National Alliance
for Care at Home

Facts and Figures

2025 EDITION

Published February 2026

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Please see the Data Sources section at the end of this report for details on the data sources used within this publication.

Section 1: Introduction

About this Report

For over two decades, the Facts and Figures report has provided an overview of hospice care delivery.

This report is published by the National Alliance for Care at Home. Historical versions were developed and published by National Alliance for Care at Home (the Alliance).

This year, the Alliance partnered with the Research Institute for Care at Home (the Institute) to bring more up-to-date data than ever for this report. Where possible, this Facts and Figures report shares the same underlying data as the Institute's Hospice Chartbook.

The 2025 edition of the Alliance Facts and Figures provides specific information on:

- Hospice patient characteristics
- Location and level of care
- Medicare hospice spending
- Hospice provider characteristics
- Quality of care

Currently, most hospice patients have their costs covered by Medicare through the Medicare Hospice Benefit.

What is hospice care?

Considered the model for quality, compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's private residence, but may also be provided in freestanding hospice facilities, hospitals, nursing homes, assisted living facilities, or other long-term care facilities. Hospice services are available to patients with any terminal illness. Hospice providers promote inclusivity in the community by ensuring all people regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease, or other characteristics have access to high-quality, end-of-life care.

How is hospice care delivered?

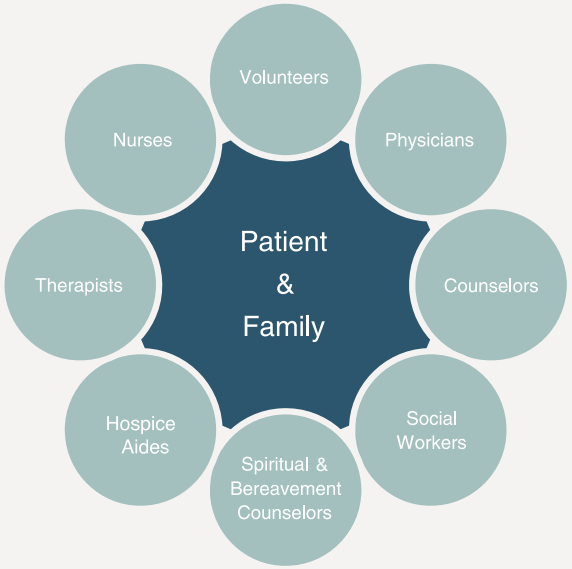
Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally-ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff are on-call 24 hours a day, seven days a week.

The findings in this report reflect those patients who received care through 2024, provided by the hospices certified by the Centers for Medicare & Medicaid Services (CMS) and reimbursed under the Medicare Hospice Benefit.

Introduction (continued)

The hospice team develops a care plan to meet each patient's individual needs for pain management and symptom control. This interdisciplinary team (IDT), as illustrated in Figure 1, usually consists of the patient's personal physician; hospice physician or medical director; nurses; hospice aides; social workers; bereavement counselors; spiritual care providers; and trained volunteers. In addition to the IDT, the hospice will support the physical, psychosocial, and spiritual needs of the beneficiary.

Figure 1: Structure of the interdisciplinary team



What services are provided?

The hospice interdisciplinary team:

- Manages the patient's pain and other symptoms
- Assists the patient and loved ones with the emotional, psychosocial, and spiritual aspects of dying
- Provides medications and medical equipment
- Instructs the informal caregivers on how to care for the patient
- Provides grief support and counseling to the patient as well as the surviving family and friends for up to 13 months after death
- Makes short-term inpatient care available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite time
- Delivers special services like speech and physical therapy, when needed

Location of Care

Most hospice care is provided in the place the patient calls home. In addition to private residences, this includes nursing homes, assisted living facilities, and other residential settings. Hospice care may also be provided in freestanding hospice facilities and hospitals, typically when the patient needs higher-level inpatient care. Patient populations and length of stay tend to differ by care location.

Introduction (continued)

Levels of Care

Hospice patients may require differing intensities of care during the course of their illness. While hospice patients may be admitted at any level of care, changes in their status may require a change in their level of care.

The Medicare Hospice Benefit affords patients four levels of care to meet their clinical needs: routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the interdisciplinary team, medication, medical equipment, and supplies.

- **Routine Home Care** (RHC) is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care at their residence.
- **Continuous Home Care** (CHC) is care provided for between eight and 24 hours a day to manage pain and other acute medical symptoms. CHC services must be predominately nursing care, supplemented with caregiver and hospice aide services intended to maintain the terminally-ill patient at home during a pain or symptom crisis.
- **Respite Care** (also referred to as Inpatient Respite Care (IRC)) is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long-term care facility with enough 24-hour nursing personnel present.
- **General Inpatient Care** (GIP) is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. GIP begins when other efforts to manage symptoms are not sufficient. GIP can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility with a registered nursing available 24 hours a day to provide direct patient care.

