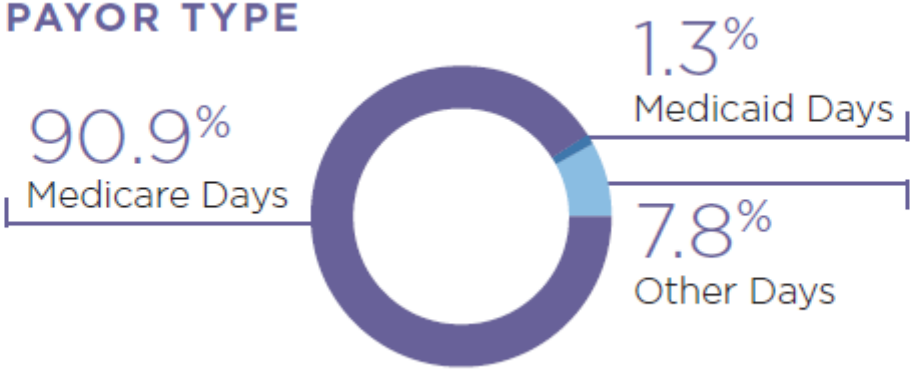
(Number of Medicare beneficiaries dying on hospice/ number of Medicare beneficiaries who died)

51.0%

Number of Medicare Days

1,588,272

PAYOR TYPE



AVERAGE DAILY CENSUS

4,351

LENGTH OF STAY (DAYS)

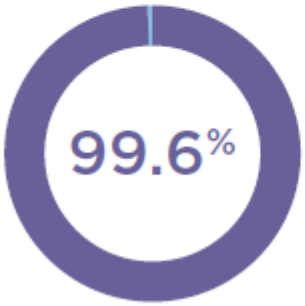
MEAN 67

MEDIAN 25

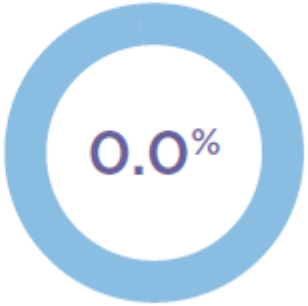
TOTAL MEDICARE PAYMENTS

$335M

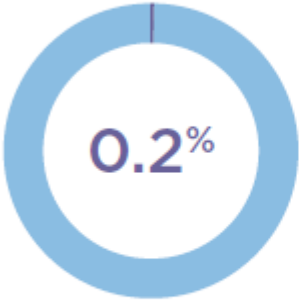
PERCENTAGE OF MEDICARE DAYS at level of care



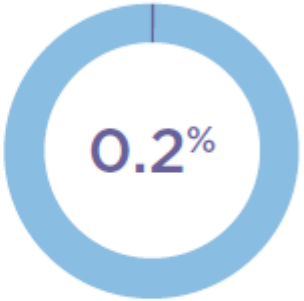
Routine Home Care



Continuous Home Care



General Inpatient



Respite

PERCENTAGE OF MEDICARE DAYS in most prominent locations of care

48.4% Home

37.1% Assisted Living

8.3% Nursing Facilities

5.5% All Other

0.7% Hospice Inpatient

Hospice Utilization

- Is a measure of ACCESS…
- Is a measure of QUALITY…

Care Flanders. 2010. Palliative sedation guideline. [in Dutch]. Available from http://www.pallialine.be/template.asp?f=rl_sedatie.htm#page=page-1. Accessed March 29, 2011.

Death Service Ratio: A Measure of Hospice Utilization and Cost Impact

To the Editor:

In October 2007, Taylor et al.[1] published compelling data showing that use of hospice care reduces United States Medicare expenditures at the end of life. In a case-control study of a sample of Medicare decedents (1993–2003), the authors compared 1819 hospice decedents with 3638 matched controls. Hospice use reduced Medicare program expenditures after the initiation of hospice by an average of $2309 per hospice user ($7318 for hospice users vs. $9627 for controls; $P < 0.001$). For cancer, maximum savings of $7000 occurred with a length of stay (LOS) in hospice between 60 and 100 days; for other primary conditions, maximum savings of $3500 occurred with a LOS of 50–110 days.[1] Thus, cost savings were maximized with much longer periods of hospice use than is common among Medicare beneficiaries (median LOS of 16 days in not-for-profit, and 20 days in for-profit hospices).[2]

Medicare expenditures for all Medicare beneficiaries who died under the care of one of these provider types. In North Carolina, average costs to Medicare for patients who died with a history of the following types of service use were hospice, $19,249; home health agency, $19,810; SNF, $25,842; hospital, $30,603; and multiple settings, $30,732 vs. not receiving care from any service, $6853. Notably, a North Carolina patient receiving end-of-life care through hospice received $11,354 less in care paid for by Medicare than did a patient receiving hospital-based care.

