
Medicare and Hospice

Hospice relies on the combined knowledge and skill of an interdisciplinary team of professionals—physicians, nurses, medical social workers, therapists, counselors, home care aides, and volunteers—who coordinate an individualized plan of palliative care for each patient and family. Provided primarily in clients' homes, services include medical, emotional, and spiritual care for terminally ill patients and their families to bring them comfort, peace, and a sense of dignity at a very trying time. Hospice reaffirms the right of every patient and family to participate fully in the final stages of life.

Medicare-certified Hospices

Medicare identified 3257 hospices in January 2008. There are also an estimated 200 volunteer hospices in the United States that are not Medicare certified. In 2002, 47 states had licensed hospices.¹ In 2006, hospices served 964,614 Medicare patients.² Less is known about hospices that do not participate in Medicare or Medicaid because rules and regulations for licensure vary by state.

In 1982, Congress created the Medicare hospice benefit, reserving such services for terminally ill Medicare beneficiaries with life expectancies of 6 months or less “if the disease runs its normal course.” Effective with the enactment of the Balanced Budget Act of 1997, the Medicare hospice benefit was divided into the following benefit periods:

- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of subse-

quent 60-day benefit periods as long as the patient continued to meet program eligibility requirements.

Beneficiaries must be recertified as terminally ill at the beginning of each benefit period.

From 1984 to January 2008, the total number of hospices participating in Medicare rose from 31 to 3257—a more than 105-fold increase. Of these hospices, 2050 are freestanding, 627 are home health

agency-based, 562 are hospital-based, and 18 are skilled nursing facility (SNF)-based.

Who Pays? How Much?

National healthcare expenditures for 2007 are projected at \$2.25 trillion.³ Although little specific information is available on national expenditures for hospice, detailed data are available on Medicare hospice expenditures and utilization. Some data also are available on hospice spending under the Medicaid program. In addition to Medicare and Medicaid, other sources of hospice revenue are private insurance companies. Community donations and grants also contribute to the revenue base, often to fund unreimbursed hospice services for patients with little or no insurance.

The Medicare hospice benefit still represents a small proportion of to-

Covered Hospice Services

Services provided as necessary for palliative treatment for conditions related to the terminal illness include: nursing care, medical social worker services, physician services, counseling (including dietary, pastoral, and other), inpatient care (including both respite care and short-term inpatient care for procedures necessary for pain control and acute and chronic symptom management), home care aide and homemaker services, medical appliances and supplies (including drugs and biologicals), physical and occupational therapies, and speech-language pathology services. Bereavement services for families are provided for up to 13 months following a patient's death.

tal Medicare spending. In 2007, an estimated 2.3% of Medicare benefit payments were spent on hospice care, and the same is expected in 2008 (Table 1). Meanwhile, approximately 35% of the estimated \$428 billion in Medicare spending for FY 2007 and 34% of the projected \$453 billion in spending for FY 2008 will go to hospitals for Part A and Part B. In FY 2007, approximately 14% of Medicare spending will go to physician services, and approximately 13% in FY 2008.

Despite the consistent portion of spending from Medicare, a growing number of Medicare benefici-

Medicare payments for hospice services are made on a prospective basis under 4 levels of care, adjusted by an area wage index.

aries are receiving hospice care, and the outlays for hospice have grown. Table 2 provides past year

expenditures on hospice, as well as the number of Medicare beneficiaries served by Medicare-certified hospice, the average number of days per patient, and the average cost per patient. Free-standing hospices served the majority of Medicare hospice clients, while SNF-based hospices served the fewest. The average length of stay for patients in these facilities ranged from 52.6 to 69 days. (Table 3 details Medicare-subsidized hospice utilization for FY 2005 by type of hospice.) Table 4 illustrates Medicare hospice expenditures and utilization by type of care for FY 2002 through FY 2005. Table 5 reveals average Medicare reimbursements per unit of care for the 4 categories of hospice care and hospice-related physician services for FY 2004, FY 2006, and FY 2008.

