CHAPTER 10

Hospice services

RECOMMENDATION

10 For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 10

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and supportive services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When a beneficiary elects hospice, they agree to receive palliative care for their terminal illness and related conditions under the hospice benefit and forgo care related to the terminal illness outside of hospice. Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA). In 2024, more than 1.8 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,700 providers, and Medicare hospice expenditures totaled $28.3 billion.

In this chapter

Assessment of payment adequacy

The indicators of FFS Medicare payment adequacy for hospices were positive.

***Beneficiaries' access to care*—**In 2024, indicators of beneficiaries' access to care were positive. The number of hospice providers and measures of hospice utilization increased.

- ***Capacity and supply of providers*—**In 2024, the number of hospice providers increased by 2.6 percent as more for-profit hospices entered the market, a trend that has continued for more than a decade.
- ***Volume of services*—**The share of decedents using hospice increased to 52.9 percent in 2024, up from 51.7 percent in 2023, reaching a new high. The number of hospice users and total days of hospice care also increased in 2024. For decedents, average lifetime length of stay increased by about 3 days to 99.6 days, and median length of stay increased by 1 day to 19 days in 2024. For hospice patients receiving routine home care, the frequency and length of in-person hospice visits by hospice staff was stable in 2024, an average of 3.9 visits per week, each just under an hour long on average.

***Quality of care*—**Measures of patient experience from the Hospice Consumer Assessment of Healthcare Providers and Systems were stable in the most recent period. Performance on a measure of processes of care at admission—reflecting a composite score calculated by CMS using data on seven processes of care submitted by hospices—improved slightly but was very high and topped out for most providers (i.e., scores are so high and unvarying that one can no longer make meaningful distinctions among providers or gauge improvement in performance). A measure of in-person nurse and social worker visits in the last three days of life improved in the most recent period.

***Providers' access to capital*—**Hospices are generally not as capital intensive as many other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (an increase of about 5 percent in 2024) and reports of continued investor interest in the sector suggest that capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers. Hospital-based and home health–based hospices have access to capital through their parent providers.

***FFS Medicare payments and providers' costs*—**Hospice FFS Medicare margins are presented through 2023 because of the standard data lag required to calculate cap-overpayment amounts. Between 2022 and 2023, average costs per day increased by 3.0 percent. The aggregate FFS Medicare margin for 2023 was 8.0 percent, down from 9.8 percent in 2022. In 2024, cost growth slowed, with hospices' average cost per day increasing by 1.1 percent. The projected 2026 FFS Medicare margin is 9 percent.

How should FFS Medicare payments change in 2027?

Under current law, the FFS Medicare base payment rate for hospice services is projected to increase by 2.3 percent in 2027. Based on the positive indicators of payment adequacy and the strong FFS Medicare margins, current payment rates appear sufficient to support the provision of high-quality care without an increase to the payment rates in 2027. The Commission recommends that the Congress eliminate the update to the hospice base payment rates for fiscal year 2027. ■

As required by law, the Commission annually makes payment-update recommendations for providers paid under Medicare's traditional fee-for-service (FFS) payment systems. Such providers include hospices that furnish palliative and supportive services to Medicare beneficiaries who are terminally ill and whose prognosis indicates that the individual's life expectancy is six months or less if the illness runs its normal course.

Background

The hospice benefit covers services that are reasonable and necessary for palliation of the terminal illness and related conditions. The hospice benefit covers a broad set of palliative services (e.g., visits by nurses, aides, social workers, physicians, and therapists; drugs, durable medical equipment, and supplies; short-term inpatient care and respite care; bereavement services for the family; and other services for palliation of the terminal illness and related conditions). To receive hospice services, a beneficiary must elect the hospice benefit. When a beneficiary elects hospice, they agree to receive palliative care for their terminal illness and related conditions under the hospice benefit and forgo care related to the terminal illness outside of hospice. Medicare continues to cover items and services unrelated to the terminal illness outside of hospice. Most commonly, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities, assisted-living facilities, hospice facilities, and other inpatient settings. In 2024, Medicare's hospice prospective payment system (PPS) paid about $28.3 billion for hospice services for more than 1.8 million Medicare beneficiaries.

Beneficiaries elect hospice for defined benefit periods. When a beneficiary first elects hospice, two physicians—a hospice physician and the beneficiary's attending physician—are required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.[1] The first hospice benefit period spans up to 90 days. After the first period, the hospice physician can recertify the patient for a second 90-day period and for an unlimited number of 60-day periods after that, as long as the patient's terminal illness continues to engender a life expectancy of six months or less. Beneficiaries can disenroll from hospice at any time (referred to as "revoking hospice") and can reelect hospice for a subsequent period as long as they meet the eligibility criteria.

Enrollment in the hospice benefit is voluntary; it is a choice made by individual beneficiaries and their families. Patient autonomy and care according to a patient's preferences are important principles in end-of-life care. The decision of whether to elect hospice is a deeply personal one for a beneficiary and their family, influenced by their preferences and beliefs and informed by discussions with their physician and health care providers about disease progression, prognosis, and options for care. While it is important that eligible beneficiaries have the option to elect hospice, it is also important that beneficiaries can choose not to enroll in hospice care and remain with conventional care throughout the end of life.

The most important benefit of hospice is its effect on patient care. The Medicare hospice benefit offers beneficiaries the option to receive end-of-life care focused on symptom management and quality of life and can enable some beneficiaries to die at home (rather than in the hospital) if they wish to do so. When the Congress expanded the Medicare benefit to include hospice care in 1983, it was thought that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). The literature is mixed on whether hospice has reduced Medicare spending compared with conventional care, with findings varying in part depending on the methodology used.[2] The Commission has additional research underway in this area.

Medicare payment for hospice services

The FFS Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day that a patient is enrolled, regardless of whether the hospice staff visits the patient or otherwise provides a service each day. This payment design is intended to encompass not only the cost of visits but also other costs that a hospice incurs for palliation and management of the terminal illness and related

conditions (e.g., on-call services, care planning, and nonvisit services like drugs and medical equipment).

Payments are made according to a fee schedule that has four levels of care. Routine home care (RHC) is the most common level of care, accounting for 98.8 percent of Medicare-covered hospice days in 2024. There are three other specialized levels of care: continuous home care (CHC), which is provided in the home during periods of patient crisis; general inpatient care (GIP), which is provided when symptoms require management in an inpatient setting; and inpatient respite care (IRC), which is provided to enable a short respite for a patient's primary caregiver. In both 2023 and 2024, 89 percent of Medicare hospice patients received at least one day of RHC, 16 percent received at least one day of GIP, 4 percent received at least one day of IRC, and 2 percent received at least one day of CHC (with some patients receiving more than one level of hospice care over the course of their hospice stay). The per diem payment for RHC is higher during the first 60 days of a hospice episode and reduced for days 61 and beyond. For the other three levels of care, the daily payment rate is higher than for RHC. Medicare makes additional payments for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC.

When the Congress established the hospice benefit, it included a "cap" limiting the aggregate Medicare payments that an individual hospice can receive.[3] The cap is not applied individually to the payments received for each beneficiary, but rather to the total payments across all Medicare patients served by the hospice in the cap year. Each hospice's aggregate payments are capped at a level equal to their number of patients in the year multiplied by the aggregate cap amount. If a hospice's total Medicare payments exceed that amount, it must repay the excess to the program. Unlike the daily hospice payments, the cap is not adjusted for geographic differences in costs. The hospice aggregate cap in 2026 ($35,361) is equivalent to the amount that Medicare pays for an RHC hospice stay of about 178 days (assuming a wage index of 1.0). Because the cap is applied in the aggregate across the provider's entire patient population (including both short and long stays) and not at the stay level, a hospice provider can furnish a substantial number of long stays and remain under the cap.[4] In 2023, we estimate that nationally about 28 percent of hospices, which provided care to about 8 percent of hospice patients, exceeded the cap and were required to return payments to the program. Above-cap hospices are disproportionately concentrated in four states that have been subject to enhanced program-integrity efforts by CMS. The Commission first recommended in March 2020 that the hospice cap be wage adjusted and reduced by 20 percent to make the cap more equitable across providers and focus payment reductions on providers with long stays and high margins (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2020).

