CHAPTER 9

Hospice services

RECOMMENDATION

9 For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice.

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

CHAPTER 9

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA). In 2023, more than 1.7 million Medicare beneficiaries (including more than half of decedents) received hospice services from about 6,500 providers, and Medicare hospice expenditures totaled $25.7 billion.

Assessment of payment adequacy

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

***Beneficiaries' access to care*—**In 2023, indicators of beneficiaries' access to care were positive. The number of hospice providers increased substantially, and measures of hospice utilization increased.

- ***Capacity and supply of providers*—**In 2023, the number of hospice providers increased by more than 10 percent as more for-profit

In this chapter

hospices entered the market, a trend that has continued for more than a decade. Particularly rapid market entry of providers in a few states where CMS has raised program-integrity concerns contributed to the large growth in 2023.

- ***Volume of services*—**The share of decedents using hospice increased to 51.7 percent in 2023, up from 49.1 percent in 2022 and similar to the prepandemic high of 51.6 percent in 2019. The number of hospice users and total days of hospice care also increased in 2023. For decedents, average lifetime length of stay increased by about 1 day in 2023 to 96.2 days. Between 2022 and 2023, median length of stay was stable at 18 days. For hospice patients receiving routine home care, the frequency and length of in-person hospice visits by hospice staff increased slightly in 2023, to an average of 3.9 visits per week, each about an hour long.
- ***FFS Medicare marginal profit*—**In 2023, on average, FFS Medicare payments to hospice providers exceeded marginal costs by 14 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

***Quality of care*—**Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems were stable in the most recent period. Scores on a composite of seven processes of care at admission were 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). Measures of the provision of in-person visits in the last days of life for patients receiving hospice routine home care were stable or increased slightly between 2022 and 2023, but the frequency of nurse visits was still below the prepandemic level.

***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 more than 10 percent in 2023) 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 2022 because of the data lag required to calculate cap-overpayment amounts. Between 2021 and 2022, average costs per day

increased by 3.8 percent. The aggregate FFS Medicare margin for 2022 was 9.8 percent, down from 13.3 percent in 2021. If Medicare's share of pandemic-related relief funds is included, the aggregate FFS Medicare margin for 2022 was about 10.4 percent. Cost growth slowed in 2023, with hospices' average cost per day increasing by 3.0 percent. We project an aggregate FFS Medicare margin for hospices of about 8 percent in 2025.

How should FFS Medicare payments change in 2026?

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 2026. The Commission recommends that the Congress eliminate the update to the hospice base payment rates for fiscal year 2026. ■

Background

The hospice benefit covers palliative and support services for Medicare beneficiaries who are terminally ill with a medical prognosis indicating that the individual's life expectancy is six months or less if the illness runs its normal course. In 2023, more than 1.7 million Medicare beneficiaries received hospice services, and Medicare hospice expenditures totaled about $25.7 billion.

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 and agree to forgo Medicare coverage for conventional treatment of the terminal illness and related conditions. Medicare continues to cover items and services unrelated to the terminal illness and its related conditions 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.

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.

Medicare payment for hospice services

The 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 2023. 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 2023, 89 percent of Medicare hospice patients received at least one day of RHC, 18 percent received at least one day of GIP, 5 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 also 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.[2] 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. If a hospice's total Medicare payments exceed the total number of Medicare beneficiaries it served multiplied by the annual cap 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 2025 ($34,465) is equivalent to the amount that Medicare pays for an RHC hospice stay of about 179 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.[3] In 2023, we estimate that 22.6 percent of hospices, which provided care to about 6 percent of hospice patients, exceeded the cap and were required to return payments to the program. 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).

Fee-for-service (FFS) Medicare pays for hospice care for beneficiaries enrolled in either traditional FFS Medicare or Medicare Advantage (MA).[4] 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).[5] 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 benefits package fragments financial responsibility and accountability for care. The Commission stated that including hospice in the MA benefits 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).

In January 2021, as part of its value-based insurance design (VBID) models in MA, CMS's Innovation Center launched 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). According to a CMS contractor's evaluation report, about 9,630 beneficiaries in 2021 and 19,065 beneficiaries in 2022 received hospice paid for by MA plans (Eibner et al. 2023, Khodyakov et al. 2022). We estimate that these figures indicate the MA–VBID model financed care for about 1 percent in 2021 and 2 percent in 2022 of all MA beneficiaries who received hospice care in those years. In 2024, 13 MA organizations, comprising 78 plan benefit packages that cover 690 counties in 19 states and Puerto Rico, furnished hospice benefits under the VBID model (Centers for Medicare & Medicaid Services 2023a). In March 2024, CMS announced that the hospice component of the MA–VBID model would sunset in December 2024, citing plan-implementation challenges and declining numbers of participating plans as reasons for the decision (Centers for Medicare & Medicaid Services 2024a).[6]

The most important benefit of hospice is its effect on patient care. The Medicare hospice benefit was designed to provide beneficiaries with a choice in their end-of-life care, giving them the option to receive care focused on symptom management and to die at home or in another location consistent with their preferences. 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 saved the Medicare program money in the aggregate compared with conventional care, with findings varying in part depending on the methodology used. 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.[7] The Commission has additional research underway in this area.

TABLE 9-1

Increase in total number of hospices driven by entry of for-profit providers

Category	2019	2020	2021	2022	2023	Average annual percent change 2019–2022	Percent change 2022–2023
All hospices	4,840	5,058	5,358	5,899	6,535	6.8%	10.8%
For profit	3,434	3,693	4,025	4,581	5,068	10.1	10.6
Nonprofit	1,256	1,217	1,189	1,170	1,151	–2.3	–1.6
Government	148	145	141	138	136	–2.3	–1.4
Freestanding	3,937	4,191	4,516	5,076	5,567	8.8	9.7
Hospital based	428	412	394	382	365	–3.7	–4.5
Home health based	456	436	431	420	414	–2.7	–1.4
SNF based	19	19	17	17	17	–3.6	0.0
Urban	3,973	4,193	4,501	5,051	5,701	8.3	12.9
Rural	861	856	849	834	833	–1.1	–0.1

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 ownership and hospice type particularly affect the most recent year (2023), for which we lack data on ownership for 180 providers and type of hospice for 172 providers.