Medicare's Payment Structure

Medicare payments for hospice services are made on a prospective basis under 4 levels of care, and are adjusted by an area wage index. This local adjustment is necessary to permit higher rates in areas with higher wage levels, and proportionately lower rates in areas with wage levels below the national average. Industry representatives, including the Hospice Association of America, participated in a negotiated process for rulemaking with the Health Care Financing Administration (HCFA, now CMS) to derive a new wage index. This new index, which for a period consisted of a blend of old and new area wage indexes, is still based on hospital wage data. Medicare hospice rates also vary

Table 1: Medicare Benefit Payments, FY 2008 (Projected)

| Medicare Benefit Payments* | % of Total Payments (Projected) |
|----------------------------|------------------------------------|
| Part A | |
| Hospital care | 29.3 |
| SNF | 5.0 |
| Home health | 1.4 |
| Hospice | 2.3 |
| Managed care | 10.8 |
| TOTAL | 48.8 |
| Part B | |
| Physician | 13.4 |
| Durable medical equipment | 1.9 |
| Carrier lab | 0.9 |
| Other carrier | 3.8 |
| Hospital | 4.8 |
| Home health | 2.2 |
| Intermediary lab | 0.6 |
| Other intermediary | 2.9 |
| Managed care | 10.1 |
| TOTAL | 40.6 |

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, FY 2009 President's budget (February 2008).

*Part A total does not include peer review organization payments. Figures may not add to totals due to rounding.

according to the level of care received by the beneficiary.

Section 321 of the Benefits Improvement and Protection Act of 2000 included a provision mandating a 5% increase in hospice rates for FY 2001. This increase continues as part of the hospice base rate (see “How CMS Sets Hospice Payment Rates,” on page 25).

Medicare payments to hospices are subject to an overall aggregate per patient “cap amount.” The Medicare fiscal intermediary calculates each hospice’s cap amount by multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period, beginning November 1 and ending October 31 of the following year. Each hospice must refund Medicare payments in excess of this aggregated cap amount. The cap amount is adjusted annually for inflation or deflation.

Hospice Profitability and Payment for Medicare Beneficiaries

A 2004 Government Accountability Office (GAO) report estimated that the Medicare per diem rate for all hospice care in free-standing hospices was 8% higher than Medicare costs in 2000 and more than 10% higher in 2001. The per diem costs for smaller hospices were, on average, higher than per diem costs for medium or large hospices for each of the payment categories. Costs were higher than Medicare payments for inpatient respite care days, but lower for continuous home care, routine home care, and general inpatient care days. According to an analysis by McCue and Thompson in 2005, total mar-

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gins of free-standing hospices varied by agency size and for-profit/non-profit status in 2003 free-standing hospice cost report

data. This analysis showed that the median profit margin for large for-profit agencies was 18%, but the median for large non-profits was 2%. These total margins were calculated using all payers’ payments and all patients’ costs, so they may differ from Medicare margins.

The Medicare Payment Advisory Commission (MedPAC) suggests that changes in the use and provision of hospice care should lead to a reevaluation of the hospice payment system. Such an evaluation would assess whether

Table 2: Medicare Hospice Outlays, Clients, Days per Client, and Dollar Amount Per Client

| FY/CY | Outlays (Million \$) | # of Clients | Avg. Days/Client | Avg. Amount/Client (\$) |
|-------|----------------------|--------------|------------------|-------------------------|
| 1989 | 205.4 | 60,802 | 44.8 | 3020 |
| 1991 | 445.4 | 108,413 | 44.5 | 4108 |
| 1993 | 1151.9 | 202,768 | 57.2 | 5681 |
| 1995 | 1830.5 | 302,608 | 58.8 | 6049 |
| 1997 | 2024.5 | 374,723 | 50.1 | 5402 |
| 1999 | 2435.1 | 445,146 | 44.5 | 5471 |
| 2001 | 3610.7 | 579,801 | 49.9 | 6228 |
| 2003 | 5682.3 | 713,400 | 57.6 | 7965 |
| 2004* | 6717.1 | 797,117 | 65.0 | 8405 |
| 2006* | 9228.2 | 964,614 | 71.0 | 9567 |

CMS, Office of the Actuary, Center for Health Plans and Providers (March 2005). *Data for 2004 and 2006 represent calendar year (CY) data and are from CMS/OIS/HCIS.