Clearly, hospice utilization exerts a strong force on health care system costs. How can we examine and monitor hospice utilization and impact? We propose "death service ratio" (DSR) as a simple measure of hospice use for this purpose. Calculated as a percentage—the numerator being deaths in a defined area or population served by hospice and the denominator being all deaths in that area/population—DSR serves as an indicator of hospice utilization in a region and, therefore, as an indirect indicator for impact of hospice on health care costs. We explicitly acknowledge that DSR is a crude indicator, as it does not accommodate for hospice LOS, patient complexity, or other important factors; but, in its simplicity, DSR allows regional monitoring of hospice utilization that can be linked to health system costs.

Using DSR as a primary measure, we re-

Abernethy AP, Kassner CT, Whitten E, Bull J, Taylor DH. Death Service Ratio: A Measure of Hospice Utilization and Cost Impact. J Pain Symptom Manage 2011; 41(#6 June):e5-6.

Hospice Utilization

- Is complicated…

522 Journal of Pain and Symptom Management Vol. 63 No. 4 April 2022

Original Article

Low Hospice Utilization in New York State: Comparisons Using National Data

Check for updates

Lara Dhingra, PhD, Carla Braveman, RN, MEd, Cordt Kassner, PhD, Clyde Schechter, MD, Stephanie DiFiglia, PhD, and Russell Portenoy, MD

MJHS Institute for Innovation in Palliative Care (L.D., S.D., R.P.), New York, New York, USA; Department of Family and Social Medicine (L.D., C.S., R.P.), Albert Einstein College of Medicine, New York, New York, USA; Hospice and Palliative Care Association of New York State (HPCANYS) (C.B.), Albany, New York, USA; Hospice Analytics Inc. (C.K.), Colorado Springs, Colorado, USA; Department of Neurology (R.P.), Albert Einstein College of Medicine, New York, New York, USA

Abstract

Context. Hospice utilization in New York State (NYS) is low compared to the rest of the U.S.

Objectives. The first part of a mixed-m
hospice-related barriers in nine categorie
between NYS and the rest of the country

Methods. Ten Medicare or publicly av
insured patients dying in 2018. Multivari
enrollment or length of stay between NYS

Results. The NYS population was rela
(SES), and saw more physicians during t
beds, and fewer for-profit hospitals, SNFs
pice utilization was associated with higher
for-profit SNF facilities; and fewer hospic

Conclusion. NYS's low hospice utiliza
health care system. Combined with info
improve hospice utilization. J Pain Symp

Journal of Palliative Medicine > Vol. 25, No. 10 > Original Articles

Low Hospice Utilization in New York State: Framework for Compiling and Ranking Barriers

Lara Dhingra, Carla Braveman, Kailey Roberts, Stephanie DiFiglia, Cordt Kassner, and Russell Portenoy

Published Online: 30 Sep 2022 | https://doi.org/10.1089/jpm.2022.0004

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Abstract

Background: The hospice benefit can improve end-of-life outcomes, but is underutilized, particularly in low enrollment states such as New York. Little is known about this underutilization.

Objective: The first part of a mixed-methods study aimed to compile and rank barriers to hospice utilization and identify differences between New York and the rest of the United States.

Setting/Subjects and Design: Clinicians, administrators, and hospice employees participated in six sessions (6–12 per session) across New York State, USA. During each session, a methodology known as nominal group technique was used to elicit barriers to hospice, identify those specific to New York, and suggest interventions to improve access. The analysis involved first categorizing and ranking barriers, and then conducting a thematic analysis of session transcripts to examine barriers specific to New York and proposed interventions to improve utilization.

Results: Fifty-seven participants ranked 54 barriers, which were grouped into nine categories. These reflected concerns about clinician knowledge and attitudes or beliefs; patient and family knowledge, attitudes or beliefs, and resources; and both structural elements and practices of hospices, nursing homes, palliative care services, and other entities in the health care system. Thirteen barriers from eight categories were ranked among the top five by ≥10% of participants; only 10 of the 54 were judged to be specific to New York. Thematic analysis highlighted 14 barriers important in New York and suggested 11 interventions to improve hospice access.

Conclusions: A categorization and ranking of barriers may guide future interventions to improve low hospice utilization. Novel studies with heterogeneous stakeholders are needed.