Volunteer Services

The U.S. hospice movement was founded by volunteers who continue to play an important and valuable role in hospice care and operations. Moreover, hospice is unique as it is the only Medicare benefit which requires volunteers to provide at least five percent of total patient care hours.

Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services to support patient care and clinical services ("clinical support")
- Engaging in a variety of activities such as fundraising, outreach and education, and serving on a hospice's board of directors (general support)

Bereavement Services

Counseling or grief support for the patient and their loved ones is an essential part of hospice care. After the patient's death, bereavement support is offered to families for at least one year. These services can take a variety of forms, including telephone calls, visits, written materials about grieving, phone or video calls, and support groups. Individual counseling may be offered by the hospice, or the hospice may make a referral to a community resource.

Some hospices also provide bereavement services to the community in addition to supporting patients and their families.

Quality of Care

In 2010, the Patient Protection and Affordable Care Act (ACA) mandated the initiation of a quality reporting program for hospices known as the Hospice Quality Reporting Program (HQRP). All Medicare-certified hospices must comply with HQRP reporting requirements; failure to comply results in a reduction to the Annual Payment Update (APU) for the corresponding fiscal year.

Introduction (continued)

CMS determines the quality measures hospices must report and the processes they must use to submit data for those measures. In addition, data from HQRP measures are displayed on Care Compare, the official CMS website for publicly reported healthcare quality measures. Currently, the measures included in the HQRP are the Hospice Outcomes and Patient Experience Tool (starting in 2025; formerly Hospice Item Set Comprehensive Assessment Measure) at Admission, Hospice Visits in Last Days of Life, the Hospice Care Index, and the CAHPS® Hospice Survey.

The HQRP has difficulty representing a large portion of participating hospices due to measurement, sampling, and strategy issues. This edition includes an expanded feature on CMS hospice quality monitoring.

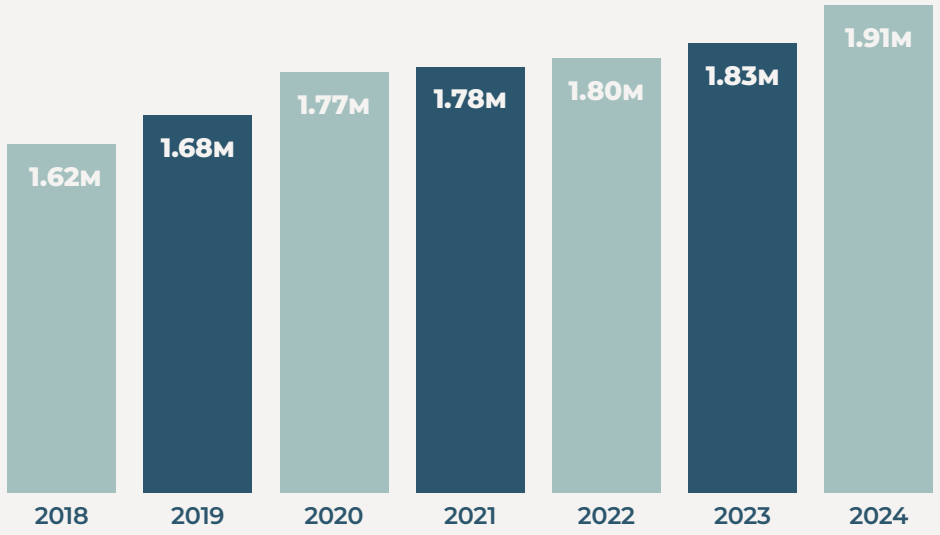
Section 2: Who Receives Hospice Care?

How many Medicare beneficiaries received care?