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

Are FFS Medicare payments adequate in 2025?

To address whether payments in 2025 are adequate to cover the costs of efficient delivery of care and how much providers' payments should change in the coming year (2026), 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, use of hospice services, and FFS Medicare marginal profit—shows that beneficiaries' access to care in 2023 was favorable.

Capacity and supply of providers: Supply of hospices continued to grow in 2023, driven by an increase in for-profit providers

In 2023, 6,535 hospices provided care to Medicare beneficiaries, a 10.8 percent increase from the prior year (Table 9-1). Market entry of for-profit, freestanding providers drove the growth in supply. Particularly rapid market entry of providers in a few states where CMS has raised program-integrity

concerns contributed to the large growth in number of providers in 2023. We report on changes in the capacity and 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).

In 2023, the number of for-profit hospices grew by more than 10 percent (Table 9-1, p. 273). Between 2022 and 2023, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed from 2019 to 2022. In 2023, among the hospices for which we have data, about 80 percent of providers were for profit; however, they furnished care to 57 percent of Medicare hospice patients because, on average, for-profit providers were smaller than nonprofit providers (latter data not shown). The number of freestanding providers increased by almost 10 percent in 2023.[8] The number of home health–based and hospital-based hospices declined in 2023, while the number of skilled nursing facility (SNF)–based providers was unchanged.[9] In 2023, based on available data, we found that about 87 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 was generally stable in 2023, after falling about 1 percent per year between 2019 and 2022 (Table 9-1, p. 273). As of 2023, we estimate that 87 percent of hospices were located in urban areas and 13 percent were in rural areas; about 17 percent of Medicare beneficiaries (including beneficiaries in FFS and MA) lived in rural areas in 2023. 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 2023 (Table 9-2).

In 2023, the substantial growth in the number of hospice providers was concentrated in a few states. Between 2022 and 2023, several states had large gains in the raw number of hospices: California gained 425 hospices (a 26 percent increase), Texas gained 81 hospices (a 10 percent increase), Arizona gained 35 hospices (a 17 percent increase), Georgia gained 19 hospices (an 8 percent increase), and Nevada gained 16 hospices (a 16 percent increase). The 2023 growth in the number of providers in these five states combined (about 19 percent) substantially exceeded the growth in the number of providers excluding these five states (about 2 percent). Substantial market entry in several of these states is a continuation of trends seen over a longer time horizon. From 2019 to 2022, California, Texas, Arizona, and Nevada all experienced average annual growth in the number of hospice providers that exceeded the national average growth rate, with California and Texas experiencing the largest gains in the raw number of providers (California gained 621 providers and Texas gained 176 providers over that period). In our March 2021 report to the Congress, an analysis of new hospices in California and Texas found that these providers tended to be small and had long average lengths of stay, high live-discharge rates, and high rates of exceeding the aggregate cap; nearly all were for profit (Medicare Payment Advisory Commission 2021). In 2023, beyond the five states with the greatest growth in the number of providers, other states and the District of Columbia had more modest changes, with 26 additional states experiencing an increase in the number of providers, 12 experiencing no change, and 8 experiencing a decrease. The two states with the biggest decline in the number of hospices were Pennsylvania (eight hospices) and Louisiana (three hospices); hospice use among decedents in these states increased between 2022 and 2023 despite the decline in the number of providers.

The rapid entry of providers in California has led to program-integrity efforts by the state. 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). In addition, 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

TABLE 9–2

In 2023, the share of decedents using hospice increased overall and across all beneficiary subgroups

	Share of Medicare decedents who used hospice					
	2010	2019	2022	2023	Average annual percentage point change 2010–2022	Percentage point change 2022–2023
All decedent beneficiaries	43.8%	51.6%	49.1%	51.7%	0.4	2.6
FFS beneficiaries	42.8	50.7	49.1	51.7	0.5	2.6
MA beneficiaries	47.2	53.2	49.2	51.7	0.2	2.5
Dually eligible for Medicaid	41.5	49.3	43.9	46.6	0.2	2.7
Not Medicaid eligible	44.5	52.4	51.1	53.6	0.6	2.5
Age						
< 65	25.7	29.5	26.6	28.6	0.1	2.0
65–74	38.0	41.0	37.7	40.2	0.0	2.5
75–84	44.8	52.2	49.4	51.9	0.4	2.5
85+	50.2	62.7	61.8	64.0	1.0	2.2
Race/ethnicity						
White	45.5	53.8	51.7	54.3	0.5	2.6
Black	34.2	40.8	37.4	39.7	0.3	2.3
Hispanic	36.7	42.7	38.2	40.4	0.1	2.2
Asian American	30.0	39.8	38.0	39.2	0.7	1.2
North American Native	31.0	38.5	37.2	39.4	0.5	2.2
Sex						
Male	40.1	46.7	43.9	46.3	0.3	2.4
Female	47.0	56.3	54.4	56.9	0.6	2.5
Beneficiary location						
Urban	45.6	52.8	50.2	52.6	0.4	2.4
Micropolitan	39.2	49.7	47.3	50.1	0.7	2.8
Rural, adjacent to urban	39.0	49.5	47.9	50.9	0.7	3.0
Rural, nonadjacent to urban	33.8	43.8	42.1	44.9	0.7	2.8
Frontier	29.2	36.2	35.3	37.1	0.5	1.8

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.

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

In recent years, CMS has announced a number of steps to increase program-integrity efforts for hospice providers overall and specifically in four states. In August 2023, for newly enrolled hospices in Arizona, California, Nevada, and Texas, CMS stated that it was implementing a provisional period of enhanced oversight that involves the agency conducting medical review before making payments on these providers' claims (Centers for Medicare & Medicaid Services 2023b). In September 2024, CMS announced it was expanding prepayment medical review in those four states (Centers for Medicare & Medicaid Services 2024c). In August 2023, CMS also indicated that it was undertaking a pilot project, not just in the four states mentioned, to review hospice claims following an individual's first 90 days of hospice care (Centers for Medicare & Medicaid Services 2023b).