Dhingra L, Braverman C, Kassner CT, Schechter C, DiFiglia S, and Portenoy R. Low Hospice Utilization in New York State: Framework for compiling and ranking barriers. II. Low Hospice Utilization in New York State: Comparisons using national data. Published online, J Palliative Medicine, 4/22: https://www.liebertpub.com/doi/abs/10.1089/jpm.2022.0004.

Dhingra L, Braverman C, Roberts K, DiFiglia S, Kassner CT, and Portenoy R. Low Hospice Utilization in New York State (II): Framework for compiling and ranking barriers. J Palliative Medicine Published Online: 30 Sep 2022; https://doi.org/10.1089/jpm.2022.004.

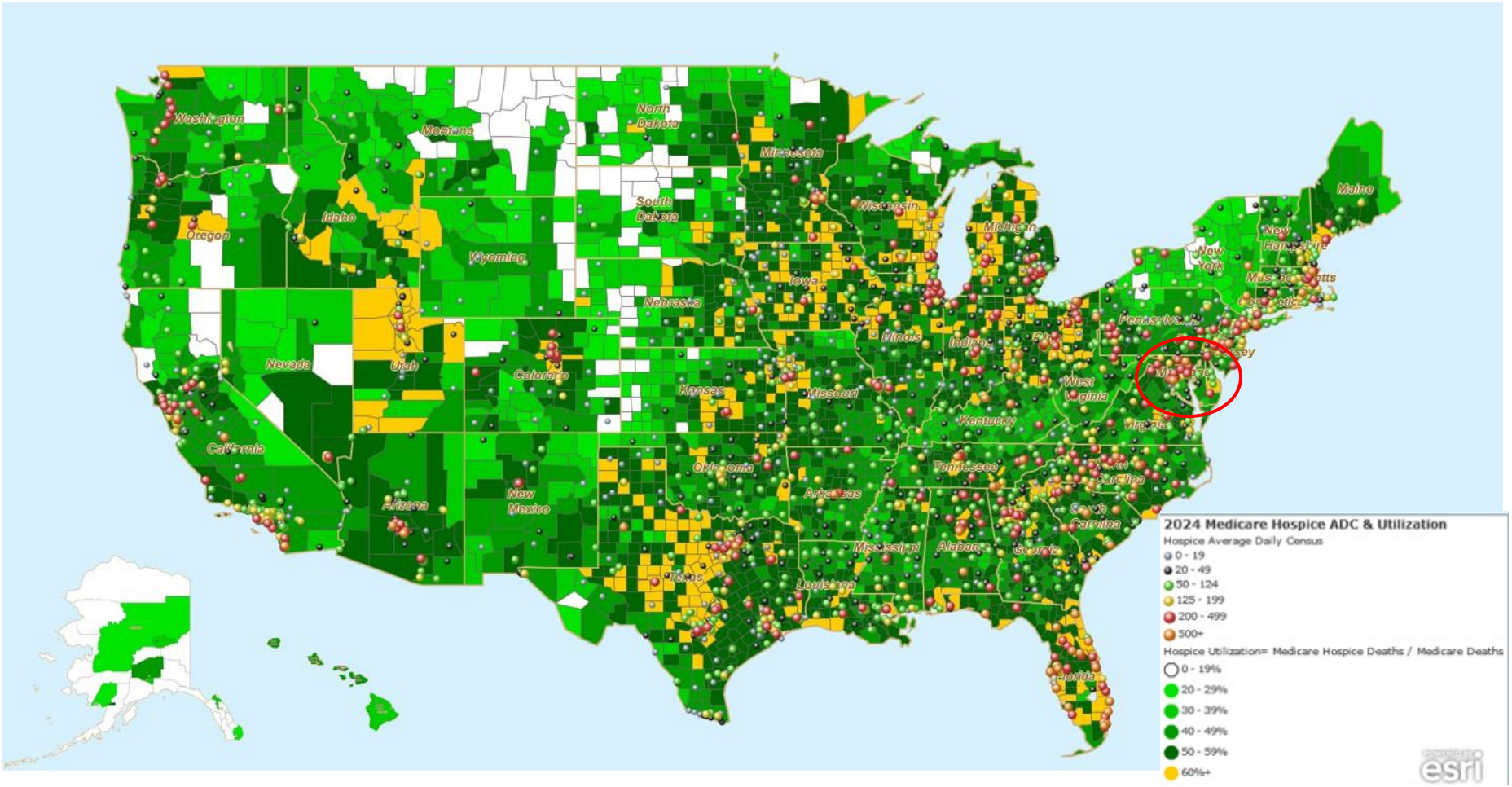
National Hospice Utilization – Post COVID-19!