As seen in Figure 2, 1.91 million Medicare beneficiaries were enrolled in hospice care for one day or more in calendar year (CY) 2024. This is a 4.4% increase from 2023, a greater year-over-year increase than seen since 2020. This includes patients who:

- Died while enrolled in hospice in 2024
- Were enrolled in hospice in 2023 and continued to receive care in 2024
- Left hospice care alive during 2024 (live discharges)

Figure 2: Number of Medicare hospice users (millions of beneficiaries)

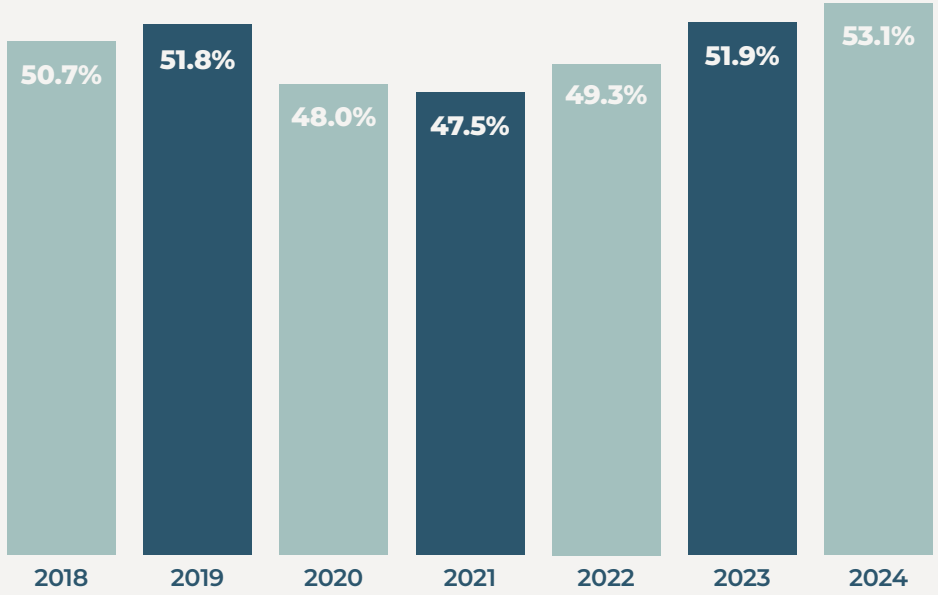


Source: *InfoMax by Hospice Analytics*

What proportion of Medicare decedents were served by hospice?

Of all Medicare decedents[1] in CY 2024, 53.1% received one day or more of hospice care and were enrolled in hospice at the time of death. This represents new growth in use from prior to the pandemic. Utah had the highest hospice utilization by Medicare decedents (68%) and New York had the lowest utilization (29%)

Figure 3: Share of Medicare decedents who used hospice (percentage)