Volume of services: Measures of hospice use increased in 2023

Nationally, the share of Medicare decedents using hospice increased in 2023, rebounding to prepandemic levels. In 2023, 51.7 percent of Medicare decedents received hospice services, up from 49.1 percent in 2022 and similar to the 2019 rate of 51.6 percent (Table 9-2, p. 275). 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 again in 2022, growing by 1.8 percentage points that year and by an additional 2.6 percentage points in 2023 (2022 growth rate not shown).

In 2023, the share of decedents using hospice increased across all subgroups examined (Table 9-2, p. 275). While hospice-use rates rose for all groups, 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, a group that has lower-than-average hospice use, increased to 31 percent in 2023, up from 29 percent in 2022 (data not shown). In 2023, hospice-use rates were similar for FFS and MA decedents.

Between 2022 and 2023, hospice-use rates increased among all racial and ethnic groups examined—White, Black, Hispanic, Asian American, and North American Native beneficiaries. Nevertheless, hospice-use rates continued to be higher for White decedents (Table 9-2, p. 275). 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 2023, decedents' hospice-use rates increased across all categories of rural and urban counties (Table 9-2, p. 275). 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 2023 (Table 9-2). Hospice use is lowest among beneficiaries in frontier counties, although hospice use in these areas has also grown.

In 2023, measures of hospice use for all hospice enrollees (not just decedents) increased. That year, 1.74 million Medicare beneficiaries received hospice services, a slight increase (1.3 percent) from 2022. The number of hospice days furnished also increased 5.7 percent to about 138 million days (Table 9-3).[10]

Hospice length of stay increased in 2023 Average lifetime length of stay among decedents was 96.2 days in 2023, up from 95.3 days in 2022 (Table 9-3). Median length of stay was stable at 18 days. Most hospice

TABLE 9–3

Hospice use increased in 2023

					Average annual percent change		Percent change
	2010	2019	2022	2023	2010–2019	2019–2022	2022–2023
Hospice use among Medicare decedents							
Number of Medicare decedents (in millions)	1.99	2.32	2.64	2.50	1.7%	4.3%	–5.2%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.30	1.29	3.6	2.6	–0.3
Average lifetime length of stay among decedents (in days)	87.0	92.5	95.3	96.2	0.7	1.0	0.9
Median lifetime length of stay among decedents (in days)	18	18	18	18	0 days	0 days	0 days
Medicare use and spending for all hospice users (not limited to decedents)*							
Total spending (in billions)	$12.9	$20.9	$23.7*	$25.7*	5.5	4.3*	8.3*
Number of Medicare hospice users (in millions)	1.15	1.61	1.72*	1.74*	3.8	2.3*	1.3*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	130.2*	137.7*	4.6	2.3*	5.7*

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 beginning 2021. According to CMS contractor evaluation reports, 19,065 MA beneficiaries received hospice care under the model in 2022 (Eibner et al. 2023, Khodyakov et al. 2022). An evaluation report with data on experience in the third year of the model (2023) is not available yet.

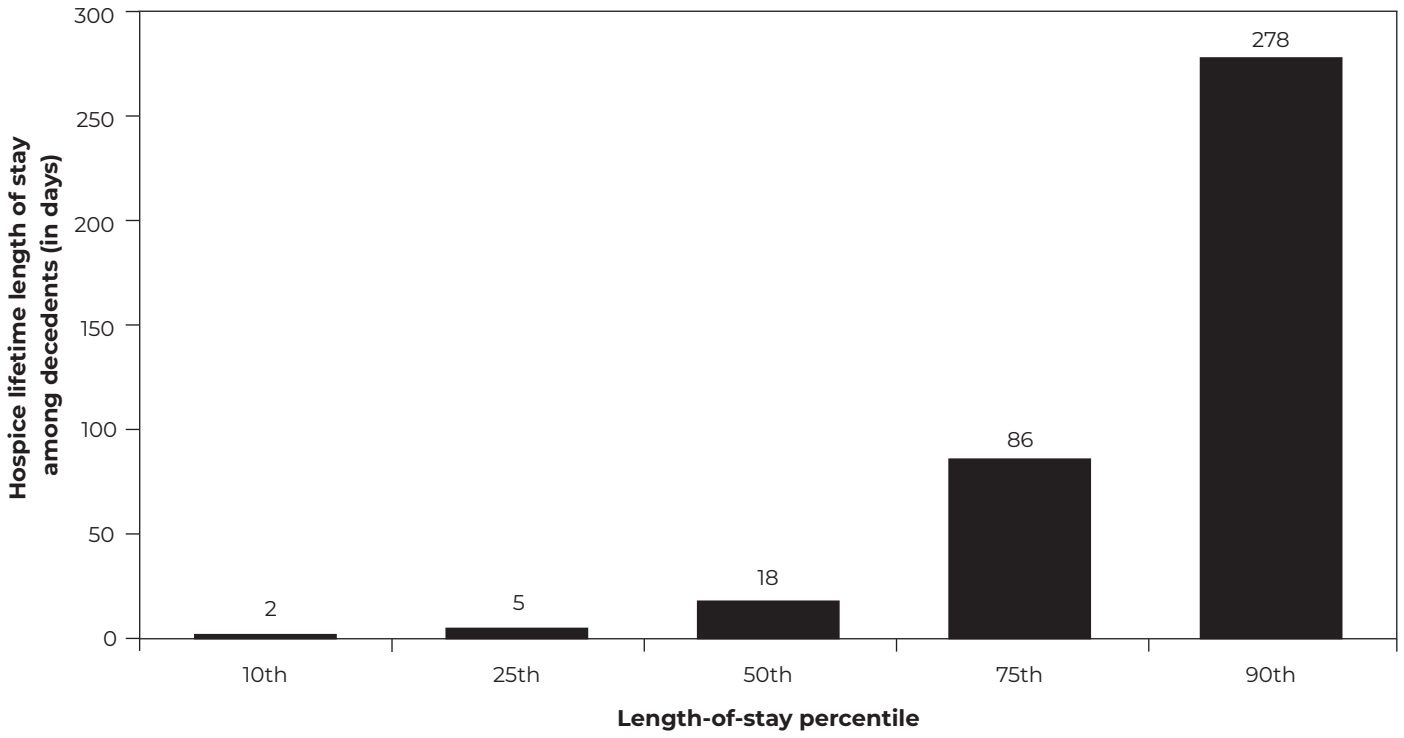
Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

decedents have short stays, but some have very long stays (Figure 9-1, p. 278). Between 2022 and 2023, 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 84 days to 86 days at the 75th percentile and from 275 days to 278 days at the 90th percentile) (Figure 9-1; 2022 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 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 2023, average lifetime length of stay was longer among decedents