	2019 Hospice Utilization	2020 Hospice Utilization	2021 Hospice Utilization	2022 Hospice Utilization	2023 Hospice Utilization	2024 Hospice Utilization
National	50.5%	46.7%	44.9%	47.3%	49.5%	**50.6%**

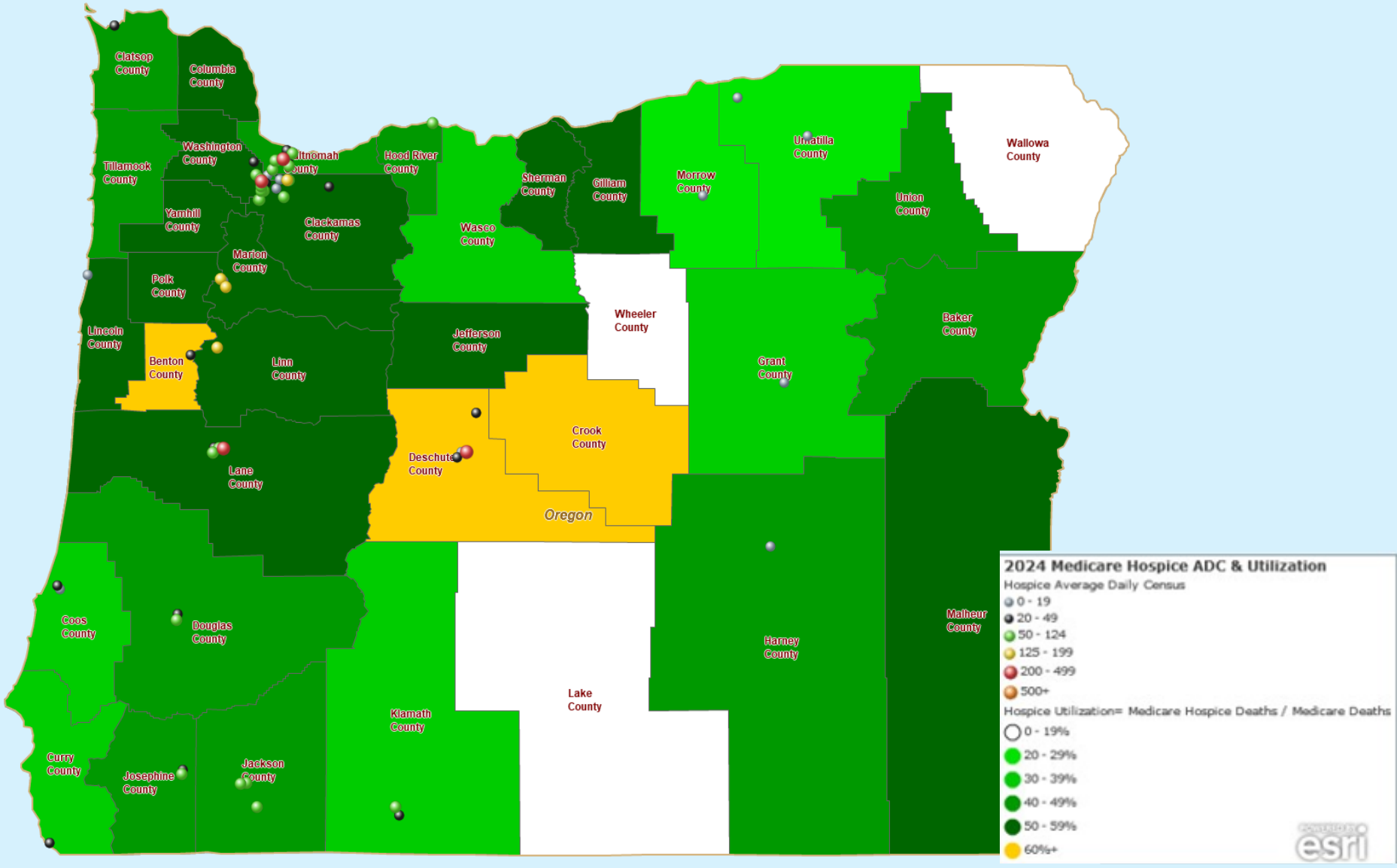
- 2020 Hospice Utilization *decreased* nationally for the first time ever.
- 2021 Hospice Utilization *decreased* nationally again – but a smaller decrease.
- 2022 Hospice Utilization *rebounded* nationally – bringing us back to 2020…
- 2023 Hospice Utilization *rebounded* nationally – almost to the 2019 high…
- 2024 Hospice Utilization *rebounded* nationally – *to the highest percentage to date!*

- ***Why?*** The number of hospice deaths has remained steady, but the number of Medicare deaths (which skyrocketed during COVID-19) is returning to expected levels.