Table 3: Medicare Hospice Outlays, Clients, and Days per Client, by Type of Agency, FY 2005

| Auspice | % of Outlays | Number of Clients | Average Days (per Client) |
|--------------|--------------|-------------------|---------------------------|
| Freestanding | 70.8 | 583,821 | 69.0 |
| Hospital | 11.9 | 117,597 | 52.6 |
| SNF | 0.4 | 3,854 | 54.9 |
| Home health | 17.0 | 161,777 | 53.6 |
| TOTAL | 100.0 | 791,568 | 63.8 |

Source: Centers for Medicare & Medicaid Services, Standard Analytical Files–100% Final Action Claims (Nov. 2006).

Note: The total for average days per client is weighted by the number of beneficiaries in each hospice type.

changes to the benefit structure and payment rates, which were developed 25 years ago, would improve the accuracy of the payment rate. Accurate payment for all types of patients is important to ensure that the program is paying rates that cover providers' costs for all types of patients. Making this determination is difficult, as Medicare administrative data offer little detail about hospice services used by each patient. Type of services provided, type of personnel providing the care, and frequency and duration of patient visits are not collected on Medicare claims. Only payment category billed and the number of days for each category are currently available. Medicare would have to

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collect additional data in order to make a comprehensive evaluation of patient costs and service use by hospice patients. CMS will begin collecting data on visit frequency and charges in July, 2008.

Medicare Beneficiary Liability

Beneficiary liability for the cost of hospice services is minimal. Hos-

pices may charge a 5% coinsurance for each drug furnished outside the inpatient setting, but that coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiary liability is 5% of Medicare's respite care payment per day. Beneficiary copayment for respite care may not exceed the Part A inpatient deductible, which is \$1024 per year for calendar year (CY) 2008.⁴

Medicaid-Funded Hospice

Hospice is an optional Medicaid service, currently not available in 3 states (Connecticut, New Hampshire, Oklahoma) and several territories. In FY 2004, hospice services comprised only 0.4% of total Medicaid payments. Medicaid hospice expenditures totaled \$1,129 million

Table 4: Medicare Hospice Utilization by Type of Care, FY 2002–FY 2005

| Type of Care | Units of Care | | | | % of Care by Type FY 2005 |
|------------------------|---------------|------------|------------|------------|------------------------------|
| | FY 2002 | FY 2003 | FY 2004 | FY 2005 | |
| Routine Days | 33,028,464 | 39,898,744 | 47,054,341 | 53,999,676 | 96.5 |
| Continuous hours | 2,510,587 | 3,212,941 | 4,048,227 | 4,748,147 | 1.1 |
| Inpatient respite days | 67,620 | 75,481 | 85,389 | 96,646 | 0.2 |
| General inpatient days | 885,337 | 1,045,845 | 1,138,866 | 1,250,678 | 2.2 |
| Physician procedures | 478,272 | 573,545 | 639,872 | 778,906 | N/A |

Source: CMS, Office of the Actuary, Center for Health Plans and Providers (November 2006).

Table 5. Average Medicare Reimbursements for Hospice Care, FY 2004, FY 2006, and FY 2008

| | FY 2004 Reimbursement (\$) | FY 2006 Reimbursement (\$) | FY 2008 (Projected Reimbursement \$) |
|----------------------------------|-------------------------------|-------------------------------|---|
| Routine home care (per day) | 118.08 | 126.49 | 135.11 |
| Continuous home care (per hour) | 28.72 | 30.76 | 32.86 |
| Inpatient respite (per day) | 122.15 | 130.85 | 139.76 |
| General inpatient care (per day) | 525.28 | 562.69 | 601.02 |

Source Data from CMS, Center for Health Plans and Providers. 2004 data from CMS Program Memorandum Intermediaries Transmittal A-03-057 (July 3, 2003). 2006 data from CMS Transmittal #R655CP (August 2005). 2008 data from CMS Manual System Transmittal 1280 (June 29, 2007).
Note: Average reimbursements based on total outlays and total units of care.

in FY 2004, an increase of 25.8% from the \$898 million spent in FY 2003. As is true for Medicare, hospice services represent a relatively small part of total Medicaid payments. In FY 2004, 33.7% of nearly \$259 billion in Medicaid vendor payments went to hospital and SNF services.

