

Other services

Dialysis

Hospice

Clinical laboratory

Chart 11-1 The capacity of dialysis organizations declined between 2023 and 2024

	2024	Average annual percent change	
		2019–2023	2023–2024
Total number of:			
Dialysis facilities	7,605	0.2%	–1.4%
Hemodialysis stations	137,200	0.8	–1.0
Mean number of hemodialysis stations per facility	18		
	Share of total facilities		
Hospital based	5%	–2.5	–0.9
Freestanding	95	0.3	–1.4
Urban	84	0.4	–1.2
Rural	16	–1.3	–1.2
For profit	90	0.5	–0.8
Nonprofit	10	–2.5	–6.8

Note: “Nonprofit” includes facilities designated as either nonprofit or government facilities. “Average annual percent change” is based on comparing 2019, 2023, and 2024 end-of-year files. Provider location reflects the county where the provider is located, urban or rural (the latter includes micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes.

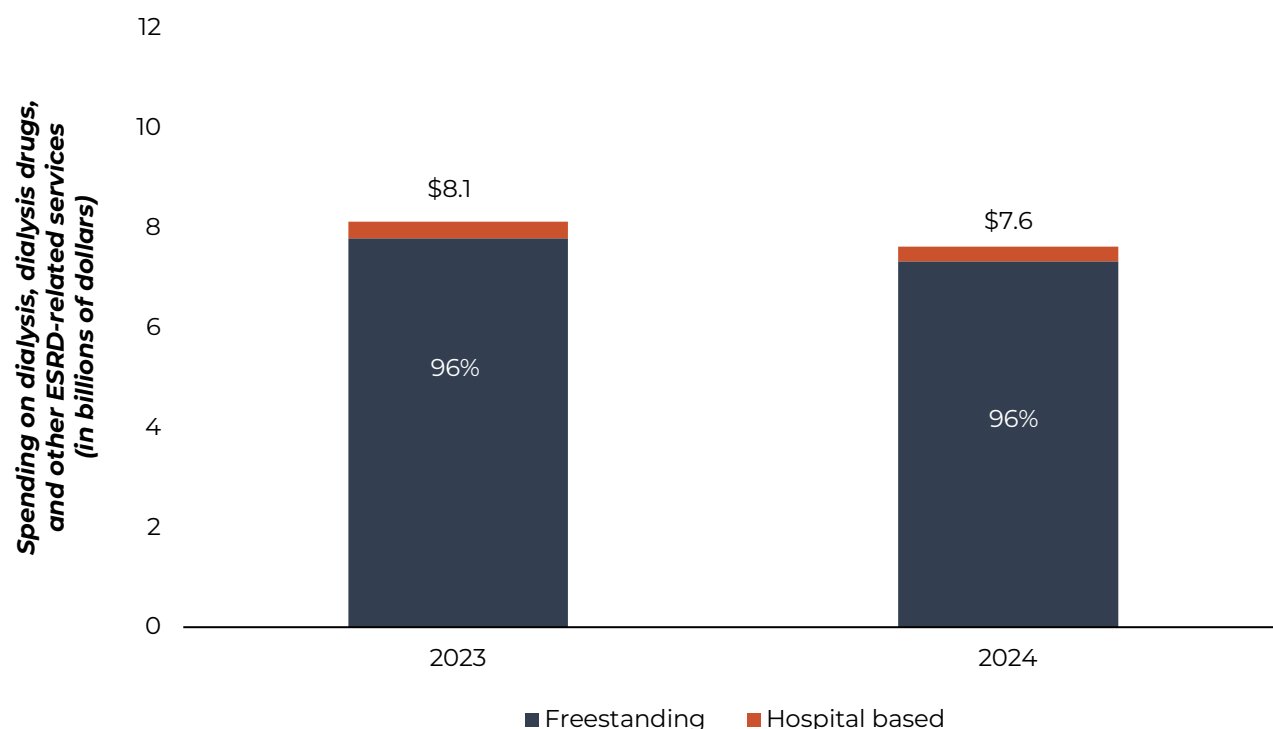
Source: Compiled by MedPAC from the institutional outpatient claims files and the Dialysis Compare files from CMS.

> Between 2019 and 2023, growth in the number of dialysis facilities and in-center treatment stations exceeded growth in the number of patients on dialysis, across fee-for-service (FFS) Medicare and Medicare Advantage (MA). During that period, the number of facilities and their capacity to provide care—as measured by hemodialysis stations—both grew, by 0.2 percent and 0.8 percent annually, respectively. By comparison, the number of Medicare beneficiaries on dialysis (in FFS Medicare and MA combined) declined by 1 percent per year between 2019 and 2023 (data not shown).