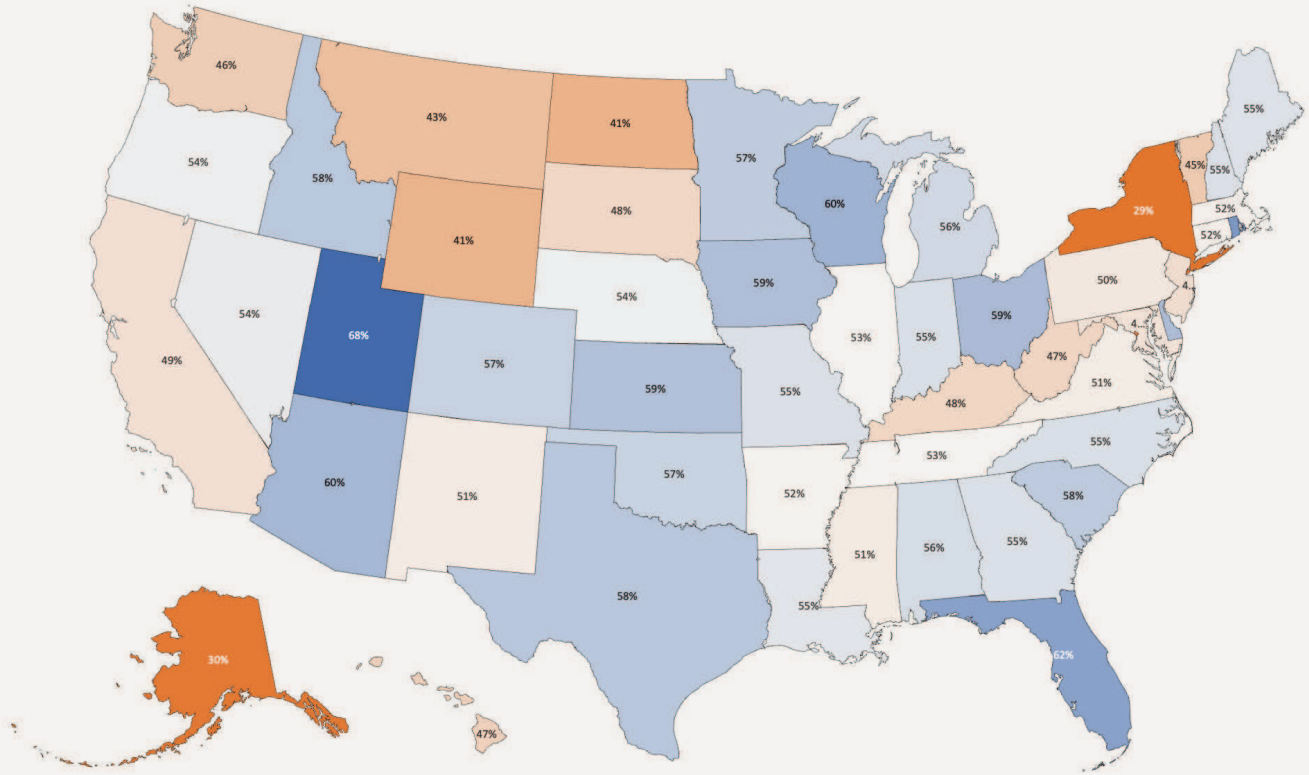


Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

1. Decedents refers to Medicare beneficiaries who have died.

Who Receives Hospice Care? (continued)

Figure 4: Share of Medicare decedents who used hospice, by state



State	Hospice Beneficiaries	State	Hospice Beneficiaries	State	Hospice Beneficiaries
UT	15,126	GA	55,622	NJ	37,709
FL	150,304	AL	37,003	CA	176,754
RI	6,528	NC	58,146	HI	6,692
WI	36,900	NE	9,560	VT	3,359
IA	20,029	LA	27,533	SD	3,927
AZ	45,760	MO	36,933	MS	19,010
DE	6,656	OK	26,620	WV	11,914
OH	78,330	NH	7,663	KY	22,823
TX	145,160	AR	19,659	WA	29,761
MN	29,696	IL	58,605	MT	4,937
ID	10,152	NV	16,332	WY	2,222
SC	35,137	TN	40,753	ND	2,642
KS	17,968	MA	32,395	VI	384
ME	9,375	VA	40,524	AK	1,299
MI	60,241	PA	72,087	DC	1,561
IN	38,740	NM	11,339	NY	48,618
OR	23,325	MD	25,195	PR	10,278
CO	24,528	CT	16,100		

Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Who Receives Hospice Care? (continued)

What percent of hospice patients were enrolled in Medicare Advantage within the year?

In CY 2024, Medicare Advantage (MA) continued its growth to cover a larger portion of the Medicare population, as seen in Figure 5. Traditional Medicare administers the Medicare Hospice Benefit, even for MA enrollees. From 2021-2024, some hospice care had been administered by MA plans under the value-based insurance design (VBID) model, however this program ended early due to operational difficulties and low participation. As demonstrated in Figure 6, utilization of the hospice benefit has become similar across Medicare Advantage and Traditional Medicare. This may be due to the increased size and diversification of the MA patient pool, Figure 5.

Source: *Medicare Enrollment, December 2025 (https://data.cms.gov/tools/medicare-enrollment-dashboard)*

Source: *MedPac March 2023 Report to Congress, Table 10-3; MedPAC 2025 Databook chart 11-11*

Figure 5: Medicare Advantage v. Traditional Medicare beneficiaries (in millions)