Managed Care and Hospice

Healthcare services in the United States are increasingly financed through managed care organizations. A managed care contract generally specifies a negotiated fee, often called a capitated payment, for the care of patients. A fully capitated plan specifies a lump sum payment per enrollee to cover all care provided through the plan. An enrollee's choice of provider and access to specialty care varies under managed care arrangements, but there tend to be incentives for consumers to use certain providers who are part of the managed care organization's network. In contrast, traditional health insurance, commonly known as "fee-for-service," pays care providers based on the number of services delivered, with few limitations on which



Competition has created incentives for hospices to enter managed care provider networks.

providers it will pay.

A MedPAC report released in June 2006 revealed that about 38% of the individuals in Medicare's managed care plan, Medicare+Choice, chose hospice compared to 31% enrolled in the traditional Medicare benefit at time of death.⁵ Managed care is most prevalent in the employer-based health insurance market. In 2002, 95% of insured workers received health benefits through a managed care plan.⁶ Managed care enrollment has increased among Medicaid beneficiaries, particularly in states that have federal waivers to convert their Medicaid program to a managed care program. As of December 31, 2006, 65.44% of all Medicaid beneficiaries were enrolled in managed care.⁷

Medicare managed care enrollment has increased at a slower pace. As of January 2008, 20.1% of Medicare beneficiaries were enrolled in Medicare Advantage.⁸

When a Medicare-eligible patient who is an enrollee of a Medicare-participating managed care organization (MCO) elects hospice care, the hospice services must be provided through a Medicare-approved hospice, and the individual must meet the eligibility requirements specified by Medicare. The patient does not need a referral from the MCO, and is not required to disenroll from the MCO. Medicare pays the hospice for its services and the MCO for attending physician services and services not related to the patient's terminal illness. In addition, MCOs are required to inform enrollees about the availability of hospice care if a Medicare-certified hospice is located in the MCO's service area or it is common practice to refer patients to hospice programs outside their service area.

The increasingly competitive healthcare market has created incentives for hospices to enter managed care provider networks. Hos-

Table 6. Comparison of Hospital, SNF, and Hospice Medicare Charges, 1999 to 2007 (Odd Years)¹

| | Charges per Day of Care (\$) | | | | |
|--------------------|------------------------------|------|------|------|------|
| | 1999 | 2001 | 2003 | 2005 | 2007 |
| Hospital inpatient | 2583 | 3069 | 4117 | 4999 | 5549 |
| SNF | 424 | 422 | 487 | 504 | 572 |
| Hospice | 113 | 120 | 129 | 137 | 114 |

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

pices have considerable experience managing payments under the Medicare prospective reimbursement system's per-patient cap. Little is known about the extent to which hospices have entered into managed care arrangements or what impact these arrangements have on hospice clients.

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

2003 National Long Term Care Survey) showed reduced Medicare expenditures in the last year of life. These savings averaged \$2309 per hospice user, with a maximum of \$7000 for cancer and \$3500 for other primary conditions. These savings were greatest for a cancer

Who Are Hospice Patients?

In a June 2006 MedPAC report, 2003 data from the National Center for Health Statistics (NCHS) showed that cancer as the primary hospice diagnosis decreased from 75% in 1992 to 58% in 2000 and to 43% in 2002-2003 (Figure 1). The balance between hospice patients with cancer diagnoses and those with noncancer diagnoses has shifted dramatically in that 10-year period.

The number of Medicare hospice clients increased to 964,614 in CY 2006, and the average length of stay increased from 65.3 days in CY 2005 to 71.0 days in CY 2006. The share of beneficiaries aged 95 or older who died while in hospice care rose from 12% to 23% between 1998 and 2002 (Figure 2). Hospice use by beneficiaries in nursing facilities grew from 11% to 35% from 1992 to 2000.⁹

How Cost Effective Is Hospice?