> Between 2023 and 2024, however, the number of facilities’ in-center hemodialysis stations declined by 1 percent, while the number of beneficiaries on dialysis, across FFS Medicare and MA, also declined by 1 percent (latter data not shown). The recent decline in the total number of dialysis facilities may be attributable to factors such as (1) the decline in the rate of new end-stage renal disease (ESRD) cases and excess mortality of persons with ESRD due to the coronavirus pandemic; (2) slower growth in the number of individuals newly diagnosed with ESRD; (3) the growing trend toward home dialysis; and (4) efforts by some dialysis providers to optimize their facilities’ capacity utilization.

> Between 2023 and 2024, the number of for-profit and nonprofit facilities decreased by 0.8 percent and 6.8 percent, respectively. The average size of a facility has remained relatively constant at 18 dialysis treatment stations per facility.

Chart 11-2 FFS Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2023 and 2024



Note: FFS (fee-for-service), ESRD (end-stage renal disease). Dollar amounts are nominal figures, not adjusted for inflation.

Source: Compiled by MedPAC from the institutional outpatient claims files from CMS.

- > In 2024, total FFS Medicare spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was \$7.6 billion. Medicare paid all facilities under a prospective payment system that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests that were paid separately before 2011.
- > Between 2023 and 2024, total FFS ESRD expenditures decreased by 6 percent on a nominal basis. The spending decline is due in large part to the increasing enrollment of dialysis beneficiaries in MA plans beginning in 2021. As beneficiaries with ESRD shifted to MA in 2021 through 2024, the number of FFS beneficiaries on dialysis fell 12 percent per year, on average, between 2021 and 2023, and by 7 percent between 2023 and 2024. The number of FFS treatments fell 11 percent per year (data not shown).
- > Freestanding dialysis facilities treated most FFS dialysis beneficiaries and accounted for 96 percent of FFS expenditures on outpatient dialysis in 2023 and 2024.

Chart 11-3 Small increase in the number of patients with ESRD over the last decade

	2013		2023		2013–2023
	Patients (thousands)	Share of patients	Patients (thousands)	Share of patients	Average annual percent change
Total	661.9	100%	830.9	100%	2%
Dialysis	467.3	71	557.9	67	2
In-center hemodialysis	414.7	63	472.1	57	1
Home hemodialysis ^a	7.0	1	13.7	2	7
Peritoneal dialysis ^{a,b}	44.0	7	67.9	8	4
Other dialysis ^c	1.6	0.2	4.2	0.5	10
Functioning graft and kidney transplant	194.6	29	273.0	33	3

Note: ESRD (end-stage renal disease). Totals may not equal the sum of components due to rounding. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients. The “functioning graft and kidney transplant” category includes patients who had a functioning graft at the start of the year in question (i.e., 2013 or 2023) or received a transplant during the year in question.

^a Home dialysis methods.

^b “Peritoneal dialysis” refers to patients receiving either continuous ambulatory peritoneal dialysis or continuous cyclic peritoneal dialysis.

^c “Other dialysis” includes other types of peritoneal dialysis methods and “uncertain dialysis.”

Source: Compiled by MedPAC from the U.S. Renal Data System.

> People with ESRD require either dialysis or a kidney transplant to live. The total number of patients with ESRD increased on average by 2 percent per year between 2013 and 2023. Between 2022 and 2023, the growth rate of the total number of patients with ESRD on dialysis was 1 percent, while the growth rate for those with functioning graft and kidney transplant was 5 percent (data not shown). Most patients with ESRD undergo dialysis.

> In hemodialysis, a patient’s blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient’s blood is cleansed by using the lining of their abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.

> In 2023, most people with ESRD (57 percent) underwent hemodialysis administered in a dialysis facility (usually three times a week). Between 2013 and 2023, the total number of in-center hemodialysis patients grew on average by 1 percent annually, while the total number of peritoneal dialysis patients increased on average by 4 percent annually. Although a smaller proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew on average by 7 percent per year during this period.

> Patients with functioning grafts have had a successful kidney transplant. Patients undergoing a kidney transplant may receive either a living or deceased donor’s kidney. In 2023, 23 percent of transplanted kidneys were from living donors and the remainder were from cadaver donors (data not shown).