FFS Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA).[5] Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a provider paid by FFS Medicare (while Medicare continues to pay the MA plan for Part D services and Part C rebates, but not Part A and Part B services).[6] In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefit package (Medicare Payment Advisory Commission 2014). In making this recommendation, the Commission expressed concern that the carve-out of hospice from the MA benefit package fragments financial responsibility and accountability for care. The Commission stated that including hospice in the MA benefit package could have a number of potential benefits: It would give plans responsibility for the full continuum of care and promote integrated, coordinated care; it would give MA plans greater incentive to develop and test innovative programs to improve end-of-life care; and it would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, accountable care organizations, and FFS) (Medicare Payment Advisory Commission 2014). From 2021 to 2024, as part of its value-based insurance design (VBID) models in MA, CMS's Innovation Center implemented a voluntary demonstration permitting MA organizations to provide hospice and palliative care services for their enrollees to test the effects of adding the hospice benefit to MA (Centers for Medicare & Medicaid Services 2020). In 2023, the last year for which data are currently available from a CMS contractor report, 23,828 beneficiaries who were enrolled in MA plans participating in the hospice VBID model started hospice that year paid for by the MA plan. CMS ended the hospice component of the MA–VBID model in December 2024, citing plan-

TABLE 10-1 **Increase in total number of hospices driven by entry of for-profit providers**

Category	2019	2020	2021	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
All hospices	4,840	5,058	5,358	5,899	6,535	6,706	7.8%	2.6%
For profit	3,435	3,694	4,024	4,581	5,243	5,497	11.2	4.8
Nonprofit	1,254	1,217	1,190	1,172	1,155	1,070	–2.0	–7.4
Government	149	145	141	138	136	130	–2.3	–4.4
Freestanding	3,942	4,190	4,515	5,074	5,695	5,740	9.6	0.8
Hospital based	430	413	394	383	365	350	–4.0	–4.1
Home health based	449	436	432	421	415	415	–1.9	0.0
SNF based	19	19	17	17	17	16	–2.7	–5.9
Urban	3,973	4,193	4,501	5,051	5,701	5,877	9.4	3.1
Rural	861	856	849	834	833	829	–0.8	–0.5

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census) and reflect the hospice's office location. Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report, or the hospice is included in the cost report of a hospital, home health agency, or SNF). Some categories do not sum to totals because of missing data for some providers. Missing data on hospice type particularly affect the most recent year (2024), for which we lack data on this characteristic for 185 providers. Numbers for 2023 and earlier years in certain categories may differ from those in our prior reports due to refinements in methodology and/or use of updated data.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, Hospice Enrollments dataset, and Medicare hospice claims data from CMS.

implementation challenges and declining numbers of participating plans as reasons for the decision (Centers for Medicare & Medicaid Services 2024).[7]

Are FFS Medicare payments adequate in 2026?

To address whether payments in 2026 are adequate to cover the costs of efficient delivery of care and how much providers' payments should change in the coming year (2027), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs.

Overall, our indicators of FFS Medicare payment adequacy for hospice care are positive.

Beneficiaries' access to care: Hospice supply grew substantially, and use increased

Our analysis of access indicators—including trends in the supply of providers and use of hospice services—shows that beneficiaries' access to care in 2024 was favorable.

Supply of hospices continued to grow in 2024, driven by an increase in for-profit providers

In 2024, 6,706 hospices provided care to Medicare beneficiaries, a 2.6 percent increase from the prior year (Table 10-1). Market entry of for-profit providers drove the growth in supply. We report on changes in the supply of hospice providers but caution that the number of hospice providers is not necessarily

an indicator of beneficiary access to hospice care because the number does not capture the size of providers, their capacity to serve patients, or the size of their service areas. Commission analyses of data from 2008 and 2019 found that hospice-use rates across states appear unrelated to a state's number of hospice providers per 10,000 beneficiaries (data not shown) (Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2010).

In 2024, the number of for-profit hospices grew about 5 percent (Table 10-1, p. 299). Between 2023 and 2024, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed over a number of years. In 2024, among the hospices for which we have data, about 82 percent of providers were for profit; however, they furnished care to 60 percent of Medicare hospice patients because, on average, for-profit providers had smaller patient censuses than nonprofit providers (latter data not shown). The number of freestanding providers increased, while the number of home health–based hospices was unchanged and the number of hospital-based and skilled nursing facility (SNF)–based hospices declined in 2024.[8,9] In 2024, we found, based on only hospices without missing data, that about 88 percent of hospices were freestanding, and these hospices furnished care to 84 percent of Medicare hospice patients (latter data not shown).

The number of rural hospices declined just under 1 percent in 2024, continuing the trend observed from 2019 to 2023 of rural providers declining about 1 percent per year on average (Table 10-1, p. 299). As of 2024, we estimate that 88 percent of hospices were located in urban areas and 12 percent were in rural areas. As noted above, the number of hospices located in rural areas is not reflective of hospice access for rural beneficiaries because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service areas. Further, some urban hospices provide services in rural areas. Indeed, as discussed below, the share of rural decedents using hospice grew in 2024 (Table 10-2).

The moderate growth in the number of hospices in 2024 follows a period of substantial growth in provider supply driven by rapid provider entry in a few states. Between 2019 and 2023, the number of hospice providers grew an average of 7.8 percent per year nationally (Table 10-1, p. 299). Over that period, four states had above-average growth in the number of hospices: California (gain of 1,046 hospices, a 19 percent per year increase), Texas (gain of 257 hospices, a 9 percent per year increase), Arizona (gain of 96 hospices, a 14 percent per year increase), and Nevada (gain of 60 hospices, a 21 percent per year increase) (data not shown). In 2024, growth in the number of hospices slowed in three of the four states (California, Texas, and Arizona), contributing to the more moderate growth in the overall number of providers observed in 2024. Between 2023 and 2024, Arizona gained 1 hospice (a less than 1 percent increase); California gained 38 hospices (a 2 percent increase); Texas gained 44 hospices a (5 percent increase); and Nevada gained 23 hospices (a 20 percent increase). In addition, beyond the four states, other states and the District of Columbia had generally modest changes in the number of providers in 2024 relative to 2023, with 24 additional states experiencing an increase in the number of providers, 15 experiencing no change, and 8 experiencing a decrease. The two states with the biggest decline in the number of hospices were Louisiana (four hospices) and Mississippi (two hospices); hospice use among decedents in these states increased between 2023 and 2024 despite the decline in the number of providers.

The rapid entry of providers in Arizona, California, Nevada, and Texas in recent years has spurred program-integrity efforts by the State of California and CMS, which may partly account for the slowdown in provider entry observed in some of these states in 2024. California placed a moratorium on new hospice licenses in 2022 and bolstered its state laws governing hospice referral and patient-enrollment practices (California Legislature 2021). The California state auditor issued a report on hospice care in Los Angeles County, stating that "growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for hospice services" and identifying "numerous indicators of fraud and abuse" (Tilden 2022). Further, the California auditor's report stated that "the fraud indicators we found particularly in Los Angeles County include the following: A rapid increase in the number of hospice agencies with no clear correlation to increased need. Excessive geographic clustering of hospices with sometimes dozens of separately licensed agencies located in the same building. Unusually long durations of hospice services provided to individual patients. Abnormally high rates

TABLE 10–2

In 2024, the share of decedents using hospice increased overall and across all beneficiary subgroups

	Share of Medicare decedents who used hospice						
	2010	2019	2022	2023	2024	Average annual percentage point change 2010–2023	Percentage point change 2023–2024
All decedent beneficiaries	43.8%	51.6%	49.1%	51.7%	52.9%	0.6	1.2
FFS beneficiaries	42.8	50.7	49.1	51.7	52.9	0.7	1.2
MA beneficiaries	47.2	53.2	49.2	51.7	52.9	0.3	1.2
Dually eligible for Medicaid	41.5	49.3	43.9	46.7	48.1	0.4	1.4
Not Medicaid eligible	44.5	52.4	51.1	53.6	54.6	0.7	1.0
Age							
<65	25.7	29.5	26.6	28.6	29.8	0.2	1.2
65–74	38.0	41.0	37.7	40.3	41.1	0.2	0.8
75–84	44.8	52.2	49.4	51.9	52.9	0.5	1.0
85+	50.2	62.7	61.8	64.1	65.2	1.1	1.1
Race/ethnicity							
White	45.5	53.8	51.7	54.3	55.6	0.7	1.3
Black	34.2	40.8	37.4	39.7	40.9	0.4	1.2
Hispanic	36.7	42.7	38.2	40.0	40.4	0.3	0.4
Asian American	30.0	39.8	38.0	39.0	39.7	0.7	0.7
North American Native	31.0	38.5	37.2	39.3	41.0	0.6	1.7
Sex							
Male	40.1	46.7	43.9	46.4	47.6	0.5	1.2
Female	47.0	56.3	54.4	56.9	58.1	0.8	1.2
Beneficiary location							
Urban	45.6	52.8	50.2	52.7	53.8	0.5	1.1
Micropolitan	39.2	49.7	47.3	50.2	51.6	0.8	1.4
Rural, adjacent to urban	39.0	49.5	47.9	50.9	52.6	0.9	1.7
Rural, nonadjacent to urban	33.8	43.8	42.1	44.9	46.5	0.9	1.6
Frontier	29.2	36.2	35.3	37.1	38.8	0.6	1.7

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. "Beneficiary location" refers to the beneficiary's county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definitions. The "frontier" category is defined as population density equal to or less than six people per square mile and overlaps the categories of residence. Yearly figures presented in the table are rounded, but figures in the columns for percentage-point change were calculated on unrounded data. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

of still-living patients discharged from hospice care. Hospice agencies using possibly stolen identities of medical personnel" (Tilden 2022).