FIGURE 9–1

Most hospice decedents had relatively short stays, but some had very long stays, 2023



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 the Common Medicare Environment and the Medicare Beneficiary Database from CMS.

admitted to hospice for neurological conditions and chronic obstructive pulmonary disease (164 days and 131 days, respectively) than among decedents with cancer (51 days). Length of stay was also longer among patients in assisted-living facilities (169 days) or nursing facilities (113 days) compared with patients at home (97 days).

For-profit hospices have substantially longer average lengths of stay than nonprofit hospices (115 days compared with 72 days, respectively, in 2023). 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 187 days for for-profit hospices and 130 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 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).)

Although most patients have short hospice stays, long stays account for the majority of Medicare spending on hospice. In 2023, Medicare spent more than $15 billion, just over 60 percent of hospice spending that year,

for patients with stays exceeding 180 days (Table 9-4). About $5.8 billion of that spending was for additional 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 2022, about 22.6 percent of hospices exceeded the aggregate payment cap, up from 18.9 percent in 2021 (Table 9-5, p. 280).[12] On average, each above-cap hospice exceeded the cap by about $419,000 in 2022, down slightly from $451,000 in 2021. The share of hospices exceeding the cap varies widely by state. We estimate that most states had a relatively low share (5 percent or fewer or in some cases none) of their providers exceeding the cap in 2022. The states with the greatest entry of new providers are also the states with the highest share of the state's hospices over the cap. We estimate that over half of hospices in California exceeded the cap in 2022 and roughly a quarter of hospices in Texas, Nevada, and Arizona. Above-cap hospices have fewer patients per year, on average, than below-cap hospices 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). Above-cap hospices have substantially longer stays than below-cap hospices, even for patients with similar diagnoses. Above-cap hospices also have substantially higher rates than other hospices of discharging patients alive, even when we compare patients with similar diagnoses. 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 2023, Gruber et al. 2023). The Commission has further research underway concerning the cap.

In-person hospice visits increased slightly in 2023 In 2023, the average number and length of hospice in-person visits increased slightly (Table 9-6, p. 281). In 2023, beneficiaries 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 per week on average (Table 9-6).[13] Each visit in 2023 was about an hour long on average, across the different types of staff. In-person nurse and social worker visits, which declined modestly during the pandemic, rebounded to the prepandemic level in 2023. Aide visits also increased modestly in 2023 but remained below the prepandemic level.

In 2020 through mid-2023, some in-person visits may have been replaced by telehealth visits. Through the end of the public health emergency (May 11, 2023), hospices were given the flexibility to provide RHC visits via telecommunications technology if it was feasible and appropriate to do so. We lack data on telehealth visits provided by hospices except for social worker phone calls, which has limited our ability to determine the extent to which telehealth visits were used to supplement in-person visits in 2020 through 2023.

TABLE 9–4

About 60 percent of Medicare hospice spending was for patients with stays exceeding 180 days, 2023

	Medicare hospice spending, 2023 (in billions)
All hospice users in 2023	$25.7
Beneficiaries with LOS > 180 days	15.6
Days 1–180	5.0
Days 181–365	4.8
Days 366+	5.8
Beneficiaries with LOS ≤ 180 days	10.1

Note: LOS (length of stay). "LOS" reflects the beneficiary's lifetime days with hospice as of the end of 2023 (or at the time of discharge in 2023 if the beneficiary was not enrolled in hospice at the end of 2023). All spending reflected in the chart occurred only in 2023. Components do not sum to totals because of rounding.

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

TABLE 9–5 **Hospices that exceeded Medicare's annual payment cap, 2018–2022**

Year	2018	2019	2020	2021	2022
Estimated share of hospices exceeding the cap	16.3%	19.0%	18.6%	18.9%	22.6%
Average payments over the cap per hospice exceeding it (in thousands)	$334	$384	$422	$451	$419
Payments over the cap as a share of overall Medicare hospice spending	1.3%	1.7%	1.8%	2.0%	2.3%

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 2018 through 2022 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.

Hospices with available capacity continued to have a strong financial incentive to admit Medicare beneficiaries Another component of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. To assess this component, we examine the FFS Medicare marginal profit—the percentage of revenue from FFS Medicare that is left as profit after accounting for the allowable variable costs of providing services to Medicare patients.[14] (Variable costs are those that vary with the number of patients treated. By contrast, fixed costs are those that are the same in the short run regardless of the number of patients treated (e.g., rent).) If the FFS Medicare marginal profit is positive, a provider with excess capacity has a financial incentive to care for an additional beneficiary; if the FFS Medicare marginal profit is negative, a provider may have a disincentive to care for an additional beneficiary. (See the text box in Chapter 2 on the different margin measures MedPAC uses to assess provider profitability.) We found that the 2022 FFS Medicare marginal profit for hospice providers was roughly 14 percent, suggesting that providers with the capacity to do so had a strong incentive to treat Medicare patients.

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 were very high in 2023 and topped out for most providers. Measures of the provision of in-person visits at the end of life were stable or increased slightly in 2023, but the frequency of nurse visits remained below the prepandemic level.