Chart 11-4 The number of White patients with ESRD declined between 2019 and 2023, while the number of other racial and ethnic groups increased

	Share of total in 2023	Average annual percent change 2019–2023
Total (N = 815,896)	100%	1%
Age (years)		
0–17	1	1
18–44	14	1
45–64	41	0
65–79	35	2
80+	9	1
Sex		
Male	59	1
Female	41	0
Race/ethnicity		
White	41	–1
Black	29	1
Native American	1	3
Asian American	7	3
Hispanic	20	3
Underlying cause of ESRD		
Diabetes	37	–1
Hypertension	27	2
Glomerulonephritis	14	0
Other causes	22	3

Note: ESRD (end-stage renal disease). ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients. Components may not sum to totals due to rounding.

Source: Compiled by MedPAC from the U.S. Renal Data System.

> Among all patients with ESRD (including those who are not covered by Medicare), nearly 44 percent were over age 65 in 2023. About 41 percent were White.

> Diabetes is the most common cause of renal failure.

> The number of patients with ESRD increased by 1 percent annually between 2019 and 2023. The number of individuals of Native American, Asian, and Hispanic origins with ESRD increased by 3 percent annually between 2019 and 2023, compared with a 1 percent annual increase in the number of Black individuals with ESRD. In contrast, the number of White patients with ESRD decreased by 1 percent annually during that period.

Chart 11-5 A greater share of MA beneficiaries than FFS beneficiaries on dialysis are over age 65, Black, dually eligible for Medicare and Medicaid, and urban residents, 2024

	FFS beneficiaries on dialysis	MA beneficiaries on dialysis
Total	195,800	224,100
Age		
Under 45 years	10%	6%
45–64 years	33	31
65–74 years	28	32
75–84 years	22	24
85+ years	8	7
Sex		
Male	59	56
Female	41	44
Race/ethnicity		
White	45	33
Black	28	40
Hispanic	16	19
Asian	6	5
All others	6	4
Residence, by type of county		
Urban	84	86
Rural	16	14
Dual eligibility		
Fully dually eligible	34	38
Partially dually eligible	6	13
Not dually eligible	60	49
Part D enrollment		
Yes	75	98
No	25	2
New to dialysis	18	18
LDO	73	74
Non-LDO	27	26
Existing dialysis	82	82

Note: MA (Medicare Advantage), FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius)). Beneficiaries on dialysis were identified using the risk-score file, and FFS versus MA enrollment was identified using CMS enrollment data during January 2024. “Residence” reflects the beneficiary’s county of residence in one of two categories, urban or rural (the latter category includes micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Data as of January 2024. Components may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from CMS enrollment data, risk-score file, U.S. Census delineation file, CMS-2728.

> Beginning in January 2021, the 21st Century Cures Act permitted beneficiaries on dialysis to enroll in MA plans without any restrictions. As a result of this statutory change, the share of beneficiaries on dialysis enrolled in MA plans increased rapidly from 25 percent in January 2020 to 55 percent by December 2024 (data not shown).

> In 2024, 63 percent of MA beneficiaries on dialysis were 65 years or older (of which 31 percent were 75 years or older), 40 percent were Black, 13 percent had partial dual eligibility, and 86 percent resided in urban areas. By comparison, among FFS beneficiaries on dialysis, 58 percent were 65 years or older (of which 30 percent were 75 years or older), 28 percent were Black, 6 percent had partial dual eligibility, and 84 percent resided in urban areas.

Chart 11-6 Dialysis quality of care: Some measures show progress, others need improvement, 2019–2023

Outcome measure	2019	2022	2023
Share of in-center hemodialysis patients:			
Receiving adequate dialysis	98%	97%	97%
Dialyzed with an AV fistula	63	60	59
Share of peritoneal dialysis patients receiving adequate dialysis	91	91	91
Share of all dialysis patients managing anemia			
Mean hemoglobin < 10 g/dL	30	31	31
Mean hemoglobin 10 to <12 g/dL	65	63	63
Mean hemoglobin ≥ 12 g/dL	5	6	6
Share of all dialysis patients wait-listed for a kidney	13	12	12
Renal transplant rate per 100 patient years	3.9	4.2	4.5
Annual mortality rate per 100 patient years*	16.6	18.3	17.1
Total hospital admissions per patient year*	1.7	1.6	1.7
Hospital days per patient year*	11.4	11.8	11.7

Note: AV (arteriovenous), g/dL (grams per deciliter [of blood]). The rate per patient year is calculated by dividing the total number of events by the fraction of the year that patients were followed. Analysis of data on dialysis adequacy is based on measures used by CMS in its ESRD [End-Stage Renal Disease] Quality Incentive Program. The U.S. Renal Data System (USRDS) adjusts hospitalization and mortality measures by age, gender, race/ethnicity, and primary diagnosis of ESRD.