In recent years, CMS has reported taking a number of steps to increase program-integrity efforts for hospice providers overall and specifically in four states. Beginning July 2023, for newly enrolled hospices in Arizona, California, Nevada, and Texas, CMS has implemented a provisional period of enhanced oversight (PPEO) that involves conducting medical review before making payments on these providers' claims (Centers for Medicare & Medicaid Services 2025a). CMS reports that under the PPEO initiative, the agency reviewed claims for 668 hospices in the four states and revoked Medicare enrollment of 122 of these providers as of June 2025. In addition, CMS reported expanding prepayment review to existing hospices in the four states as of September 2024. Beyond these efforts focused specifically on these states, CMS has reported undertaking broader initiatives including a nationwide hospice site-visit project, streamlining the beneficiary disenrollment process (for beneficiaries wishing to disenroll from hospice), establishment of a rapid response team to resolve beneficiary complaints about inappropriate hospice enrollment, and a pilot project to review hospice claims following an individual's first 90 days of hospice care (Centers for Medicare & Medicaid Services 2025a, Centers for Medicare & Medicaid Services 2023a). CMS has also undertaken several other types of measures to enhance aspects of program integrity for hospice providers (e.g., requiring physicians certifying hospice eligibility to be enrolled in Medicare or have officially opted out, categorizing hospice as "high risk" for Medicare enrollment screening purposes, and requiring hospices to reapply for enrollment if there is a majority ownership change within 36 months of enrollment or a prior majority ownership change) (Centers for Medicare & Medicaid Services 2023b, Centers for Medicare & Medicaid Services 2023c).

Volume of services: Measures of hospice use increased in 2024

Nationally, the share of Medicare decedents using hospice increased in 2024. In that year, 52.9 percent of Medicare decedents received hospice services, up from 51.7 percent in 2023, reaching a new high (Table 10-2, p. 301). The hospice-use rate, which had increased in the prior decade from 2010 to 2019, declined in the first two years of the pandemic to 47.3 percent in 2021 as beneficiary deaths outpaced growth in the number of hospice users (2021 data not shown) (Medicare Payment Advisory Commission 2023). The hospice-use rate began increasing in 2022 and increased again in both 2023 and 2024.

In 2024, the share of decedents using hospice increased across all subgroups examined (Table 10-2, p. 301). However, hospice use remained more common among decedents who were older, female, White, residents of urban areas, and not eligible for Medicaid (i.e., not dually eligible for Medicare and Medicaid). Hospice use among beneficiaries with end-stage renal disease (who used dialysis at some time during the last year of life), a group that has lower-than-average hospice use, increased to 31.4 percent in 2024, up from 31.0 percent in 2023 (data not shown). In 2024, hospice-use rates were similar for FFS and MA decedents.

Although overall between 2010 and 2024 hospice-use rates increased among all racial and ethnic groups examined, rates continued to be higher for White decedents (Table 10-2, p. 301). The reasons for these differences are not fully understood. Researchers have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care and advance care planning, disparities in access to care or information about hospice, socioeconomic factors, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000, LoPresti et al. 2016, Martin et al. 2011).

In 2024, decedents' hospice-use rates increased across all categories of rural and urban counties (Table 10-2, p. 301). Historically, a greater share of urban decedents than rural decedents have used hospice. However, the difference in hospice-use rates between decedents in urban and rural counties has lessened over time as hospice-use rates grew more in rural counties than urban counties between 2010 and 2024 (Table 10-2). Hospice use is lowest among beneficiaries in frontier counties, although hospice use in these areas has also grown.

In 2024, measures of hospice use for all hospice enrollees (not just decedents) increased. That year, 1.82 million Medicare beneficiaries received hospice services, a 4.6 percent increase from 2023. The number of hospice days furnished increased substantially, 7.7 percent, to about 148 million days (Table 10-3).[10]

TABLE 10–3

Hospice use increased in 2024

	2010	2019	2022	2023	2024	Average annual percent change 2010–2019	Average annual percent change 2019–2023	Percent change 2023–2024
Hospice use among Medicare decedents								
Number of Medicare decedents (in millions)	1.99	2.32	2.64	2.50	2.52	1.7%	1.8%	0.7%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.30	1.29	1.33	3.6	1.9	3.0
Average lifetime length of stay among decedents (in days)	87.0	92.5	95.3	96.2	99.6	0.7	1.0	3.5
Median lifetime length of stay among decedents (in days)	18	18	18	18	19	0 days	0 days	1 day
Medicare use and spending for all hospice users (not limited to decedents)*								
Total spending (in billions)	$12.9	$20.9	$23.7*	$25.7*	28.3*	5.5%	5.3%*	10.4%*
Number of Medicare hospice users (in millions)	1.15	1.61	1.72*	1.74*	1.82*	3.8	2.0*	4.6*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	130.2*	137.7*	148.2*	4.6	3.1*	7.7*

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. Total spending, number of hospice users, number of hospice days, and average length of stay displayed in the table are rounded; the percentage-change columns for the number of hospice users and total spending are calculated using unrounded data.
* These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation hospice model of MA value-based insurance design (VBID) from 2021 to 2024. According to a CMS contractor evaluation report, 19,065 MA beneficiaries in 2022 and 23,828 MA beneficiaries in VBID-participating MA plans in 2023 started hospice that year under the model (Eibner et al. 2025). An evaluation report with data on experience in the fourth year of the model (2024) is not available yet.

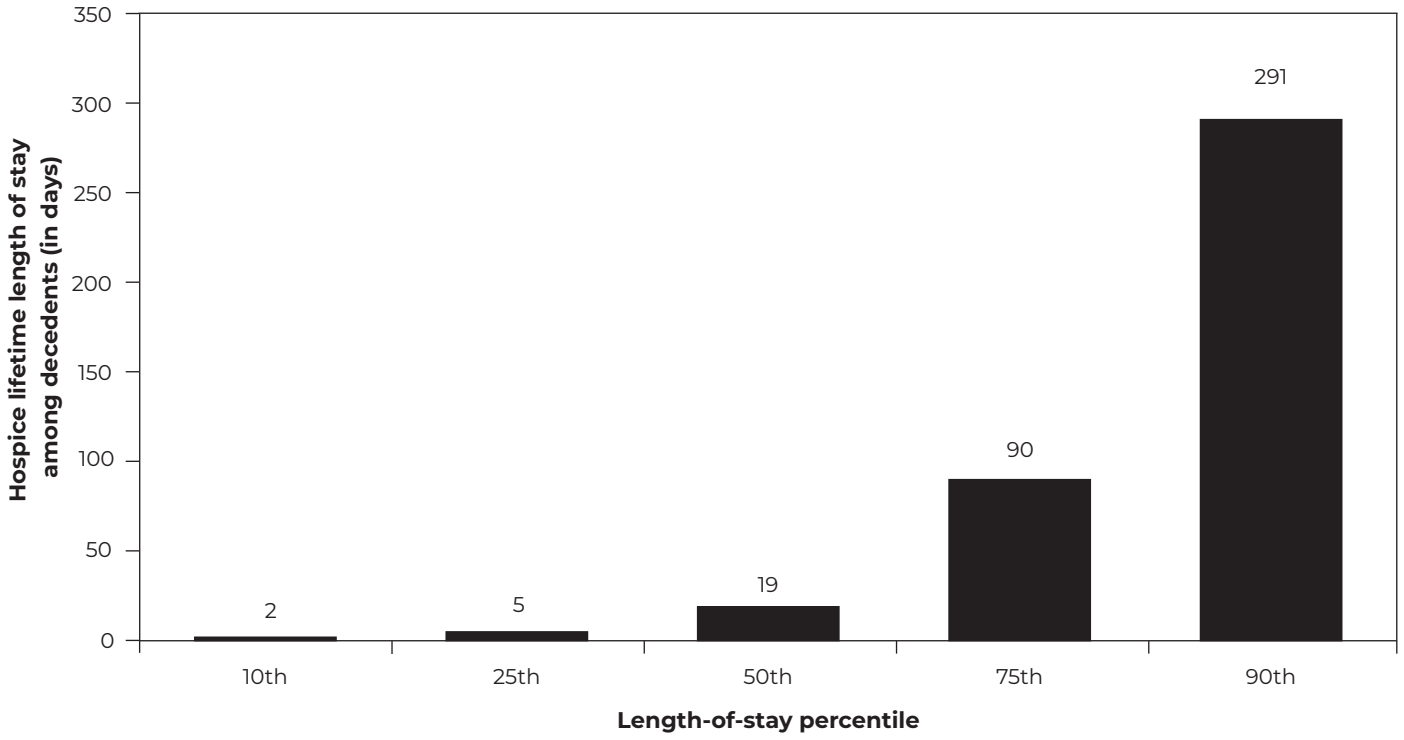
Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

Hospice length of stay increased in 2024 Average lifetime length of stay among decedents was 99.6 days in 2024, up from 96.2 days in 2023 (Table 10-3). Median length of stay increased by 1 day to 19 days in 2024. Most hospice decedents have short stays, but some have very long stays (Figure 10-1, p. 304). Between 2023 and 2024, length of stay among decedents with the shortest stays remained the same (2 days at the 10th percentile and 5 days at the 25th percentile), and it increased among those with longer stays (from 86 days to 90 days at the 75th percentile and from 278 days to 291 days at the 90th percentile) (Figure 10-1; 2023 data not shown).