Compared to hospital and skilled nursing, hospice is a cost-effective service. Table 6 compares the average costs for a Medicare patient to stay 1 day in a hospital, a SNF, and a hospice. Hospice charges per day are substantially lower than hospitals and SNFs.

A study conducted by Duke University (using data from the 1993-

Figure 1. Hospice Patients by Diagnosis, 1992, 2000, and 2002-2003

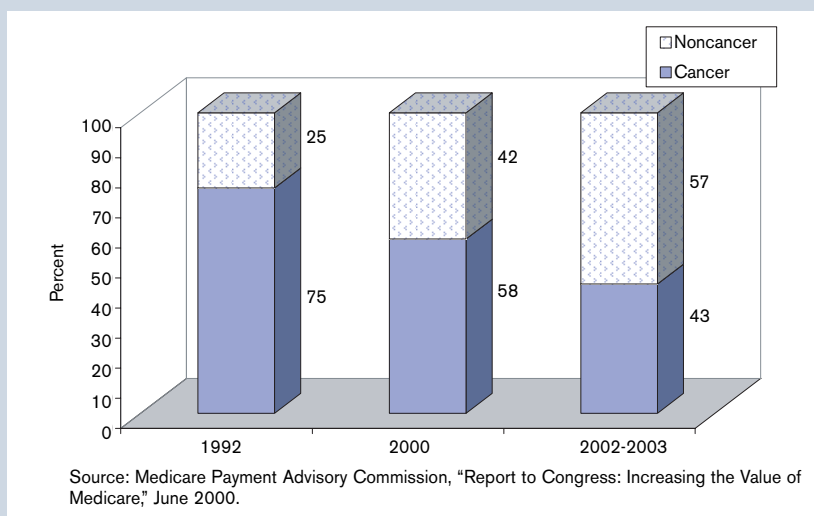
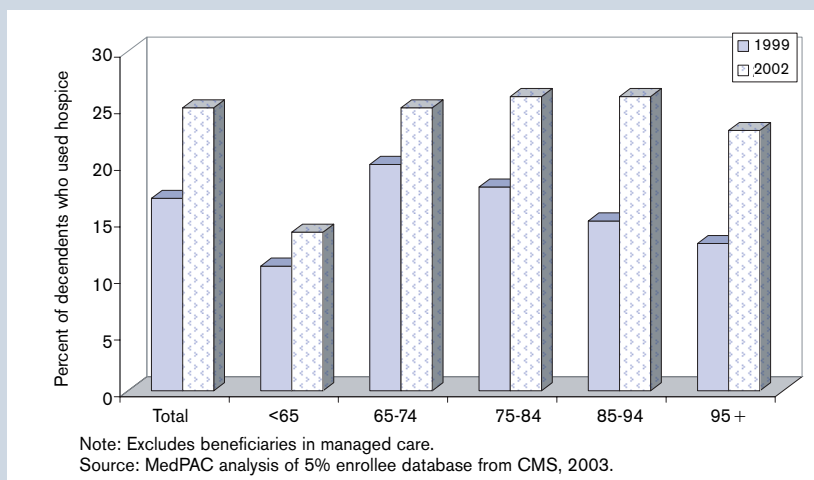


Figure 2. Growth in Hospice Use Is Greatest Among Older Decedents



How CMS Sets Hospice Payment Rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit, regardless of the amount of services furnished on a given day. Payments are intended to cover costs that the hospice incurs in furnishing services identified in patients' care plans. Payments are made based on the level of care required by the beneficiary:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each care category's base rate has a labor share and a nonlabor share. The labor share of the base payment amount is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket index.

The fiscal year 2008 payment rates for the period of October 1, 2007 through September 2008 increased

by 3.3% of the 2007 payment rates, as depicted in the chart that follows.

There are 2 caps that apply to the hospice benefit:

- The number of days of inpatient care it may furnish is limited to not more than 20% of total patient care days
- An aggregate payment amount that is based on the number of Medicare patients electing the benefit within the cap period

The hospice aggregate cap is adjusted annually by the medical expenditure category of the Consumer Price Index for all urban consumers. For the cap year ending October 31, 2007, the cap was \$21,410.04.