2024 Hospice Utilization
(Medicare Hospice Deaths / Total Medicare Deaths)



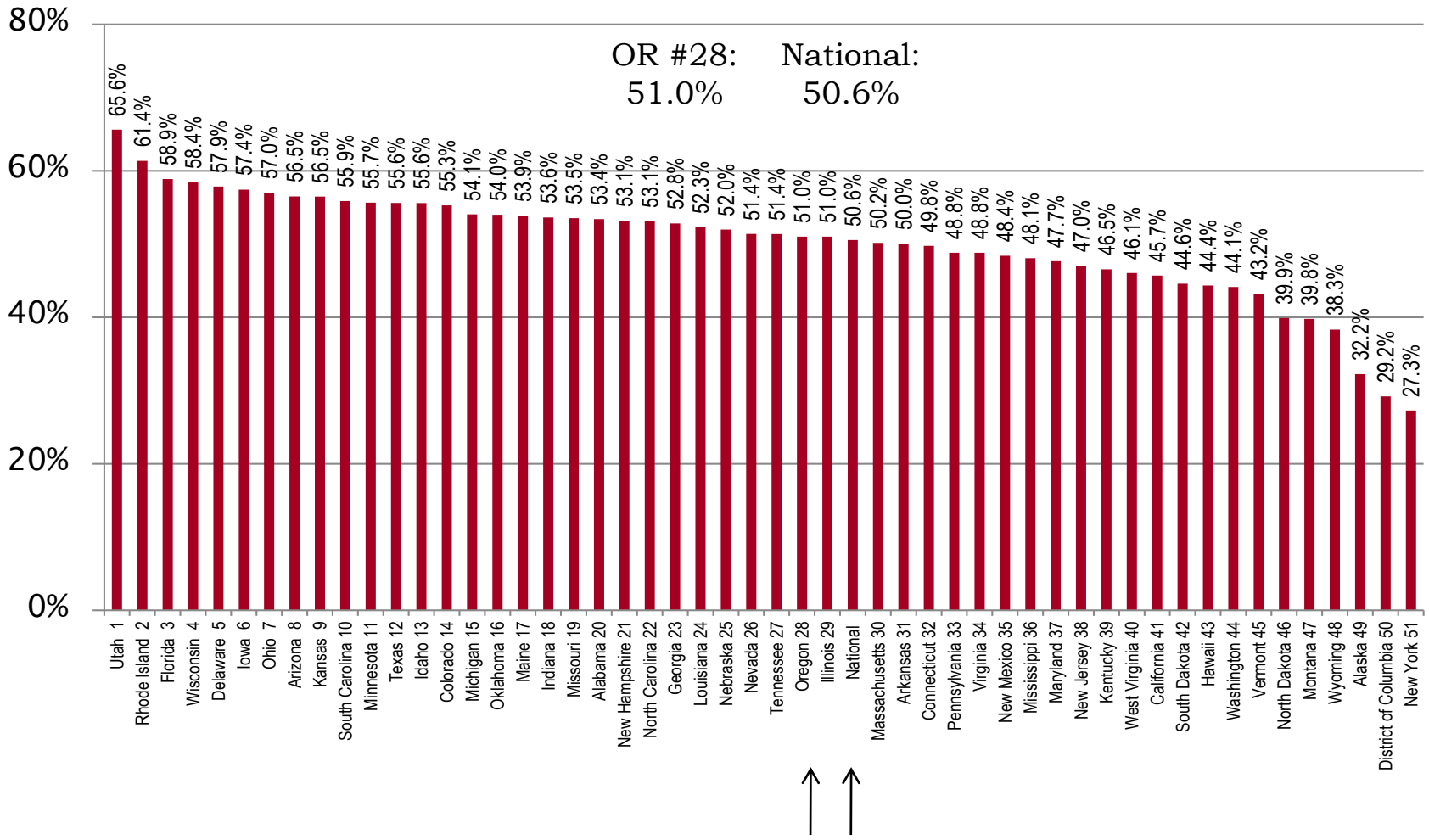
2024 Hospice Utilization – Oregon
(Medicare Hospice Deaths / Total Medicare Deaths)