Length of stay has implications for our broader assessment of payment adequacy because patients' length of stay affects provider profitability. Hospices furnish more services at the beginning and end of a hospice episode and fewer services in the middle, making long stays more profitable for providers than

FIGURE 10–1

Most hospice decedents had relatively short stays, but some had very long stays, 2024



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

Source: MedPAC analysis of the Common Medicare Environment and the Medicare Beneficiary Database from CMS.

short stays (Medicare Payment Advisory Commission 2013). Hospice lengths of stay vary by observable patient characteristics—such as patient diagnosis and location—so hospice providers can identify and enroll patients who are likely to have long (more profitable) stays if they so choose. For example, in 2024, average lifetime length of stay was longer among decedents admitted to hospice for neurological conditions and chronic obstructive pulmonary disease (169 days and 133 days, respectively) than among decedents with cancer (51 days). Length of stay was also longer among patients in assisted-living facilities (174 days) or nursing facilities (120 days) compared with patients at home (100 days).

For-profit hospices have substantially longer average lengths of stay than nonprofit hospices (120 days compared with 71 days, respectively, in 2024). For-profit hospices have more patients admitted for diagnoses that tend to have longer stays, but they also have patients with longer stays than nonprofit hospices for all types of diagnoses. For example, among hospice decedents admitted for neurological conditions, average length of stay was 194 days for for-profit hospices and 129 days for nonprofit hospices.[11] These differences in patient mix and length of stay contribute to the variation observed among providers' profit margins, discussed below. (See our March 2021 report to the Congress for a text box discussing approaches that could be explored to modify the hospice payment system to reduce variation in profitability by length of stay and address aberrant utilization patterns by some providers (Medicare Payment Advisory Commission 2021).)

TABLE 10–4

Over 60 percent of Medicare hospice spending was for patients with stays exceeding 180 days, 2024

	Medicare hospice spending, 2024 (in billions)
All hospice users in 2024	$28.3
Beneficiaries with LOS > 180 days	17.5
Days 1–180	5.6
Days 181–365	5.3
Days 366+	6.6
Beneficiaries with LOS ≤ 180 days	10.9

Note: LOS (length of stay). "LOS" reflects the beneficiary's lifetime days with hospice as of the end of 2024 (or at the time of discharge in 2024 if the beneficiary was not enrolled in hospice at the end of 2024). All spending reflected in the chart occurred only in 2024. Components do not sum to totals because of rounding.

Source: MedPAC analysis of Medicare hospice claims data and an Acumen data file on hospice lifetime length of stay (which is based on an analysis of historical claims data).

Although most patients have short hospice stays, long stays account for the majority of Medicare spending on hospice. In 2024, Medicare spent more than $17 billion, just over 60 percent of hospice spending that year, for patients with stays exceeding 180 days (Table 10-4). About $6.6 billion of that spending was for hospice care for patients who had already received at least one year of hospice services (which is already twice the presumptive eligibility period for the hospice benefit).

Among the hospices with very long stays are those that exceed the hospice aggregate cap. We estimate that in 2023, about 28 percent of hospices (which furnished care to about 8 percent of hospice beneficiaries in 2023) exceeded the aggregate payment cap, up from about 23 percent in 2022 (Table 10-5).[12] On average,

TABLE 10–5

Hospices that exceeded Medicare's annual payment cap, 2019–2023

	2019	2020	2021	2022	2023
Estimated share of hospices exceeding the cap	19%	19%	19%	23%	28%
Average payments over the cap per hospice exceeding it (in thousands)	$384	$422	$451	$419	$410
Payments over the cap as a share of overall Medicare hospice spending	1.7%	1.8%	2.0%	2.3%	2.9%

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from CMS claims-processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing vary across contractors. The cap years for 2019 through 2023 are aligned with the federal fiscal year (October 1 to September 30 of the following year).

Source: MedPAC analysis of Medicare hospice claims data, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

each above-cap hospice exceeded the cap by about $410,000 in 2023. Hospices that exceed the cap are disproportionately located in four states—Arizona, California, Nevada, and Texas. Excluding these four states, we estimate that the share of hospices exceeding the cap in 2023 was about 6 percent, up slightly from 5 percent in 2022. In contrast, we estimate that more than half of hospices in California exceeded the cap in 2023 and approximately 30 percent to 40 percent of hospices in Texas, Nevada, and Arizona. These four states have experienced rapid entry of new providers in recent years, particularly through 2023. In mid-2023, CMS began a program of enhanced oversight for newly enrolling hospices in these states, motivated by concerns about rapid entry of providers, market saturation, and fraud, waste, and abuse (Centers for Medicare & Medicaid Services 2025b). As we have discussed in past reports, above-cap hospices have substantially longer stays and higher live-discharge rates than below-cap hospices (even for patients with similar diagnoses), and they tend to treat fewer patients per year and are more likely to be for profit, freestanding, recent entrants to the Medicare program, and located in urban areas (Medicare Payment Advisory Commission 2022). As the Commission has noted in past reports, these length-of-stay and live-discharge patterns suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the Office of Inspector General and CMS (Medicare Payment Advisory Commission 2024, Medicare Payment Advisory Commission 2012). Recent studies have raised questions about the effect of the cap on beneficiary outcomes and Medicare spending (Coe and Rosenkranz 2025, Gruber et al. 2025).[13] The Commission has further research underway concerning the cap.

In-person hospice visits were stable between 2023 and 2024 In 2024, the average number and length of hospice in-person visits was generally stable compared with the prior year (Table 10-6). In 2024, beneficiaries who were enrolled in hospice received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8, 1.9, and 0.3 visits, respectively, per week on average (Table 10-6). The number of in-person nurse visits, which declined slightly during the pandemic, has rebounded. The average number of aide visits per week was stable in 2024 compared with 2023 but remained below the 2019 level. Each hospice visit in 2024 averaged just under an hour long, similar to 2023, and aide visits were slightly longer on average than nurse and social worker visits. Overall, the average total visit time per week was stable between 2023 and 2024 but remained below the prepandemic level.

From 2020 through mid-2023 (i.e., through the end of the public health emergency on May 11, 2023), hospices were given the flexibility to provide RHC visits via telecommunications technology as a substitute for in-person visits if it was feasible and appropriate to do so. However, hospices were not required to report data on the telehealth visits they furnished (except for social worker phone calls) during that period. Therefore, we lack data to determine whether telehealth visits were used to substitute for in-person visits from 2020 to 2023.

Quality of care is difficult to assess, but available indicators appear stable

Scores on available quality metrics, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey were stable in the most recent period. Scores on a composite of seven processes of care at admission increased slightly but were very high in the most recent period and topped out for most providers. Measures of the provision of in-person nurse and social worker visits at the end of life increased in the most recent period.

Consumer Assessment of Healthcare Providers and Systems

The Hospice Quality Reporting Program requires hospice providers to participate in a CAHPS hospice survey.[14] The survey gathers information from the patient's informal caregiver (typically a family member) after the patient's death.[15] Areas of focus include how the hospice performed on the following measures: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, and training family or other informal caregivers in the home setting. Respondents are also asked to rate the hospice on a scale of 1 to 10 and to say whether they would recommend the hospice.

All hospice providers are required to report CAHPS data, except those that are exempt due to being too small or too new (i.e., having an eligible patient population

TABLE 10–6

In-person hospice visits were generally stable between 2023 and 2024

	2019	2021	2022	2023	2024	Percent change 2023–2024
Average number of visits per week						
All visits	4.3	3.8	3.9	3.9	3.9	1%
Nurse visits	1.8	1.7	1.7	1.8	1.8	1
Aide visits	2.2	1.8	1.8	1.9	1.9	1
Social worker visits	0.3	0.3	0.3	0.3	0.3	–1
Average length per visit (in minutes)						
All visits	58	57	56	56	55	0
Nurse visits	56	54	53	52	52	–1
Aide visits	62	60	60	60	60	0
Social worker visits	50	49	48	47	47	–1
Average visit time per week (in minutes)						
All visits	252	215	215	217	218	0
Nurse visits	103	92	91	92	92	0
Aide visits	136	109	110	111	112	1
Social worker visits	16	13	13	13	13	–2

Note: Analysis includes only routine home care days and visits. "Visits" refers to in-person visits only and excludes postmortem visits. "Nurse visits" includes both registered nurse and licensed practical nurse visits. "Visit length" is reported by providers in the number of 15-minute increments, rounded to the nearest increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15. Components may not sum to totals due to rounding. Data displayed in table on visit frequency and time are rounded; percent change was calculated using unrounded numbers. Estimates of length of visits and total visit time for 2023 and earlier years differ from those in our prior reports due to refinements in methodology.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

of fewer than 50 patients in a reference year or being in their first year of furnishing hospice services). For those hospices that participate in CAHPS, CMS does not publicly report the data if there were fewer than 30 completed surveys for the hospice for the reporting period or there were fewer than 11 answers for a specific CAHPS measure. In the most recent reporting period (January 2023 to December 2024), just over 3,100 hospice providers had hospice CAHPS scores publicly reported on each measure, which represents less than half of all hospice providers in 2023.