Consumer Assessment of Healthcare Providers and Systems

The Hospice Quality Reporting Program requires hospice providers to participate in a CAHPS hospice survey.[15] The survey gathers information from the patient's informal caregiver (typically a family member) after the patient's death.[16] The survey addresses aspects of hospice care that are thought to be important to patients and for which informal caregivers are positioned to provide information. 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, providing information on medication side effects, 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.

TABLE 9–6

In-person hospice visits increased in 2023, with nurse and social worker visits reaching prepandemic levels

	2019	2021	2022	2023	Percent change 2022–2023
Average number of visits per week					
All visits	4.3	3.8	3.9	3.9	1%
Nurse visits	1.8	1.7	1.7	1.8	2
Aide visits	2.2	1.8	1.8	1.9	1
Social worker visits	0.3	0.3	0.3	0.3	1
Average length per visit (in minutes)					
All visits	60	58	56	61	7
Nurse visits	57	55	54	61	14
Aide visits	63	61	60	61	1
Social worker visits	52	50	49	58	20
Average visit time per week (in minutes)					
All visits	258	218	218	237	9
Nurse visits	104	94	93	107	16
Aide visits	137	1131	111	116	2
Social worker visits	17	13	14	16	21

Note: Analysis includes only routine home care days and visits. "Visits" refers to in-person visits only and excludes postmortem visits. "Nurse visits" include both registered nurse and licensed practical nurse visits. "Visit length" is reported by providers in number of 15-minute increments, rounded to the nearest 15-minute 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.

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

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 stable in the most recent period (January 2022 to December 2023) compared with the prior period (January 2021 to December 2022) (Table 9-7, p. 282). 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 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 9-7, p. 282).

Hospices that predominantly care for beneficiaries that reside in rural areas receive somewhat higher CAHPS scores than those that care for beneficiaries in urban areas. For the CAHPS analysis, we consider a hospice to be rural or urban based on the type of county in which the majority of beneficiaries treated by the hospice reside. In the most recent period, the median rural hospice received CAHPS scores that ranged from 2 percentage points to 5 percentage points higher than

TABLE 9–7

Scores on hospice CAHPS quality measures

	Median performance across hospice providers			
	Previous period (January 2021 to December 2022)	Most recent period (January 2022 to December 2023)		
	All	All	Urban	Rural
Share of caregivers rating the hospice a 9 or 10	82%	82%	81%	85%
Share of caregivers who would definitely recommend the hospice	85	85	84	89
Share of caregivers who give top ratings on:				
Providing emotional support	90	91	90	92
Treating patients with respect	91	91	91	93
Help for pain and symptoms	75	75	74	78
Hospice team communication	81	81	81	84
Providing timely help	78	78	77	82
Caregiver training	76	76	75	79

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 this analysis, a hospice is considered "rural" if more than half of the beneficiaries it serves reside in a rural county (defined as a micropolitan, rural adjacent, or rural nonadjacent county). In the most recent period, between 3,033 and 3,045 hospice providers had publicly reported CAHPS scores for these measures. These hospices accounted for just over half of all hospices in 2022.

Source: CAHPS hospice survey data from CMS.

the median urban hospice across the eight CAHPS measures (Table 9-7). For example, scores were 4 percentage points or 5 percentage points higher for the median rural hospice compared with the median urban hospice for the share of caregivers who gave top ratings on help for pain and symptoms, providing timely help, and caregiver training; who rated the hospice a 9 or 10; and who would definitely recommend the hospice.

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).[17]

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 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 6 percent at the 10th percentile to 15 percent at the 90th percentile in the most recent period in 2023, and those figures were similar to the prior period.

In December 2024, CMS began implementing the new Hospice Special Focus Program (mandated by the Consolidated Appropriations Act, 2021), which identifies providers with the poorest performance based on selected quality indicators (Centers for Medicare & Medicaid Services 2023c). Under this program, CMS identifies the poorest-performing hospices based on an algorithm that reflects the following quality indicators: condition-level deficiencies identified by state survey agencies or accrediting organizations (i.e., who carry out "surveys" (inspections) to determine compliance with Medicare conditions of participation), substantiated complaint allegations, a claims-based measure of outlier patterns of care, and performance on the hospice CAHPS survey. The CAHPS scores incorporated into the algorithm include the share of caregivers who gave bottom ratings for pain and symptom management, getting timely help, and overall rating of the hospice, as well as the share who would not recommend the hospice. CMS selects from among the 10 percent of hospices with the poorest performance on the algorithm for inclusion in the Special Focus Program. The selected hospices will be subject to more frequent surveys by state survey agencies, every 6 months over an 18-month period. These providers could face termination from the Medicare program if they are found to have additional serious deficiencies or complaints that meet certain criteria while being surveyed during the Special Focus Program. In February 2025, CMS announced it was ceasing implementation of the Hospice Special Focus Program for calendar year 2025 so the agency could further evaluate the program (Centers for Medicare & Medicaid Services 2024b).

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 96.6, up slightly from 96.2 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 August 2022, CMS added two new claims-based process measures to public reporting.[18] 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).[19] In the most recent reporting period, from January 2021 to December 2022, 14 percent of providers with data were outliers on at least 3 of 10 measures, and 2 percent were outliers on at least half of the measures.

The second new claims-based process measure in the public-reporting program 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 measures calculate 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. Providers' performance varied substantially on this measure, ranging from 40 percent at the 25th percentile to 70 percent at the 75th percentile in the most recent period (from January 2021 through December 2022), similar to the prior reporting period.

TABLE 9–8

Measures of in-person nurse and social worker visits during the last seven days of life were stable or increased slightly from 2022 to 2023, but some remained below 2019 levels

	2019	2021	2022	2023
Nurse visits in last 7 days of life				
Share of days with visit	66%	63%	63%	63%
Average length of each visit (in minutes)	67	63	63	71
Average visit time per day (in minutes)	44	40	40	45
Social worker visits in last 7 days of life				
Share of days with visit	10%	9%	9%	10%
Average length of visits (in minutes)`	60	57	54	55
Average visit time per day (in minutes)	6	5	5	5

Note: "Nurse visits" includes both registered nurse and licensed practical nurse visits. "Visit length" is reported by providers in number of 15-minute increments, rounded to the nearest 15-minute increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15.