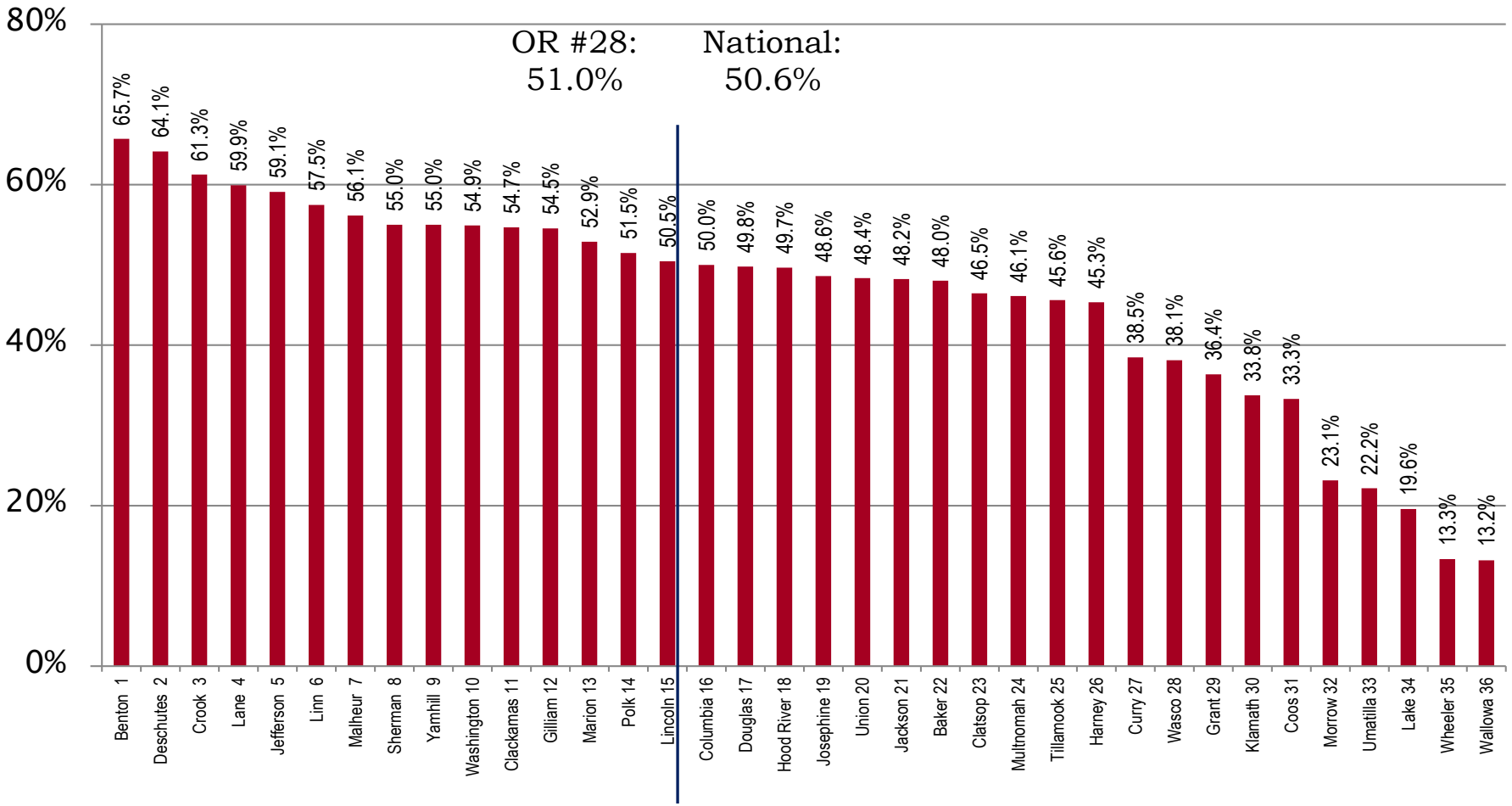
2024 Demographics & Hospice Utilization

	Oregon	National
Population (2023, 2024 NA)	*4,233,358*	*334,894,622*
Total Deaths (2023, 2024 NA)	*42,532*	*3,090,804*
Medicare Beneficiaries	982,691	70,306,074
Medicare Beneficiary Deaths	34,439	2,512,241
Medicare Hospice Unduplicated Beneficiaries	23,757 69% of Medicare deaths	1,829,143 73% of Medicare deaths
Medicare Hospice Beneficiary Deaths	17,571 **51.0% of Medicare deaths**	1,269,998 **50.6% of Medicare deaths**
Medicare Hospice Total Days of Care	1,588,272 Days	145,136,920 Days
Medicare Hospice Mean Days / Beneficiary Medicare Hospice Median Days / Beneficiary	67 Days 25 Days	80 Days 28 Days
Medicare Hospice Total Payments Medicare Hospice Mean Payment / Beneficiary	$335,175,060 $14,107	$27,756,388,541 $15,266