Sector-wide CAHPS scores—as measured by the median hospice's share of caregivers who reported the "top box," meaning the most positive, survey response in eight domains—were generally stable in the most recent period (January 2023 to December 2024) compared with the prior period (January 2022 to December 2023) (Table 10-7, p. 308). Specifically, scores for the median hospice on seven of the measures were unchanged in the most recent period, while the score increased 1 percentage point for a measure of hospice communication. Similar to the prior period, for the median hospice, 82 percent of caregivers in the most recent period rated the hospice a 9 or 10, and 85 percent would definitely recommend the hospice. Caregivers most frequently gave top ratings on measures of providing emotional support and treating patients with respect (91 percent of caregivers chose

TABLE 10–7

Scores on hospice CAHPS quality measures

	Median performance across hospice providers	
	Previous period (January 2022 to December 2023)	**Most recent period (January 2023 to December 2024)**
Share of caregivers rating the hospice a 9 or 10	82%	82%
Share of caregivers who would definitely recommend the hospice	85	85
Share of caregivers who give top ratings on:		
Providing emotional support	91	91
Treating patients with respect	91	91
Help for pain and symptoms	75	75
Hospice team communication	81	82
Providing timely help	78	78
Caregiver training	76	76

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems). The CAHPS scores in the eight listed domains reflect the share of respondents who reported the "top box" (the most positive survey response) across all providers. In the most recent period, between 3,120 and 3,134 hospice providers had publicly reported CAHPS scores for these measures. These hospices accounted for less than half of all hospices in 2023.

Source CAHPS hospice survey data from CMS.

the most positive response in those areas in the most recent period). Roughly three-quarters of caregivers gave hospices top ratings for providing help for pain and symptoms, providing timely care, and training caregivers (Table 10-7).

Recent studies have also indicated that CAHPS scores vary by ownership status. In an analysis of CAHPS data from the second quarter of 2017 to the first quarter of 2019, Anhang Price and colleagues found that nonprofit providers were more likely to be high performers and less likely to be low performers (as measured by being 3 percentage points above or below the national average CAHPS score in a domain on the CAHPS survey) than for-profit providers (Anhang Price et al. 2023). Analysis of hospice CAHPS data from January 2021 to December 2022 by Soltoff and colleagues found that nonprofit hospices had higher average scores on CAHPS measures than two types of for-profit providers (those owned by chains or private equity firms and those with other types of for-profit ownership) (Soltoff et al. 2024).[16]

Another way to consider quality performance is to examine the frequency with which caregivers report poor experiences. Two fundamental purposes of hospice are to manage a patient's symptoms in accord with the patient's preferences and to provide timely help; thus, it could be informative to examine how frequently poor performance occurs in these areas. Looking at the distribution of caregiver responses across providers on the CAHPS survey in the most recent period, for the median hospice, 10 percent of patients' informal caregivers gave the bottom rating on help for pain and symptoms (i.e., reported that the patient sometimes or never got the help they needed for pain or symptoms) and 9 percent gave the bottom rating on providing timely help (i.e., reported that the hospice team sometimes or never provided timely help). Across providers, the share of caregivers choosing the bottom rating on these two measures ranged from 5 percent or 6 percent at the 10th percentile to 15 percent at the 90th percentile in the most recent period, and those figures were similar to the prior period.

Process measures

Hospices are required to report data on seven processes of care that are important for patients newly admitted to hospice. These processes include pain screening, pain assessment, dyspnea (shortness of breath) screening, dyspnea treatment, documentation of treatment preferences, addressing beliefs and values if desired by the patient, and provision of a bowel regimen for patients treated with an opioid. CMS has a composite measure that reflects the share of admitted patients for whom the hospice performed all seven activities appropriately (or appropriately performed all the activities relevant to the patient). Hospice providers' scores on the composite measure are very high and increased slightly in the most recent period. The provider-level median score was 96.8 percent, up slightly from 96.6 percent in the previous period. The consistently high scores on the composite measure suggest that it has topped out in its ability to distinguish meaningful differences in quality for most hospices.

In addition, the Hospice Quality Reporting Program includes two claims-based process measures.[17] One is the Hospice Care Index, which identifies providers with outlier patterns of care based on hospice providers' performance across 10 indicators. These indicators include four related to the provision of visits to hospice patients, four related to aspects of live discharge, one that reflects Medicare hospice spending per beneficiary, and one that gauges whether the provider furnished any high-intensity care (CHC or GIP).[18] In the most recent reporting period, from January 2023 to December 2024, 15 percent of providers with data were outliers (with "outlier" defined as performance being among the worst 10 percent) on at least 3 of 10 measures, and 2 percent were outliers on at least half of the measures.

The second claims-based process measure focuses on visits by hospice nurses and social workers at the end of life. Measures of these visits are thought to be indicators of quality because patients' and caregivers' need for symptom management and support tends to increase in the last week of life. The measure calculates the share of hospice decedents who received in-person nurse or social worker visits on at least two of the last three days of life. In the most recent period (January 2023 to December 2024), the median hospice furnished visits on at least two of the last three days of life for 61 percent of patients, a 2 percentage point increase from 59 percent in the prior period (January 2022 to December 2023). Performance on this measure varied substantially across providers, ranging from 43 percent at the 25th percentile to 73 percent at the 75th percentile in the most recent period, up 2 percentage points from the prior reporting period (which were 41 percent and 71 percent, respectively).

Future quality measures

The Commission consistently maintains that, with quality measurement in general, outcome measures are preferable to process measures. Although outcome measures for hospice are particularly challenging, the Commission contends that outcome measures such as patient-reported pain and other symptom-management measures warrant further exploration.

As of October 2025, hospices have begun reporting patient data using a new hospice data-collection instrument (referred to as the Hospice Outcomes & Patient Evaluation (HOPE) instrument). The new instrument collects information at additional times during the hospice episode (not just at admission and discharge) and additional types of data about patient characteristics and symptoms, which may offer the opportunity for new types of quality measures. CMS has finalized two new process quality measures that will be collected via the HOPE instrument: timely reassessment of pain impact and timely reassessment of nonpain-symptom impact.

High rates of live discharge from hospice could signal problems

As the Commission has noted over the years, high rates of live discharge may signal poor quality or program-integrity issues. Hospice providers are expected to have some live discharges because patients may change their mind about using the hospice benefit and disenroll from hospice or their condition may improve such that they no longer meet the hospice-eligibility criteria. However, high rates of live discharge relative to other hospices could indicate a problem, such as a hospice provider not meeting the needs of patients and families or admitting patients who do not meet the eligibility criteria. In 2024, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 19.1 percent, up slightly from

18.5 percent in 2023.[19] Analysis of prior year (2023) data provides more details on live discharges. Some providers have disproportionately high live-discharge rates. Among providers with more than 30 discharges, the median live-discharge rate in 2023 was about 21 percent, but 10 percent of those providers had live-discharge rates of 56 percent or more in 2023 (Medicare Payment Advisory Commission 2025).

Very short hospice stays signal opportunities for quality improvement

For many years, a significant share of hospice stays have been very short. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay that is commonly thought to be less beneficial to patients and families than enrolling earlier. These short stays are generally unrelated to the adequacy of Medicare's hospice payment rates. Very short hospice stays occur across a wide range of diagnoses. In some cases, short stays may be the result of a rapid change in a patient's health condition. Broader issues in the health care delivery system that precede the hospice referral also likely contribute to short stays (Medicare Payment Advisory Commission 2022). For example, some physicians are reluctant to have conversations about hospice or tend to delay such discussions until death is imminent; some patients or families may prefer conventional care to palliative care or may prefer exhausting all treatment options before enrolling in hospice; and financial incentives in the FFS system may encourage increased volume of clinical services (compared with palliative care furnished by hospice providers) (Medicare Payment Advisory Commission 2009). The requirement that beneficiaries forgo intensive conventional care to enroll in hospice, some analysts point out, may also contribute to beneficiaries deferring hospice care, resulting in short hospice stays (Medicare Payment Advisory Commission 2009).