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

The Commission has also used claims data to examine the aggregate trend from 2019 to 2023 in nurse and social worker in-person visits in the last seven days of life. Between 2022 and 2023, the average frequency and length of nurse and social worker visits in the last seven days of life were stable or increased slightly between 2022 and 2023 (Table 9-8). Compared with the prepandemic 2019 levels, in 2023 nurse visits during the last seven days of life were on average slightly less frequent, but slightly longer than in 2019. For social worker services, visit frequency in the last seven days of life was similar in 2019 and 2023, but visit length was slightly shorter in 2023.

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.

Beginning in fiscal year 2026, hospices will report data using a new hospice patient-assessment instrument (referred to as the Hospice Outcomes & Patient Evaluation (HOPE)). The new instrument will collect information at additional times during the hospice episode (not just at admission and discharge) and will collect 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 2023, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 18.5 percent, up from 17.3 percent in 2022. Hospice claims data show "beneficiary revocation" and "beneficiary not terminally ill" were the most common reasons reported for live discharge (accounting for 6.7 percent and 6.2 percent of hospice discharges, respectively), followed by "moved out of area" (2.7 percent), "transferred hospice" (2.6 percent), and "discharge for cause" (0.4 percent).[20] Among providers with more than 30 discharges, the median live-discharge rate was about 21 percent, but 10 percent of those providers had live-discharge rates of 56 percent or more in 2023. Hospices with very high live-discharge rates were disproportionately for profit and recent entrants to the Medicare program and had an above-average rate of exceeding the aggregate payment cap. For example, our comparison of above- and below-cap hospices in 2022 found that the live-discharge rate among cancer patients was 10 percent for below-cap hospices and 26 percent for above-cap hospices; the live-discharge rate among heart failure patients was 18 percent for below-cap hospices and 55 percent for above-cap hospices.

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 other 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.

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 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, the Dementia Guide Model, MA VBID model, and the recent Medicare Care Choices Model (Medicare Payment Advisory Commission 2024).[21]

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 2023, the number of for-profit providers grew by more than 10 percent, indicating that these providers have been able to access capital. Recent financial reports for five publicly traded hospice companies generally indicate strong financial performance as of the third quarter of 2024 (Addus 2024, Amedisys

2024, Chemed 2024, Enhabit 2024, Pennant 2024). Average daily census grew modestly or substantially among these five companies in the third quarter of 2024. Admission trends varied, with three companies experiencing admission increases and two experiencing decreases. Among the publicly traded companies that report hospice-specific margins, margins increased in the third quarter of 2024 (Amedisys 2024, Chemed 2024, Enhabit 2024). Several of the publicly traded hospice companies acquired another hospice provider or opened additional locations in 2023 or 2024 (Addus 2024, Chemed 2024, Enhabit 2024, Pennant 2024). The hospice sector also continues to garner investment interest from other health care companies and private-equity firms and investors. For example, in 2023, an insurer, UnitedHealth Group, acquired LHC Group and has a pending agreement to acquire Amedisys (two large home health and hospice companies) (Parker 2023). However, overall hospice mergers and acquisition activity has slowed over the period from 2022 to 2024 following several years of increased activity (Braff Group 2024, Mertz-Taggart 2024). Some analysts attribute the slowdown in mergers and acquisitions to the recent high-interest-rate environment and expect an increase in mergers and acquisitions as interest rates decline (Parker 2024, Vossel 2024). 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.

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 accounts for about 91 percent of hospice days in 2022, and hospices' FFS Medicare margins are strong.

Medicare payments and costs: Aggregate payments exceed costs

In 2022, the FFS Medicare margin was 9.8 percent, down from 13.3 percent in 2021, 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.) Hospice costs per day increased 3.8 percent between 2021 and 2022. These costs vary substantially by providers' average length of stay: Hospices with longer stays have lower costs per day on average. (Hospice margins are presented through 2022 because of the data lag required to calculate cap overpayment amounts.) FFS Medicare margins varied widely across hospice providers. Hospice profitability is closely related to length of stay, with hospices with longer stays having 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 2022, Medicare's spending for hospice grew substantially, increasing 5.2 percent per year on average, from $12.9 billion to $23.7 billion. Between 2022 and 2023, Medicare hospice spending increased 8.3 percent, largely reflecting a 3.8 percent update to hospice base payment rates in 2023 and a 5.7 percent increase in total days of care in 2023, which was offset by the reinstatement of the sequester (which was in full effect for 2023 as opposed to partially in effect for 2022). Not included in the payment totals are the coronavirus pandemic–related federal relief funds for some providers. According to the Medicare cost reports, pandemic-related relief funds in cost-report year 2022 totaled about $150 million. Although the intent of these funds was to provide relief broadly to support care for all patients regardless of payer, the vast majority of hospice patients are Medicare beneficiaries (accounting for 91 percent of all hospice patient days in 2022). On a per day basis, Medicare's average payment to hospice providers was about $186 in 2023, up 2.4 percent from 2022.

Hospice costs

In 2023, hospice costs per day across all levels of care for hospice providers with cost-report data averaged about $167, rising 3.0 percent from 2022.