2024 Hospice Utilization
(Medicare Hospice Deaths / Total Medicare Deaths)



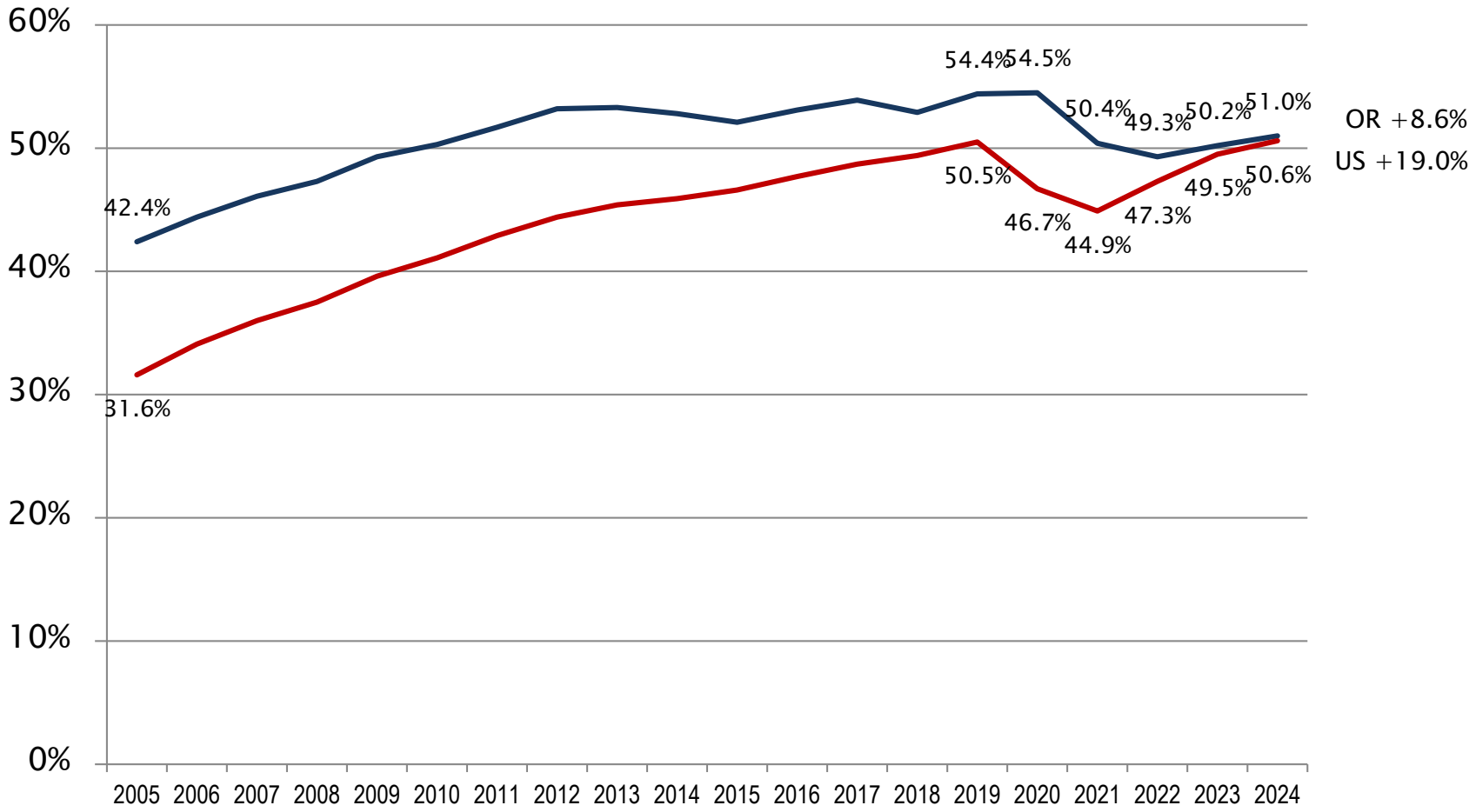
2024 Hospice Utilization x County – Oregon
(Medicare Hospice Deaths / Total Medicare Deaths)



2005-2024 State Hospice Utilization

20-Year Trends

Highest national hospice utilization rate on record!



Note: Hospice Utilization= Medicare Hospice Deaths / Total Medicare Deaths.

Released by CMS in July of 2025:

Overview

Hospice is the comprehensive, holistic program of **palliative care for terminally ill patients** and support for their families. Once a beneficiary elects hospice, they waive curative treatment for their terminal illness. CMS pays for hospice care under Medicare Part A for beneficiaries enrolled in Medicare Fee-for-Service or Medicare Advantage. Hospice agencies are paid a per diem rate based on the level of care provided (e.g., routine home care or inpatient respite care).