Multiple factors influence the decision to enroll in hospice. One such factor is the interactions that beneficiaries and their families have with clinicians upstream in the health care delivery system before hospice enrollment. Broader health care delivery-system services or initiatives may offer the potential to improve end-of-life care quality, such as advance care–planning visits (which have been covered by Medicare since 2016), or new payment models CMS is testing such as accountable care organizations and the Guiding an Improved Dementia Experience (GUIDE) Model, as well as the recent MA–VBID model and Medicare Care Choices Model (Medicare Payment Advisory Commission 2024).[20]

Hospices have good access to capital

Hospices in general require less capital than many other provider types because they do not need extensive physical infrastructure (although some hospices have built their own inpatient units, requiring significant capital). Overall, access to capital for hospices appears adequate, given the continued entry of for-profit providers in the Medicare program.

In 2024, the number of for-profit providers grew by 5 percent, indicating that these providers have been able to access capital. The most recent available financial reports for five publicly traded hospice companies generally indicate strong financial performance through the second or third quarter of calendar year 2025 (Addus 2025, Amedisys 2025, Chemed 2025, Enhabit 2025b, Pennant Group 2025).[21] Admissions and average daily census grew for all five companies in the first nine months (or first six months for Amedisys) of 2025 compared with the same period in 2024. Trends in average length of stay among discharged patients varied across companies, ranging from a modest decrease to a substantial increase. Among the four publicly traded companies that report hospice-specific margins, margins increased for three companies and decreased for one company (Addus 2025, Amedisys 2025, Chemed 2025, Enhabit 2025a). In 2025, two publicly traded hospice companies expanded by acquiring other hospice providers, and one company closed or consolidated some hospice branches (Addus 2025, Enhabit 2025b, Pennant Group 2025).

The hospice sector continues to garner investment interest from other health care companies and private equity firms and investors. For example, in 2025, an insurer, UnitedHealth Group, acquired Amedisys (a large home health and hospice company) (Parker 2025b). Over a longer time horizon from 2010 to 2021, a study by Braun and colleagues found that private equity firms and publicly traded companies have been involved in the acquisition of numerous hospice agencies (over 1,200 hospice agencies over that period), with private equity and publicly traded firms caring

for an increasing share of Medicare hospice patients (25 percent in 2021 according to the study) (Braun et al. 2023). However, merger-and-acquisition activity slowed over the period from 2022 to 2025, following several years of increased activity (Braff Group 2025, Mertz-Taggart 2025). Some analysts attribute the slowdown in mergers and acquisitions to high interest rates (which increased substantially in 2022 and 2023 and began to decline in 2024 and 2025) and uncertainty over future interest rates and inflation (Parker 2025a, Vossel 2025). In addition, some analysts indicate that the heightened program-integrity environment, particularly in four states, has slowed some merger-and-acquisition activity (Mertz-Taggart 2025).

Less is known about access to capital for nonprofit freestanding providers. Hospital-based and home health–based nonprofit hospices have access to capital through their parent providers. Our analysis of access to capital for these types of providers found that in 2024 hospitals' access to capital improved (see Chapter 3) and home health agencies' access to capital was adequate (see Chapter 8).

A provider's all-payer total margin—which reflects how its total revenues compare with its total costs for all lines of business and all payers—can influence a provider's ability to obtain capital. Irregularities in the way some hospices report their total revenue and total expense data on cost reports prevent us from calculating a reliable estimate of all-payer total margins for hospices. Among hospice payers, however, Medicare accounted for about 91 percent of hospice days in 2023, and hospices' FFS Medicare margins are strong.

Medicare payments and costs: Aggregate payments exceed costs

In 2023, the FFS Medicare margin was 8.0 percent, down from 9.8 percent in 2022, as per day cost growth outpaced growth in per day payments. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability and how MedPAC utilizes margins and other types of data to make a judgment about payment adequacy. Hospice margins are presented through 2023 because of the data lag required to calculate cap-overpayment amounts.) Hospice costs per day increased 3.0 percent between 2022 and 2023; cost growth slowed considerably in 2024. Hospice costs vary substantially by providers' average length of stay: Hospices with longer stays have lower costs per day, on average, resulting in higher margins. Hospices with a large share of patients in nursing facilities and assisted-living facilities also have higher FFS Medicare margins.

Medicare's payments to hospice providers

Between 2010 and 2023, Medicare's spending for hospice grew substantially, increasing 5.4 percent per year on average, from $12.9 billion to $25.7 billion. Between 2023 and 2024, Medicare hospice spending increased 10.4 percent to $28.3 billion, largely reflecting a 3.1 percent update to hospice base payment rates in fiscal year 2024 and a 7.7 percent increase in total days of care in 2024. On a per day basis, Medicare's average payment to hospice providers was about $191 in 2024, up 2.6 percent from 2023.

Hospice costs

In 2024, hospice costs per day across all levels of care for hospice providers with cost-report data averaged about $168, rising 1.1 percent from 2023.

Hospice costs per day vary substantially by type of provider, which is one reason for differences in hospice margins across provider types (Table 10-8, p. 312). In 2024, freestanding hospices had lower average costs per day than provider-based hospices (i.e., home health–based and hospital-based hospices). For-profit and rural hospices also had lower average costs per day than their respective counterparts.[22] Many factors contribute to variation in hospice costs across providers. One factor is length of stay. Hospices with longer stays have lower costs per day on average, and freestanding and for-profit hospices have substantially longer stays than other hospices (Medicare Payment Advisory Commission 2022). Another factor is overhead costs. Included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which likely contribute to these hospices' higher costs.[23] The Commission maintains that payment policy should focus on the efficient delivery of services and that if freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly; the higher costs of provider-based hospices should not be a reason for increasing Medicare payment rates.

TABLE 10–8 **Total hospice costs per day varied by type of provider, 2024**

	Average total cost per day
All	$168
Freestanding	162
Home health based	186
Hospital based	275
For profit	147
Nonprofit	214
Urban	170
Rural	156

Note: "Cost per day" reflects aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care) divided by the total number of days of hospice care for all payers. "Day" reflects the total number of days for which the hospice is responsible for care of its patients, regardless of whether the patient received a visit on a particular day. Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services file from CMS.

Hospice margins

Between 2022 and 2023 (the year of our margin estimate), hospice costs per day grew 3.0 percent. Cost growth outpaced growth in per day payments (which is the result of a combination of factors, including the annual payment update of 3.8 percent in 2023, full reinstatement of the sequester in 2023 (which was reinstated for only a portion of cost-report year 2022), shifts in the mix of days, and the effects of the aggregate cap). As a result, the aggregate FFS Medicare margin for hospice providers in 2023 was 8.0 percent, down from 9.8 percent in 2022 (Table 10-9).[24] FFS Medicare margins varied widely across individual hospice providers: –16 percent at the 25th percentile, 6 percent at the 50th percentile, and 21 percent at the 75th percentile (data not shown). Our estimates of FFS Medicare margins exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs, consistent with our approach used in other Medicare sectors.[25]

In addition, these margin estimates do not include federal pandemic relief funds that were received by hospice providers.

Hospice margins vary by provider characteristics, such as type of hospice (freestanding or provider based), type of ownership (for profit or nonprofit), patient volume, and urban or rural location (Table 10-9). In 2023, freestanding hospices had a higher aggregate FFS Medicare margin (10.2 percent) than home health–based (4.4 percent) or hospital-based hospices (–25.6 percent) (Table 10-9). Provider-based hospices typically have lower FFS Medicare margins than freestanding hospices for several reasons, including their shorter stays and the allocation of overhead costs from the parent provider to the provider-based hospice. In 2023, the aggregate FFS Medicare margin of for-profit hospices was strong, at 13.7 percent. Overall, nonprofit hospices had a slightly negative margin (–1.3 percent), but the margin was positive among freestanding nonprofit hospices (2.6 percent; data not shown). Generally, hospices' FFS Medicare margins vary by the provider's volume: Hospices with more patients have higher margins on average. Hospices in urban areas had a slightly higher aggregate FFS Medicare margin (8.3 percent) than those in rural areas (5.3 percent).

Margins also vary by whether a hospice exceeds the aggregate cap. In 2023, below-cap hospices had an aggregate FFS Medicare margin of 9.0 percent. Above-cap hospices had a high FFS Medicare margin in 2023 before the return of overpayments (17.8 percent) and a slightly negative estimated margin after the return of overpayments (–1.4 percent) that year (Table 10-9). Although our estimate of above-cap hospices' "margin after the return of overpayments" assumes that 100 percent of cap overpayments are returned to the government, the Office of Inspector General (OIG) audits suggest that some portion of cap overpayments may be uncollectible. For example, OIG audits of three Medicare claims-processing contractors found that the share of cap overpayments that were classified as uncollectible (meaning at least 180 days delinquent and unlikely to be collected) varied, ranging from 4 percent to 20 percent to 27 percent across the three contractors (Office of Inspector General 2024, Office of Inspector General 2022, Office of Inspector General 2021).