Hospice costs per day vary substantially by type of provider (Table 9-9), which is one reason for differences in hospice margins across provider types. In 2023, 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. 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. Freestanding and for-profit hospices have substantially longer stays than other hospices and thus have lower costs per day (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 provider-based hospices' higher costs compared with freestanding providers.[22] 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 9–9 **Total hospice costs per day varied by type of provider, 2023**

	Average total cost per day
All hospices	$167
Freestanding	161
Home health based	180
Hospital based	259
For profit	148
Nonprofit	201
Urban	168
Rural	157

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 2021 and 2022 (the year of our margin estimate), hospice costs per day grew 3.8 percent. Cost growth outpaced growth in per day payments (which largely reflected the annual payment update of 2.0 percent in 2022 and reinstatement of the sequester in mid-2022). As a result, the aggregate FFS Medicare margin for hospice providers in 2022 was 9.8 percent, down from 13.3 percent in 2021 (Table 9-10, p. 288).[23] FFS Medicare margins varied widely across individual hospice providers: –13.4 percent at the 25th percentile, 8.1 percent at the 50th percentile, and 23.6 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.[24] In addition, these margin estimates do not include federal pandemic relief funds that were received by hospice providers in 2022. However, if a portion of these relief funds that freestanding hospice providers received in 2022 were included in our margin estimates, the FFS Medicare margin with relief funds was 10.4 percent (compared with 9.8 percent excluding relief funds).[25]

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 9-10, p. 288).

In 2022, freestanding hospices had a higher aggregate FFS Medicare margin (12.4 percent) than home health–based (3.8 percent) or hospital-based hospices (–23.5 percent) (Table 9-10). 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 2022, the aggregate FFS Medicare margin was considerably higher for for-profit hospices (16.1 percent) than for nonprofit hospices (0.3 percent). The aggregate FFS Medicare margin for freestanding nonprofit hospices was higher (5.1 percent; data not shown) than the margin for nonprofit hospices overall. 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 (10.0 percent) than those in rural areas (8.1 percent).

TABLE 9–10

Hospice providers' aggregate FFS Medicare margins by selected characteristics, 2018–2022

Category	Share of		FFS Medicare margin				
	Hospice providers, 2022	Hospice patients, 2022	2018	2019	2020	2021	2022
All	100%	100%	12.4%	13.4%	14.2%	13.3%	9.8%
Freestanding	86	83	15.1	16.2	16.7	15.5	12.4
Home health based	7	9	8.4	9.7	11.2	10.9	3.8
Hospital based	6	8	–16.5	–18.4	–18.2	–15.6	–23.5
For profit	78	55	19.0	19.2	20.5	19.2	16.1
Nonprofit	20	43	3.8	6.1	5.8	5.2	0.3
Urban	86	89	12.6	13.6	14.3	13.4	10.0
Rural	14	11	10.3	11.5	13.5	12.3	8.1
Patient volume (quintile)							
Lowest	20	2	–3.1	–4.5	–2.1	–4.4	–12.3
Second	20	4	5.6	6.2	4.9	3.1	–6.4
Third	20	9	13.8	13.5	14.2	13.3	5.5
Fourth	20	18	14.0	15.8	17.9	15.5	12.2
Highest	20	67	12.7	13.9	14.4	14.0	11.7
Below cap	77	94	12.6	13.8	14.8	14.0	10.8
Above cap (excluding cap overpayments)	23	6	10.3	10.0	7.7	2.5	–1.6
Above cap (including cap overpayments)	23	6	21.8	22.5	22.8	21.8	18.5
Share of stays > 180 days							
Lowest quintile	20	27	–3.0	–2.5	–0.4	0.0	–4.1
Second quintile	20	29	8.5	10.3	11.8	11.1	8.2
Third quintile	20	20	16.8	19.9	20.0	20.5	17.8
Fourth quintile	20	17	20.8	22.8	24.1	22.2	18.6
Highest quintile	20	7	17.6	13.4	13.4	9.7	2.7
Share of patients in nursing facilities and assisted-living facilities							
Lowest half	50	44	6.1	6.6	7.5	7.1	1.8
Highest half	50	56	17.3	18.7	18.9	17.6	15.1

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).

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

Margins also vary by whether a hospice exceeds the aggregate cap. In 2022, below-cap hospices had an aggregate FFS Medicare margin of 10.8 percent. Above-cap hospices had a high FFS Medicare margin in 2022 before the return of overpayments (18.5 percent) and a slightly negative estimated margin after the return

of overpayments (–1.6 percent) that year (Table 9-10). 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).[26]

Hospice profitability is closely related to length of stay. Hospices with longer stays have higher margins. For example, in an analysis of hospice providers based on the share of their patients' stays exceeding 180 days, we found that the 2022 aggregate FFS Medicare margin ranged from –4.1 percent for hospices in the lowest quintile to 18.6 percent for hospices in the second-highest quintile (Table 9-10). Hospices in the quintile with the greatest share of patients exceeding 180 days had an aggregate FFS Medicare margin of 2.7 percent after the return of cap overpayments, but without the hospice aggregate cap, these providers' aggregate FFS Medicare margin would have been 21.8 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 can (Table 9-10). For example, in 2022, 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 about 15 percent compared with a margin of about 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 may create 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 2025 aggregate FFS Medicare margin

To project the 2025 aggregate FFS Medicare margin, we model the policy changes that went into effect between 2022 (the year of our most recent margin estimates) and 2025. For 2023, we assume rates of payment and cost growth based on preliminary data for that year. For 2024 and 2025, we assume revenue growth based on the annual payment updates in 2024 (3.1 percent) and 2025 (2.9 percent). The updates for these years reflect the statutorily required market basket update and productivity adjustment. In addition, our margin projection reflects full reinstatement of the 2 percent sequester beginning in July 2022. (The sequester was suspended from May 2020 to March 2022 and was reinstated at 1 percent from April to June 2022.) It also reflects the payment-rate penalty that providers face for not reporting quality data, which increased in 2024 to 4 percent. In addition, we assume a rate of cost growth similar to historical trends. Taking these factors into account, we project an aggregate FFS Medicare margin of about 8 percent for hospices in 2025.

How should FFS Medicare payments change in 2026?

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 2026 will not be set until summer 2025; however, using CMS's third-quarter 2026 projections of the market basket (3.1 percent) and productivity adjustment (0.6 percent) would increase hospice payment rates by 2.5 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 2026.

RECOMMENDATION 9

For fiscal year 2026, the Congress should eliminate the update to the 2025 Medicare base payment rates for hospice.