For claims with dates of service on or after January 1, 2008, hospices must report the Core Based Statistical Area for the location where services are furnished for all levels of hospice care.

Additional information about the hospice benefit is available at the Hospice Center Web Page at <http://www.cms.hhs.gov/center/hospice.asp>

Fiscal Year 2008 Hospice Payment Rates

| Code | Description | Rate (\$) | Wage Component Subject to Index (\$) | Nonweighted Amount (\$) |
|------|---|-----------|--------------------------------------|-------------------------|
| 651 | Routine Home Care | 135.11 | 92.83 | 42.28 |
| 652 | Continuous Home Care Full Rate = 24 hours of care \$32.86 hourly rate | 788.55 | 541.81 | 246.74 |
| 655 | Inpatient Respite Care | 139.76 | 75.65 | 64.11 |
| 656 | General Inpatient Care | 601.02 | 384.71 | 216.31 |

CMS. Payment System Fact Sheet. CMS Web site. http://www.cms.hhs.gov/mlnproducts/downloads/hospice_pay_sys_fs.pdf. Accessed April 10, 2008.

diagnosis when hospice was used for the last 58 to 103 days of life, and for other primary conditions, the last 50 to 108 days of life. The study directors estimate that increasing the length of hospice use for 7 in 10 Medicare hospice users would increase savings.¹⁰ Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, also provide strong evidence that hospice is a

less costly approach to care for the terminally ill. A 1988 study conducted by Abt Associates for HCFA (now CMS) concluded that during the first 3 years of the hospice benefit, Medicare saved \$1.26 for every \$1.00 spent on hospice care.¹¹ The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days

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

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The June 2006 MedPAC Report to Congress states that more than 25% of hospice patients are on the benefit less than 1 week. Using CMS Medicare claims data, MedPAC found the median length of stay for hospice patients was only 15 days.¹² Hospice use grew from 22% of eligible dying in 2000 to 31% in 2004.⁹ The total number of covered days of hospice care doubled during that same period. The reluctance of caregivers, patients, and families to accept a terminal prognosis, along with the difficulty of predicting death may account for part of the delay.

Education about hospice and its benefits may help broaden its use and improve end-of-life care (see “Ask the Experts” on page 39 of this issue for more discussion on delay in entering hospice).

The Demand for Hospice

Hospice is a humane and compassionate way to deliver health care and supportive services. Based largely on interviews with family members, a study of the end-of-life experience of 3357 older decedents and seriously ill patients who died reported that 40% were in severe pain prior to their death, and 25% experienced moderate to great anxiety or depression before they died.¹³ The researchers found that very few patients received hospice care prior to their deaths, and they suggested that encouraging hospice might alleviate some of the distress that patients typically face at the end of life. Hospice care allows terminally ill patients and their families to remain together in the comfort and dignity of their homes, preserving one of our country’s most important social values by

keeping families together. In addition, hospice care allows family members to take an active role in providing or supplementing the care given by formal caregivers.

The number of patients accessing the Medicare Hospice benefit has increased in recent years. The largest growth has been in residents of nursing facilities. MedPAC’s 2004 *Report to the Congress* noted that the number of hospice patients residing in nursing facilities increased from 11% to 36% from 1992 through 2000. Brown University researchers, in a study entitled, “Hospice Enrollment and Hospitalization of Dying Nursing Home Patients,”¹⁴ revealed that when hospice care is integrated into nursing home care, there are decreased hospitalizations for the SNF patients.

The Future of Hospice

Trends indicate that as more patients and families are educated about its many benefits, hospice is growing as an attractive alternative to facing death in a clinical setting. Nevertheless, only a fraction of those who have the option of hospice care choose to participate in it. Physicians and nurses caring for patients with terminal illnesses in clinical facilities need to open the dialogue with families about the option of hospice and its possible benefits to patients and their

caregivers. Until clinicians, patients, and families become more comfortable talking about death and the dying process, hospice will remain marginalized as an excellent option for accessing supportive services during an extremely difficult time.

The information in this article was abstracted with permission from *Hospice Facts and Statistics*. Hospice Association of America, 2008. <http://www.nahc.org/facts/HospiceStats08.pdf>. MPM

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