* Lower values suggest higher quality.

Source: All measures except the share of patients receiving adequate dialysis and anemia management were compiled by MedPAC using data from the USRDS. Measure of share of patients receiving adequate dialysis and anemia management was compiled by MedPAC using data from CMS's 100 percent institutional outpatient files.

> Changes in the available quality-of-care measures are challenging to interpret due to the effects of the coronavirus pandemic on many of our quality measures. Sadly, patients with ESRD have been at increased risk for COVID-19-associated morbidity and mortality.

> Between 2019 and 2023, anemia management and dialysis adequacy remained relatively steady.

> All hemodialysis patients require vascular access—the site on the patient's body where blood is removed and returned during dialysis. Use of arteriovenous fistulas, considered the best type of vascular access, declined between 2019 and 2023.

> Annual mortality rates decreased during 2022 and 2023. All-cause hospital admissions held steady between 2022 and 2023.

> We report access to kidney transplantation because it is widely believed to be the best treatment option for individuals with ESRD. Between 2019 and 2023, the share of dialysis patients accepted on the kidney-transplant waiting list declined from 13 percent to 12 percent, while the renal transplant rate per 100 dialysis-patient years increased from 3.9 to 4.5.

Chart 11-7 Hospice use increased in 2024

	2019	2022	2023	2024	Average annual change 2019–2023	Change 2023–2024
Medicare payments (in billions)	\$20.9	\$23.7*	\$25.7*	\$28.3*	5.3%*	10.4%*
Beneficiaries in hospice (in millions)	1.61	1.72*	1.74*	1.82*	2.0*	4.6*
Number of hospice days for all hospice beneficiaries (in millions)	121.8	130.2*	137.7*	148.2*	3.1*	7.7*

Note: Total payments, number of hospice users, and number of hospice days displayed in the table are rounded; the percentage change is calculated using unrounded data. Dollar amounts are nominal figures, not adjusted for inflation.

* 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's hospice MA value-based insurance design hospice model from 2021 to 2024. According to a CMS evaluation report, 19,065 MA beneficiaries in 2022 and 23,828 MA beneficiaries in 2023 started hospice that year paid for by MA plans (similar data for 2024 are not available) (Eibner, C., D. Khodyakov, E. A. Taylor, et al. 2025. *Evaluation of the Medicare Advantage value-based insurance design model test: 2020–2023*. Report prepared for the Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation: RAND Health Care. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/vbid-2020-2023-eval-report>).

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

> Total Medicare payments to hospices were about \$28.3 billion in 2024, about 10 percent higher on a nominal basis than the prior year.

> The number of Medicare beneficiaries receiving hospice services and the total number of days of hospice care increased in 2024.

Chart 11-8 The share of decedents using hospice increased in 2024, reaching a new high

	2019	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Number of Medicare decedents (millions)	2.32	2.64	2.50	2.52	1.8%	0.7%
Number of Medicare decedents who used hospice (millions)	1.20	1.30	1.29	1.33	1.9	3.0
Share of decedents who used hospice	51.6%	49.1%	51.7%	52.9%		

Note: The "number of Medicare decedents who used hospice" reflects hospice use in the last calendar year of life. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

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

> In 2024, the share of decedents using hospice increased to 52.9 percent as the number of beneficiaries who died in 2024 increased 0.7 percent and the number of decedents using hospice increased to a greater extent (3.0 percent).

> With the onset of the coronavirus pandemic, the hospice use rate declined in 2020 and 2021 but has increased since 2022 (data not shown). In 2024, the hospice use rate reached a new high, 52.9 percent.

> The decline in hospice use in 2020 and 2021 reflected the effects of the pandemic. Elderly people who die of COVID-19, similar to those who die of pneumonia and influenza, have been much more likely to die in the hospital and less likely to die at home or in a nursing facility than elderly people who die of other illnesses (data not shown).