RATIONALE 9

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 2023, the number of providers increased by more than 10 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, average length of stay increased and median length of stay was stable. The 2022 FFS Medicare marginal profit was about 14 percent. Access to capital remains adequate: The number of for-profit providers increased by more than 10 percent, and financial reports suggest that the sector continues to be viewed favorably by investors. The 2022 aggregate FFS Medicare margin was 9.8 percent (10.4 percent if pandemic relief funds are included). The projected 2025 aggregate FFS Medicare margin is about 8 percent.

IMPLICATIONS 9

Spending

- Current law is expected to increase payment rates by 2.5 percent in fiscal year 2026. 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 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.

3 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 2023 was 18 days, and length of stay was 278 at the 90th percentile.

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

5 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 will be 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.

6 A CMS contractor report evaluated the effect of the hospice VBID model on use, quality, and costs, with data available for the first year (2021) or the first and second year (2021 and 2022) of the model, depending on the analysis (Eibner et al. 2023). The report notes that hospice VBID participation was heavily concentrated in Puerto Rico. Beneficiaries residing in Puerto Rico accounted for 55 percent in 2021 and 31 percent in 2022 of all beneficiaries enrolled in MA plans that participated in the hospice VBID model. The report evaluated the first-year effect of the hospice MA–VBID model on utilization and quality using data from 2019 (two years prior to the model) and 2021 (the first year of the model) and a difference-in-difference model that compared trends for beneficiaries enrolled in MA plans participating in the hospice VBID model with other MA beneficiaries. The evaluation found that hospice use and patterns of care did not appear to be significantly affected by the VBID model in 2021. In terms of quality, the report indicated that hospice CAHPS scores were higher among VBID-participating plans than the comparison group in 2021, with the increased CAHPS scores driven by Puerto Rican beneficiaries. In terms of effects on MA Prescription Drug plan (MA–PD) bids, premiums, and supplemental benefits, the evaluation found that VBID participation was associated with lower MA–PD bids in 2021 and 2022, higher supplemental benefit costs in 2021 and 2022, and a lower MA–PD premium in 2021 but not 2022. The evaluation found no effect of the model on costs to Medicare in 2021 (2022 data were not available). In the first two years of the model, the report indicated that less transitional concurrent care, hospice supplemental benefits, and nonhospice palliative care were provided than expected. Of beneficiaries who elected hospice in VBID plans in 2022, less than 1 percent received transitional concurrent care, and 6.5 percent received hospice supplemental benefits. According to the report, MA plans and hospice providers reported some implementation challenges (e.g., related to adapting information technology systems, data-reporting burden, and communications).

7 Several studies provide examples of the recent mixed findings in the literature on hospice's effect on Medicare spending. A recent working paper found that for-profit hospice enrollment led to large savings for some beneficiaries with dementia (Gruber et al. 2023). A recent 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).

8 We are missing data on certain hospice characteristics (ownership and hospice type) for more providers than typical in 2023—about 2.6 percent of providers that year. In recent years, new hospice entrants have mostly been for-profit, freestanding providers, so missing data on provider characteristics for 2023 likely understate growth in these categories. However, it is also possible that providers lacking data on ownership or hospice type for 2023 are nonprofit or

government owned or are home health–, hospital-, or SNF-based providers, which would lessen the estimated decline in these categories.

9 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.

10 This comparison of hospice use across years is based on paid Medicare claims. These data slightly understate hospice use in 2022 and 2023 because they exclude beneficiaries who received hospice care that was paid for by MA plans participating in the hospice VBID demonstration. In 2022, about 19,065 beneficiaries received hospice care that was paid for by MA plans participating in the hospice VBID demonstration, according to a CMS contractor evaluation report. A report for 2023 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 2023, the 75th percentile length of stay for hospice decedents with neurological conditions who were treated by for-profit hospices was 232 days compared with 143 days at nonprofit hospices; the 90th percentile length of stay was 543 days at for-profit hospices and 387 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 Nurse visits include visits furnished by registered nurses and licensed practical nurses (LPNs). In 2023, LPN visits made up 17 percent of all nurse visits furnished. The share of hospice nurse visits furnished by LPNs has increased slightly over the last few years, from 15 percent in 2019 to 17 percent in 2023. Data on hospice visits do not include visits by spiritual counselors or chaplains. CMS does not require hospices to report visits by these types of practitioners. The hospice conditions of participation require that hospices make an assessment of a patient's and family's spiritual needs and provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.

14 Throughout this chapter, we refer to margins as "FFS Medicare margins" because they reflect FFS Medicare payments for hospice services. Included in these margins are FFS Medicare payments to hospice providers for care furnished to FFS Medicare and MA beneficiaries who are enrolled in hospice.

15 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 2023d).

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

17 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, had generally lower CAHPS scores than other types of for-profit hospices (Anhang Price et al. 2023, Soltoff et al. 2024).

18 For both of the new 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.

19 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.

20 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.

21 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.

22 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 old, it seems likely that it continues to be a factor (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2010).

23 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.

24 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 (Section 1861(dd)(2)(A)(i) of the Social Security Act); however, the statute prohibits Medicare payment for these services (Section 1814(i)(1)(A)). Including nonreimbursable bereavement and volunteer costs in our margin calculation would reduce the aggregate Medicare margin for 2022 by at most 1.3 percentage points and 0.3 percentage points, respectively.

25 Because federal relief funds were intended to help cover lost revenue and payroll costs—including lost revenue from Medicare patients and the cost of staff who helped treat these patients—this alternate margin estimate includes a portion of these relief funds (based on the amount of relief funds received by each provider in cost report year 2022 multiplied by the provider's 2019 ratio of hospice days for Medicare patients to hospice days for all patients). Using this method, the alternate margin calculation allocates about 90 percent of federal relief funds that freestanding hospices reported on their 2022 cost reports toward hospices' care of Medicare beneficiaries in 2022.

26 If we had assumed 20 percent of cap overpayments were not collected, our estimate of above-cap hospices' FFS Medicare margin after the return of overpayments would increase almost 5 percentage points (from –1.6 percent to 3.2 percent), and the aggregate FFS Medicare margin for all hospices would increase less than 1 percentage point (from 9.8 percent to 10.2 percent).

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