Medicare hospice utilization has increased in recent years. In Fiscal Year 2024, **Medicare payments for hospice reached over $27 billion**, with approximately 1.8 million Medicare beneficiaries receiving hospice care.

CMS has taken significant action to address likely fraudulent behavior occurring in Medicare-enrolled hospices, including long lengths of stay, co-located hospices, and high rates of beneficiaries discharged alive.

Enhanced Oversight

4 States

In July 2023, CMS implemented a Provisional Period of Enhanced Oversight (PPEO) for newly Medicare-enrolled hospices and hospices that underwent a change in ownership in AZ, CA, NV, and TX.

122 Revocations

As of June 2025, 668 hospices have been subject to medical review under the PPEO. CMS has revoked the Medicare enrollment of 122 of these hospices.

Expanded Oversight

Following the success of PPEO, CMS expanded prepayment review to existing Medicare-enrolled hospices in the same four states in September 2024.

CMS: "Period of Enhanced Oversight"

CMS is placing newly enrolling hospices located in **Arizona, California, Nevada, and Texas** in a provisional period of enhanced oversight. This was due to numerous reports of hospice fraud, waste, and abuse. In 2022, the number of enrolled hospices increased significantly in these states, raising serious concerns about market oversaturation.

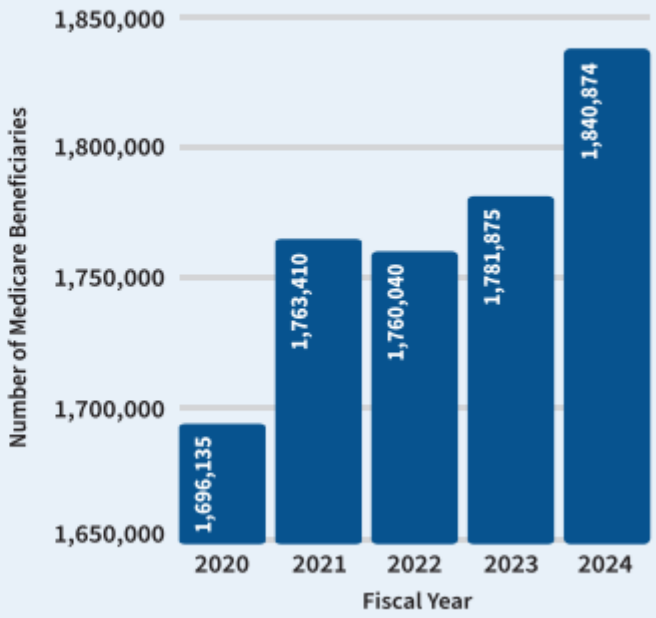
Additional Enhancements

Nationwide Hospice Site Visit Project
Conducted site visits of high-risk hospices to verify operational status and ownership information, adequate staffing, and key medical record documentation.

Streamlined Beneficiary Disenrollment
Streamlined hospice disenrollment process for Medicare beneficiaries, reducing timeline from six months to less than 12 days. Targeted beneficiary messaging and enhanced triaging of 1-800-MEDICARE hospice complaints.

Beneficiary Engagement & Education
Implemented Rapid Response Team to promptly resolve inappropriate enrollment complaints, resulting in reversal of 358 hospice elections for Medicare beneficiaries to date.

Utilization of Hospice Services



What Other States are Doing to Control Hospice Growth

24 states have Certificate of Need requirements of some type in place for hospice programs*.

California has had a moratorium on new hospice licensure since 2021 and renewed it through Jan. 1st, 2027

Nevada passed Assembly Bill No. 161, signed by the Governor in June, 2025 creates stricter licensing rules for hospices in the state. (https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/12103/Text#)

New York State recently passed Assembly Bill 565/Senate Bill 3437 which prohibits the establishment of new for-profit hospices or increasing the capacity of existing for-profit hospices

Texas-based hospice leaders and advocacy groups have met with their congressional delegation **to ask for a national or state-specific moratorium on new hospice enrollments** to combat the high saturation levels and fraudulent activities observed in the state.

* https://www.ncsl.org/health/certificate-of-need-state-laws

Oregonians deserve access to high quality hospice care, *regardless* of where they live!

Thank you.

Barb Hansen, MA, RN,CEO
hansen@oregonhospice.org

OREGON HOSPICE & PALLIATIVE CARE ASSOCIATION

Please contact Cordt Kassner, PhD, at Hospice Analytics with any questions, comments, feedback, or for additional information:

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* Review the new National Hospice Locator at www.HospiceAnalytics.com – geo-maps and detailed information on every known hospice in the United States – *now sorted by quality!*