Chart 11-9 Share of decedents using hospice increased in 2024 among all beneficiary groups

	2019	2022	2023	2024	Percentage point change 2019–2023	Percentage point change 2023–2024
All	51.6%	49.1%	51.7%	52.9%	0.1	1.2
FFS beneficiaries	50.7	49.1	51.7	52.9	1.0	1.2
MA beneficiaries	53.2	49.2	51.7	52.9	–1.5	1.2
Dually eligible	49.3	43.9	46.7	48.1	–2.6	1.4
Non-dually eligible	52.4	51.1	53.6	54.6	1.2	1.0
Age (years)						
<65	29.5	26.6	28.6	29.8	–0.9	1.2
65–74	41.0	37.7	40.3	41.1	–0.7	0.8
75–84	52.2	49.4	51.9	52.9	–0.3	1.0
85+	62.7	61.8	64.1	65.2	1.4	1.1
Race/ethnicity						
White	53.8	51.7	54.3	55.6	0.5	1.3
Black	40.8	37.4	39.7	40.9	–1.1	1.2
Hispanic	42.7	38.2	40.0	40.4	–2.7	0.4
Asian American	39.8	38.0	39.0	39.7	–0.8	0.7
North American Native	38.5	37.2	39.3	41.0	0.8	1.7
Gender						
Male	46.7	43.9	46.4	47.6	–0.3	1.2
Female	56.3	54.4	56.9	58.1	0.6	1.2
Beneficiary location						
Urban county	52.8	50.2	52.7	53.8	–0.1	1.1
Rural county, micropolitan	49.7	47.3	50.2	51.6	0.5	1.4
Rural county, adjacent to urban	49.5	47.9	50.9	52.6	1.4	1.7
Rural county, nonadjacent to urban	43.8	42.1	44.9	46.5	1.1	1.6
Frontier county	36.2	35.3	37.1	38.8	0.9	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. Before 2021, the “MA beneficiaries” group received hospice paid for by the FFS program; from 2021 to 2024, most individuals in the MA beneficiaries group received hospice paid for by FFS Medicare, but a small number received hospice paid for by their MA plan under the MA value-based insurance design model. “Beneficiary location” reflects 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 less than or equal to six people per square mile and overlaps the beneficiary county-of-residence categories. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

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

> Between 2023 and 2024, hospice use rates among decedents increased among all beneficiary groups examined. By 2024, hospice use rates had rebounded from pandemic declines and exceeded prepandemic (2019) levels for many groups. However, hospice use rates in 2024 were lower than 2019 levels for Hispanic beneficiaries (by 2.3 percentage points), dually eligible beneficiaries (1.2 percentage points), MA enrollees (0.3 percentage points), and Asian Americans (0.1 percentage points)

> In 2024, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, living in an urban area, or not dually eligible were more likely to use hospice than their respective counterparts.

Chart 11-10 Number of hospice visits for beneficiaries receiving routine home care, 2019–2024

	2019	2022	2023	2024
Average number of visits per week				
All visits	4.3	3.9	3.9	3.9
Nurse visits	1.8	1.7	1.8	1.8
Aide visits	2.2	1.8	1.9	1.9
Social worker visits	0.3	0.3	0.3	0.3
Average length per visit (number of minutes)				
All visits	58	56	56	55
Nurse visits	56	53	52	52
Aide visits	62	60	60	60
Social worker visits	50	48	47	47
Average visit time per week (number of minutes)				
All visits	252	215	217	218
Nurse visits	102	91	92	92
Aide visits	133	110	111	112
Social worker visits	16	13	13	13

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. 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.

- > In 2024, hospice enrollees received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8 visits, 1.9 visits, and 0.3 visits per week, respectively, on average.
- > The average length of hospice visits in 2024 was about an hour (55 minutes), with aide visits being slightly longer on average than nurse and social worker visits.
- > Overall, the average amount of visit time that hospice patients received per week in 2024 was about 218 minutes. On average, hospice patients received 92 minutes of nurse visits, 112 minutes of aide visits, and 13 minutes of social worker visits per week.
- > The number and length of in-person nurse, aide, and social worker visits were stable between 2023 and 2024. In 2024, the average number of aide visits and the average total visit time per week for nurse, aide, and social worker visits remained below the prepandemic (2019) levels.

Chart 11-11 Number of Medicare-participating hospices increased due to growth in for-profit hospices, 2019–2024

	2019	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
All hospices	4,840	5,899	6,535	6,706	7.8%	2.6%
For profit	3,435	4,581	5,243	5,497	11.2	4.8
Nonprofit	1,254	1,172	1,155	1,070	–2.0	–7.4
Government	149	138	136	130	–2.3	–4.4
Freestanding	3,942	5,074	5,695	5,740	9.6	0.8
Hospital based	430	383	365	350	–4.0	–4.1
Home health based	449	421	415	415	–1.9	0.0
SNF based	19	17	17	16	–2.7	–5.9
Urban	3,973	5,051	5,701	5,877	9.4	3.1
Rural	861	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.