Hospice profitability is closely related to length of stay. Hospices with longer stays have higher margins. For

TABLE 10–9

Hospice providers' FFS Medicare margins by selected characteristics, 2019–2023

Category	Share of		FFS Medicare margin				
	Hospice providers, 2023	Hospice patients, 2023	2019	2020	2021	2022	2023
All	100%	100%	13.4%	14.2%	13.3%	9.8%	8.0%
Freestanding	88	84	16.2	16.7	15.5	12.4	10.2
Home health based	6	9	9.7	11.2	10.9	3.8	4.4
Hospital based	6	7	–18.4	–18.2	–15.6	–23.5	–25.6
For profit	80	57	19.2	20.5	19.2	16.1	13.7
Nonprofit	18	42	6.1	5.8	5.2	0.3	–1.3
Urban	87	90	13.6	14.3	13.4	10.0	8.3
Rural	13	10	11.5	13.5	12.3	8.1	5.3
Patient volume (quintile)							
Lowest	20	2	–4.5	–2.1	–4.4	–12.3	–20.2
Second	20	4	6.2	4.9	3.1	–6.4	–6.8
Third	20	9	13.5	14.2	13.3	5.5	5.9
Fourth	20	18	15.8	17.9	15.5	12.2	10.6
Highest	20	67	13.9	14.4	14.0	11.7	9.5
Below cap	72	92	13.8	14.8	14.0	10.8	9.0
Above cap (excluding cap overpayments)	28	8	10.0	7.7	2.5	–1.6	–1.4
Above cap (including cap overpayments)	28	8	22.5	22.8	21.8	18.5	17.8
Share of stays > 180 days							
Lowest quintile	20	31	–2.5	–0.4	0.0	–4.1	–4.8
Second quintile	20	28	10.3	11.8	11.1	8.2	7.6
Third quintile	20	19	19.9	20.0	20.5	17.8	16.7
Fourth quintile	20	17	22.8	24.1	22.2	18.6	15.9
Highest quintile	20	6	13.4	13.4	9.7	2.7	–1.1
Share of patients in nursing facilities and assisted-living facilities							
Lowest half	50	45	6.6	7.5	7.1	1.8	0.2
Highest half	50	55	18.7	18.9	17.6	15.1	13.3

Note: FFS (fee-for-service). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Government-owned hospices operate in a different financial context from other hospices, so their margin is not necessarily comparable; therefore, data for government-owned hospices are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of Medicare hospice cost reports, Medicare hospice claims data, and Medicare Provider of Services file from CMS.

example, in an analysis of hospice providers based on the share of their patients' stays exceeding 180 days, we found that the 2023 aggregate FFS Medicare margin ranged from about −5 percent for hospices in the lowest quintile to 17 percent in the third-highest and 16 percent in the second-highest quintile (Table 10-9, p. 313). Hospices in the quintile with the greatest share of patients exceeding 180 days had an aggregate FFS Medicare margin of about −1 percent after the return of cap overpayments, but without the hospice aggregate cap, these providers' aggregate FFS Medicare margin would have been nearly 18 percent (latter figure not shown in table).

Hospices with a large share of patients in nursing facilities and assisted-living facilities have higher FFS Medicare margins than other hospices (Table 10-9, p. 313). For example, in 2023, the 50 percent of hospices with the highest share of patients residing in nursing facilities and assisted-living facilities had an aggregate FFS Medicare margin of 13.3 percent compared with a margin of 0.2 percent for providers with fewer patients residing in facilities. The higher aggregate FFS Medicare margin among hospices treating more facility-based patients is driven in part by the diagnosis profile and length of stay of patients residing in facilities. In addition, treating hospice patients in a centralized location likely creates efficiencies in terms of mileage costs and staff travel time, as well as facilities serving as referral sources for new patients. Nursing facilities can also be a lower-cost setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility.

Projected 2026 aggregate FFS Medicare margin

To project the 2026 aggregate FFS Medicare margin, we model the policy changes that went into effect between 2023 (the year of our most recent margin estimates) and 2026. For 2024, we assume rates of payment and cost growth based on preliminary data for that year. For 2025 and 2026, we assume revenue growth based on the annual payment updates in 2025 (2.9 percent) and 2026 (2.6 percent). The updates for these years reflect the statutorily required market basket update and productivity adjustment. In addition, our margin reflects the payment-rate penalty that providers face for not reporting quality data, which increased in 2024 from 2 percent to 4 percent. In addition, we assume a rate of cost growth similar to historical trends for 2025 and 2026. We also assume additional administrative costs associated with implementation of the new HOPE data collection instrument beginning in fiscal year 2026. Taking these factors into account, we project an aggregate FFS Medicare margin of about 9 percent for hospices in 2026.

How should FFS Medicare payments change in 2027?

Under current law, Medicare's base payment rates for hospice care are updated annually based on the projected increase in the hospice market basket, less an amount for productivity improvement. The final update for 2027 will not be set until summer 2026; however, using CMS's third-quarter 2025 projections of the 2027 market basket (3.1 percent) and productivity adjustment (0.8 percent) would increase hospice payment rates by 2.3 percent.

Our indicators of payment adequacy for hospices—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are positive. Current payment rates appear sufficient to support the provision of high-quality care without an increase to the base payment rates in 2027.

RECOMMENDATION 10

For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

RATIONALE 10

Our indicators of access to care are positive, and there are signs that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. In 2024, the number of providers increased by 2.6 percent. The share of Medicare decedents using hospice, the total number of beneficiaries receiving hospice care, and the total days of hospice care also increased. Among decedents, median and average length of stay increased. Access to capital remains adequate: The number of for-profit

providers increased by about 5 percent, and financial reports suggest that the sector continues to be viewed favorably by investors. The 2023 aggregate FFS Medicare margin was 8.0 percent. The projected 2026 aggregate FFS Medicare margin is about 9 percent.

IMPLICATIONS 10

Spending

- This recommendation would decrease federal program spending relative to current law by $250 million to $750 million over one year and by $1 billion to $5 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to hospice care. Given the current level of payments, we do not expect the recommendation to affect providers' willingness or ability to care for Medicare beneficiaries. ■

Endnotes

1 When a beneficiary first elects hospice, if they do not have an attending physician, the certification can be done by the hospice physician alone. For subsequent benefit periods, only the hospice physician is required to certify the patient's eligibility (even if the patient has a separate attending physician).

2 In 2015, a Commission contractor conducted research that examined the literature and carried out a market-level analysis. The contractor concluded that while hospice produces savings for some beneficiaries, such as those with cancer, overall, hospice has not reduced net Medicare program spending and may have even increased it because of very long stays among some hospice enrollees with noncancer diagnoses (Direct Research 2015). In more recent years, additional studies on this topic have had varied results, and debate about hospices' effect on Medicare spending continues. Several studies provide examples of the recent mixed findings in the literature on hospice's effect on Medicare spending. A recent study found that for-profit hospice enrollment led to large savings for some beneficiaries with dementia (Gruber et al. 2025). An industry-sponsored study reported that hospice saved 3 percent in the last year of life, with savings for long stays across all diagnoses (NORC at the University of Chicago 2023). However, several other studies that looked at spending in the last 6 or 12 months of life had more mixed results, finding that hospice was associated with higher Medicare spending or no difference in Medicare spending for beneficiaries with dementia (Aldridge et al. 2023, Zuckerman et al. 2016); lower Medicare spending for beneficiaries with cancer (Hung et al. 2020, Zuckerman et al. 2016); higher spending for beneficiaries with noncancer diagnoses and stays exceeding 30 days (Hung et al. 2020); and higher spending for beneficiaries residing in nursing facilities (Gozalo et al. 2015).

3 The Congress also established a second cap, which limits the share of inpatient care days that a hospice can provide to 20 percent of its total Medicare patient-care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are paid at the RHC payment rate.

4 For example, for a hypothetical hospice with a wage index of 1.0 whose patients received only RHC, if half of the hospice's patients each had a length of stay of 30 days, the other half could have an average length of stay of up to 335 days before that provider would exceed the cap. The length-of-stay patterns in this hypothetical example are much longer than typical for the hospice population (for patients with both short and long stays) because median lifetime length of stay among decedents in 2024 was 19 days, and length of stay was 291 at the 90th percentile.

5 Throughout this chapter, we use the term "FFS Medicare" as equivalent to the CMS term "original Medicare."

6 When an MA enrollee elects hospice, the beneficiary remains in the MA plan for Part D drugs and supplemental benefits. If an MA beneficiary is discharged alive from hospice, any Part A or Part B services that the beneficiary receives following the live discharge through the end of that calendar month are paid by FFS. At the beginning of the next month, responsibility for all Part A, Part B, and Part D services for the beneficiary reverts to the MA plan.

7 According to the most recent MA–VBID evaluation report, MA plans and hospice providers reported some implementation challenges. Specifically, the report stated that "although most continuing POs [MA plans referred to as "parent organizations"] and in-network hospices indicated that Hospice Benefit component implementation was manageable in 2023 because beneficiary volume was relatively low, they predicted that any substantial increase in the number of Hospice Benefit component-eligible beneficiaries would greatly increase implementation burden and require additional investments" (Eibner et al. 2025). According to the report, administrative processes (such as timely submission of notices of election and claims submission and adjudication) were the top implementation challenges cited by MA plans and hospices. Additional implementation challenges cited by some hospices included delayed payments, data-reporting and communication requirements varying across MA plans, lack of a definition of palliative care and transitional concurrent care, and concerns about reimbursement rates.