- > There were 6,706 Medicare-participating hospices in 2024, up by about 3 percent from 2023 and 39 percent since 2019.
- > In 2024, the number of for-profit hospices grew by about 5 percent. Between 2023 and 2024, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed from 2019 to 2023.
- > In 2024, the number of freestanding providers increased, while the number of home health–based hospices was unchanged and the number of hospital-based and SNF-based hospices declined. (A hospice's status as freestanding, hospital based, home health based, or SNF based reflects the type of cost report submitted by the provider and does not necessarily reflect the location of care.)
- > The number of hospices located in rural areas declined in 2024 by 0.5 percent, continuing the trend of falling (by just under 1 percent per year between 2019 and 2023). The number of providers located in rural areas is not necessarily an indicator of access to care because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Also, some urban hospices furnish services in rural areas. Indeed, despite the overall decline in the number of rural hospices between 2019 and 2024, the share of rural decedents using hospice grew over that period (see Chart 11-9).

Chart 11-12 Hospice cases by primary diagnosis, 2024

Diagnosis	Share of total cases
Cancer	23%
Circulatory, except heart failure	23
Alzheimer's, nervous system disorders, organic psychosis	22
Other	11
Heart failure	8
Respiratory disease	6
Chronic airway obstruction, NOS	4
Genitourinary disease	2
Digestive disease	2
All	100

Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2024, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2024. Components may not sum to 100 percent due to rounding.

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

> In 2024, the most common primary diagnoses among Medicare hospice patients were cancer (23 percent), circulatory conditions other than heart failure (23 percent) and neurological conditions such as Alzheimer's disease, nervous system disorders, and organic psychosis (22 percent).

Chart 11-13 Hospice average length of stay among decedents increased in 2024

Year	Average lifetime length of stay (in days)	Percentiles of lifetime length of stay (in days)				
		10th	25th	50th	75th	90th
2019	92.5	2	5	18	85	266
2020	97.0	2	5	18	87	287
2021	92.1	2	5	17	79	264
2022	95.3	2	5	18	84	275
2023	96.2	2	5	18	86	278
2024	99.6	2	5	19	90	291

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

Source: MedPAC analysis of data from enrollment files and the Medicare Beneficiary Database from CMS.

> The average length of stay among decedents was 99.6 days in 2024, up more than 3 days from 2023. In 2024, the length of stay at the 50th percentile (the median) increased slightly from 18 to 19 days.

> Hospice lengths of stay vary broadly. In 2024, hospice length of stay among decedents ranged from 2 days at the 10th percentile to 291 days at the 90th percentile.

> Between 2019 and 2024, growth in the average length of stay among decedents has been the result of increases in length of stay for patients with the longest stays. Length of stay grew from 266 days to 291 days at the 90th percentile.

Chart 11-14 Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2024

	Average length of stay (in days)	Percentiles of length of stay (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	51	3	15	124
Neurological	169	4	47	501
Heart/circulatory	111	2	21	336
COPD	133	3	32	389
Other	69	2	9	196
Site of service				
Home	100	4	26	274
Nursing facility	120	3	25	360
Assisted living facility	174	6	63	494
Hospice				
For profit	120	3	25	359
Nonprofit	71	2	13	195
Freestanding	102	2	19	300
Home health based	74	2	15	205
Hospital based	60	2	12	161

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2024 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. The “site of service” categories reflect where the beneficiary spent the largest share of their days while enrolled in hospice. “Diagnosis” reflects the primary diagnosis on the beneficiary’s last hospice claim.

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

- > Hospice average length of stay among decedents varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (i.e., at the 90th percentile). Length of stay varies much less for patients with shorter stays (i.e., at the 10th percentile or 50th percentile).
- > Beneficiaries with neurological conditions and COPD have the longest stays, while beneficiaries with cancer have the shortest stays, on average.
- > Beneficiaries who receive hospice services in assisted living facilities have longer stays on average than beneficiaries who receive care at home or in a nursing facility.
- > For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based (home health–based and hospital-based) hospices.

Chart 11-15 Over 60 percent of Medicare hospice spending in 2024 was for patients with stays exceeding 180 days

	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 LOS as of the end of 2024 (or at the time of death or 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 may not sum to total due to 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).

> In 2024, Medicare hospice spending on patients with stays exceeding 180 days was \$17.5 billion, just over 60 percent of all Medicare hospice spending that year.

> About \$6.6 billion, or about 23 percent, of Medicare hospice spending in 2024 was on hospice care for patients who had already received at least one year of hospice.

Chart 11-16 Hospice FFS Medicare aggregate margins, 2019–2023

	Share of hospices (2023)	Share of patients (2023)	Medicare margin				
			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
Government	2	1	N/A	N/A	N/A	N/A	N/A
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
Below cap	72	92	13.8	14.8	14.0	10.8	9.0
Above cap	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

Note: FFS (fee-for-service), N/A (not available). Medicare aggregate margins for all provider categories exclude overpayments to above-cap hospices except where specifically indicated (providers whose payments exceed the Medicare hospice aggregate cap are required to repay the excess to Medicare). 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). Components may not sum to 100 percent due to rounding.

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

- > The FFS aggregate Medicare margin was 8.0 percent in 2023, down from 9.8 percent in 2022.
- > In 2023, freestanding hospices had higher margins (10.2 percent) than home health-based (4.4 percent) and hospital-based (-25.6 percent) hospices.
- > The 2023 margin among for-profit hospices was high at 13.7 percent. Nonprofit hospices as a group had a margin of -1.3 percent in 2023, but the subset of nonprofit hospices that were freestanding had a higher margin, 2.6 percent (latter figure not shown).
- > The aggregate 2023 margin was slightly higher for urban hospices (8.3 percent) than rural hospices (5.3 percent).
- > Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a 2023 margin of about 17.8 percent before and -1.4 percent after the return of the cap overpayments.
- > Hospices with more patients whose stays were longer than 180 days generally had higher margins in 2023. Hospices in the lowest length-of-stay quintile had a margin of about -5 percent, compared with margins of about 17 percent and 16 percent for hospices in the third and fourth length-of-stay quintiles, respectively. Margins were lower in the highest quintile (about -1 percent) because some hospices in this quintile exceeded Medicare's aggregate payment cap and were required to repay the overage.

Chart 11-17 Hospices that exceeded Medicare's annual payment cap, 2019–2023

	2019	2020	2021	2022	2023
Share of hospices exceeding the cap	19%	19%	19%	23%	28%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$384	\$422	\$451	\$419	\$410
Payments over the cap as a share of overall Medicare hospice spending in cap year	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). Dollar amounts are nominal figures, not adjusted for inflation.

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

- > The hospice aggregate cap is a limit on the average annual payment per beneficiary that a hospice provider can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by the cap amount (\$35,361.44 for fiscal year 2026), it must repay the difference.
- > An estimated 28 percent of hospices exceeded the aggregate cap in 2023, up from 23 percent in 2022.
- > Hospices that exceeded the cap were disproportionately located in four states—Arizona, California, Nevada, and Texas. Excluding these four states, an estimated 6 percent of hospices exceeded the cap in 2023, up slightly from 5 percent in 2022 (data not shown).
- > On average, above-cap hospices exceeded the cap by approximately \$410,000 per provider in 2023, down slightly from about \$419,000 per provider in 2022.
- > Medicare payments over the cap represented 2.9 percent of total Medicare hospice spending in 2023.