8 Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or SNF). The type of cost report does not necessarily reflect where patients receive care. For example, all hospice types may serve some nursing facility patients.

9 We are missing data on hospice type for more providers than typical in 2024—about 2.8 percent of providers that year. In recent years, new hospice entrants have mostly been freestanding providers, so missing data on the type of hospice for 2024 likely understate growth in freestanding providers. However, it is also possible that providers lacking data on hospice type for 2024 are home health–, hospital-, or SNF-based providers, which would lessen the estimated decline or possibly result in an increase in these categories between 2023 and 2024.

10 This comparison of hospice use across years is based on paid Medicare claims. These data slightly understate hospice use in 2022 through 2024 because they exclude beneficiaries who received hospice care that was paid for by MA plans participating in the hospice VBID demonstration. About 19,065 beneficiaries in 2022 and 23,828 beneficiaries in 2023 received hospice care that was paid for by MA plans participating in the hospice VBID demonstration, according to a CMS contractor evaluation report (Eibner et al. 2025). A report for 2024 is not yet available.

11 The difference in length of stay for hospice decedents with neurological conditions treated by for-profit and nonprofit hospices is particularly pronounced for patients with the longest stays. In 2024, the 75th percentile length of stay for hospice decedents with neurological conditions who were treated by for-profit hospices was 243 days compared with 139 days at nonprofit hospices; the 90th percentile length of stay was 566 days at for-profit hospices and 380 days at nonprofit hospices.

12 The share of hospices exceeding the cap is based on the Commission's estimates. While our estimates are intended to approximate CMS claims-processing contractors' calculations, differences in available data, methodology, and the timing of the calculations can lead to different estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing may vary across contractors.

13 Coe and Rosenkranz, using data from 2001 to 2018, found that hospices nearing the cap in the last quarter of the cap year increased enrollments by 5.8 percent and live discharges by 4.3 percent (equivalent to about 1.54 additional enrollments and 0.37 additional live discharges per program year), with smaller effects post-2012 when CMS shifted from the streamlined cap methodology to the proportional methodology (Coe and Rosenkranz 2025). They also reported that hospices on track to exceed the cap did not appear to change their service provision (visit frequency or hospice care levels) and their marginally enrolled patients appeared healthier on average. Gruber et al., using data from 2000 to 2019 and assuming the streamlined cap methodology was in effect for the entire period, estimated that patients in hospices facing cap pressure were 2 percentage points more likely to die within 12 months, 1 percentage point more likely to be discharged alive, and were less likely to receive inpatient hospice care over that period (Gruber et al. 2025).

14 Recently enacted legislation has increased the penalty for hospices that do not report quality data. Beginning in fiscal year 2024, nonreporters face a 4 percent payment penalty. In the fiscal year 2024 hospice final rule, CMS estimated that the increase in the penalty from 2 percent to 4 percent in 2024 would reduce hospice spending by about $41 million (Centers for Medicare & Medicaid Services 2023c).

15 The hospice CAHPS response rate was 29 percent in the most recent period (CAHPS Hospice Survey 2024).

16 Both Soltoff et al. (2024) and Anhang Price et al. (2023) examined CAHPS performance among different types of for-profit ownership. Although the studies used different ownership category definitions, the findings had some similarity. Anhang Price et al. found that for-profit hospices owned by chains, and Soltoff found that for-profit hospices owned by chains or private equity firms generally had lower CAHPS scores than other types of for-profit hospices (Anhang Price et al. 2023, Soltoff et al. 2024).

17 For both of the claims-based quality measures, the public-reporting program uses an eight-quarter reference period with the aim of increasing the sample size at the provider level to enable CMS to report data on as many providers as possible.

18 The Medicare conditions of participation require hospices to have the capacity to furnish all four levels of hospice care, including high-intensity levels of care.

19 Our analysis focuses on the broadest measure of live discharge, including live discharges initiated by the hospice (because the beneficiary is no longer terminally ill or because the beneficiary is discharged for cause) and live discharges initiated by the beneficiary (because the beneficiary revokes hospice enrollment, transfers hospice providers, or moves out of the area). Some stakeholders argue that live discharges initiated by the beneficiary are outside the hospice's control and should not be included in a live-discharge measure. Because beneficiaries choose to revoke hospice for a variety of reasons, which in some cases are related to the hospice provider's business practices or quality of care, we include revocations in our analysis. A CMS contractor found that rates of live discharge—due to beneficiary revocations and to beneficiaries no longer being terminally ill—increase as hospice providers approach or surpass the aggregate cap (Plotzke et al. 2015). The contractor's report suggested that this pattern could reflect hospice-encouraged revocations or inappropriate live discharges and thus merit further investigation.

20 The Medicare Care Choices Model (MCCM) permitted certain terminally ill FFS beneficiaries who were eligible for, but not enrolled in, hospice to enroll in the MCCM and receive palliative and supportive care from a hospice provider while continuing to receive "curative" care from other providers. MCCM eligibility was limited to beneficiaries with a life

expectancy of 6 months or less who met several criteria (diagnoses of cancer, congestive heart failure, chronic obstructive pulmonary disease, or HIV/AIDS; at least one hospital encounter and at least three office visits in the last 12 months; no election of hospice in the last 30 days; and lived in a traditional home continuously for the last 30 days). An evaluation of the MCCM found, based on the experience of 5,153 MCCM enrollees who enrolled between January 2016 and June 2021 and died before December 2021, that the MCCM was associated with a 13 percent net reduction in Medicare expenditures for these beneficiaries relative to a matched comparison group because of greater hospice use and lower acute care costs at the end of life (Kranker et al. 2022). The evaluation also reported that MCCM enrollees were more likely to receive better-quality end-of-life care (as measured by less aggressive care in the last 30 days of life). The report cautioned against broadly extrapolating from these findings because the model involved a very small number of beneficiaries and hospice providers.

21 Financial reports for Amedisys are available only through the second quarter of 2025 because it was acquired by UnitedHealth Group in August 2025. All other companies' financial reports discussed in this section reflect 2025 through the third quarter.

22 Soltoff and colleagues (2025) analyzed hospice cost patterns by ownership type based on their research classifying hospices into the following ownership categories: private equity, publicly traded, other for profit, and nonprofit. The study found that nonprofit hospices had higher spending on direct patient care service per day than each of the three types of for-profit hospices, with spending on nurses accounting for much of the difference. In terms of spending on administrative services, the study found private equity-owned hospices had lower spending on nonsalary administrative expenses than nonprofit hospices and other types of for-profit hospices, which the authors hypothesized might reflect private equity-owned hospices having efficiencies from economies of scale.

23 In our March 2017 report, the Commission examined indirect costs for provider-based and freestanding hospices. Indirect costs include, among others, management and administrative costs, accounting and billing, and capital costs. In 2014, indirect costs made up 32 percent of total costs for freestanding hospices, compared with 40 percent for home health–based hospices and 42 percent for hospital-based hospices (Medicare Payment Advisory Commission 2017). We noted that the structure of the cost report for provider-based hospices likely results in some overallocation of overhead costs that are not actually related to the hospices' operations or management. We also noted that it is possible that provider-based hospices have higher indirect costs for certain overhead activities. For example, provider-based hospices might have higher indirect costs than freestanding providers if administrative-staff wages are higher for parent providers (e.g., hospitals or home health agencies) or if provider-based hospices expend more administrative resources coordinating with their parent provider. This pattern of higher indirect costs among provider-based hospices was observed historically over a number of years (from 2008 to 2014), and, although the data are more than 10 years old, it seems likely that it continues to be a factor (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2010).

24 The aggregate FFS Medicare margin is calculated as follows: ((sum of total Medicare payments to all providers) – (sum of total Medicare costs of all providers) / (sum of total Medicare payments to all providers)). Estimates of total Medicare costs come from providers' cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data. Although we refer to this margin as the "FFS Medicare margin," it incorporates hospices' payments and costs for MA beneficiaries whose hospice care is paid for by FFS Medicare. FFS Medicare pays for hospice care for most MA enrollees, with the exception of those who are in MA plans that are participating in the VBID hospice component.

25 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments as part of hospice revenues in our margin calculation. We also exclude from our calculation the nonreimbursable bereavement and volunteer costs, which are reported in nonreimbursable cost centers on the Medicare cost report. Statute requires that hospices offer bereavement services to family members of deceased Medicare patients (Sec. 1861(dd)(2)(A)(i) of the Social Security Act); however, the statute prohibits Medicare payment for these services (Sec. 1814(i)(1)(A)). Including nonreimbursable bereavement and volunteer costs in our margin calculation would reduce the aggregate Medicare margin for 2023 by at most 1.1 percentage points and 0.3 percentage points, respectively.

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