Chart 11-18 Hospice live-discharge rates, 2022–2024

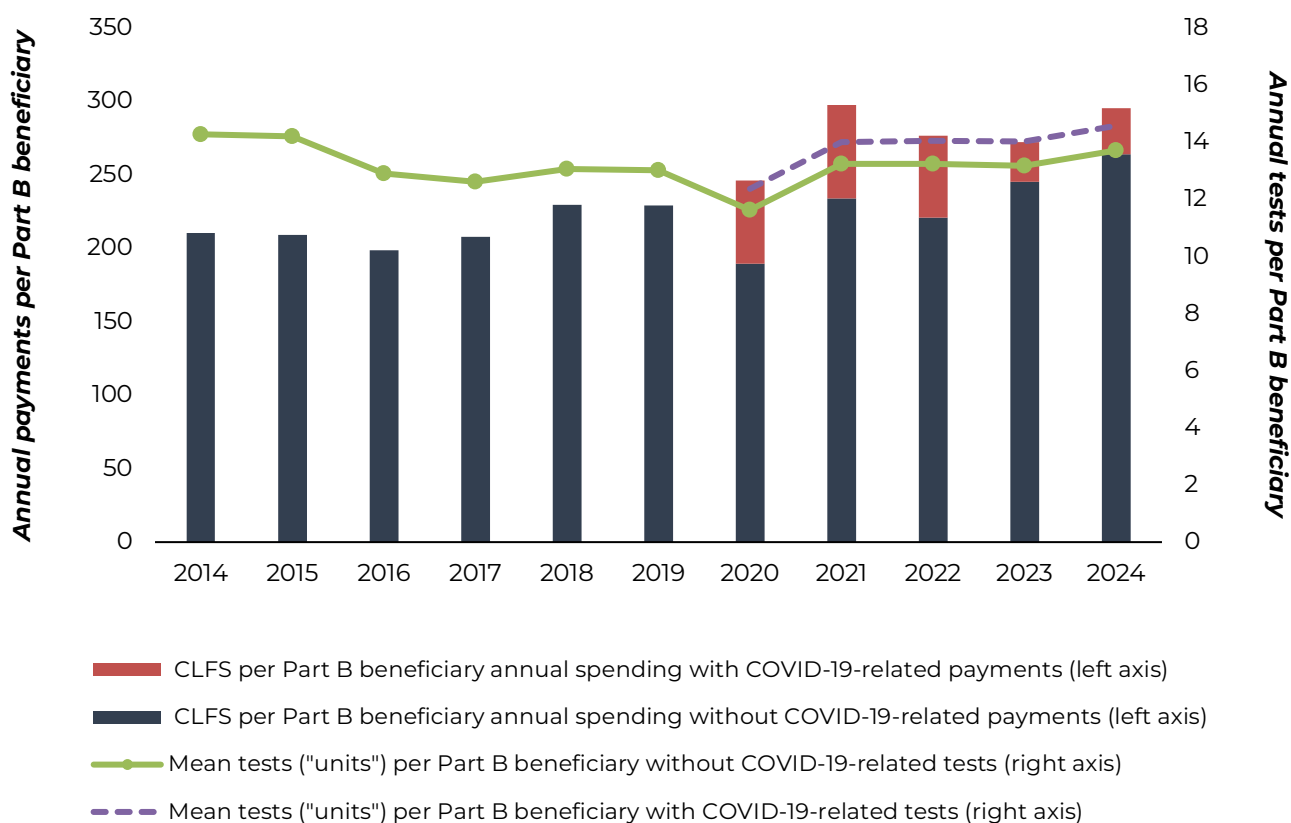
	2022	2023	2024
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	17.3%	18.5%	19.1%
No longer terminally ill	6.1	6.2	6.1
Beneficiary revocation	6.1	6.7	7.1
Transfer hospice providers	2.4	2.6	2.6
Move out of service area	2.3	2.7	3.0
Discharge for cause	0.3	0.4	0.3
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	8.3	8.6	8.8
25th percentile	12.2	13.2	13.5
50th percentile	19.2	20.7	21.7
75th percentile	29.9	33.3	35.7
90th percentile	49.9	56.1	65.2

Note: Percentages may not sum to totals due to rounding. "All discharges" includes patients discharged alive or deceased.

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

- > In 2024, the overall live-discharge rate was 19.1 percent, up from 18.5 percent in 2023.
- > The most common reasons for live discharge were the beneficiary revoking the hospice benefit and the beneficiary no longer being terminally ill, accounting for 7.1 percent and 6.1 percent, respectively, of all discharges in 2024. Less frequent reasons for live discharges included a beneficiary moving out of the service area, a beneficiary transferring hospice providers, and a beneficiary being discharged for cause.
- > Among providers with more than 30 discharges, 10 percent of providers had live-discharge rates of about 65 percent or more in 2024.
- > Small hospices as a group have substantially higher live-discharge rates than larger hospices. In 2024, the aggregate live-discharge rate was 60 percent for hospices with 30 or fewer discharges, in contrast to 19 percent for all hospices (data for small hospices not shown).

Chart 11-19 Medicare spending for clinical laboratory tests, 2014–2024



Note: CLFS (clinical laboratory fee schedule). Spending is for services paid under the CLFS. The spending data include only program payments; there is no beneficiary cost sharing for clinical laboratory tests. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of the CLFS claims standard analytic file from CMS and annual reports of the Boards of Trustees of the Medicare trust funds (2020 and 2025).

> Medicare pays for laboratory services furnished to fee-for-service beneficiaries under the CLFS. Beginning in 2018, CLFS payment rates are based on private sector rates. Before the changes, CLFS spending per Part B beneficiary was declining, falling by 0.4 percent a year from 2014 to 2017. From 2017 to 2024, CLFS spending per Part B beneficiary increased by 5.1 per year in spite of rate reductions in 2018 to 2020 and flat rates (no increase) in 2021 to 2024. The higher per beneficiary spending in 2019 to 2024 reflects several factors, including the impact of additional volume, which includes COVID-19-related laboratory tests and increases in the utilization of genetic and molecular laboratory tests.

> The number of lab “units” (an approximate measure of the number of tests a beneficiary receives) per Part B beneficiary were declining before 2017. However, the average number of CLFS tests per Part B beneficiary has generally been higher since then, reaching 14.6 in 2024—an increase of 15.6 percent compared with 2017.