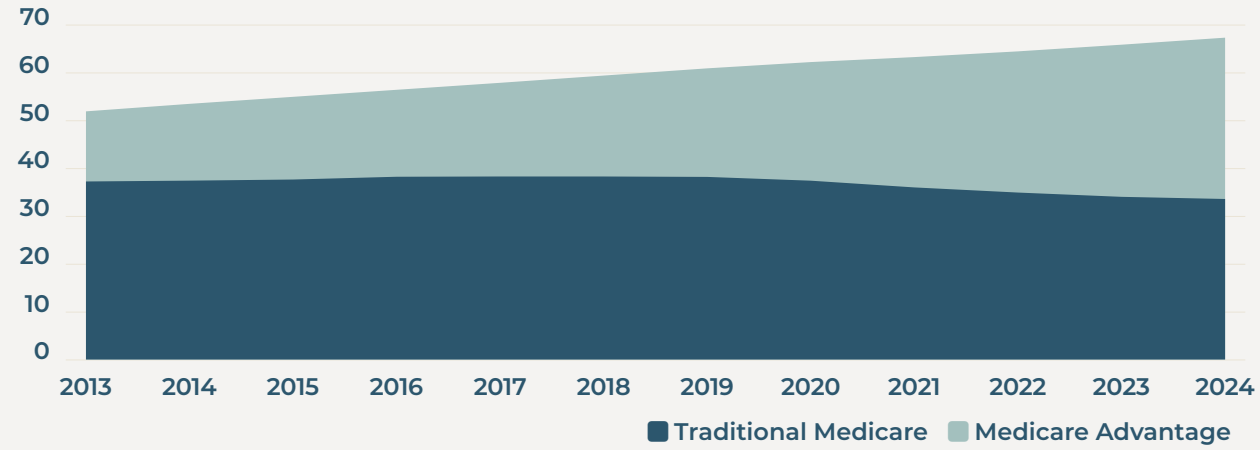
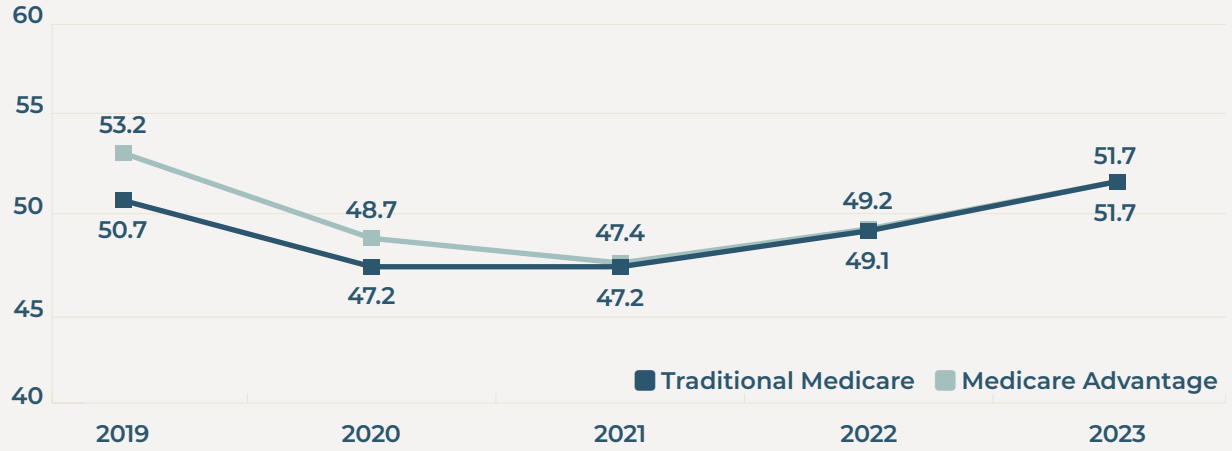


Figure 6: Medicare Advantage v. Traditional Medicare hospice use (percentage)



Who Receives Hospice Care? (continued)

What are the characteristics of Medicare beneficiaries who received hospice care?

Medicare Beneficiary and Decedent Characteristics

In CY 2024, approximately 2.5 million Medicare beneficiaries died which includes both the 1.33 million who elected hospice care and those who did not use hospice. When reviewing hospice specific demographic information, it is necessary to understand the larger population of Medicare beneficiaries and decedents as detailed in Table 1 below.

This section refers to shares of decedents which is calculated as:

$$\frac{\textit{number of beneficiaries in the group @ who both died and received hospice}}{\textit{total number of beneficiaries in the group who died}}$$

This calculation compares how each group accesses hospice but does not compare size of the groups or health disparities or inequities factors which can impact the those who access Medicare.

Table 1: CY 2024 Medicare beneficiaries and decedents, by characteristics

Demographic Characteristic	Total Medicare Enrollees	Decedents	Mortality Rate
Total	**70,306,074**	**2,512,241**	**3.6%**
Age			
Under 65 Years	11,127,048	196,025	1.8%
65-74 years	34,165,651	626,316	1.8%
75-84 Years	18,757,110	831,557	4.4%
85-94 years	5,626,632	695,028	12.4%
95 years and Over	629,633	163,315	25.9%
Sex			
Male	32,145,238	1,239,904	3.9%
Female	38,160,824	1,272,336	3.3%
Race			
Non-Hispanic White	54,107,561	2,047,373	3.8%
Black (or African-American)	7,664,196	272,370	3.6%
Asian/Pacific Islander	2,075,271	48,313	2.3%
Hispanic	2,629,476	60,378	2.3%
American Indian/Alaska Native	260,637	11,682	4.5%
Other	1,505,964	41,560	2.8%
Unknown	2,062,969	30,565	1.5%

Source: *Hospice Analytics*

Who Receives Hospice Care? (continued)

Beneficiary Sex

In CY 2024, 58.1% of females decedents enrolled in hospice and 47.9% of males did the same.

Figure 7: Share of Medicare decedents who use hospice, by sex

Among Medicare decedents who identified as female

58.1%
used hospice (2024)

Among Medicare decedents who identified as male

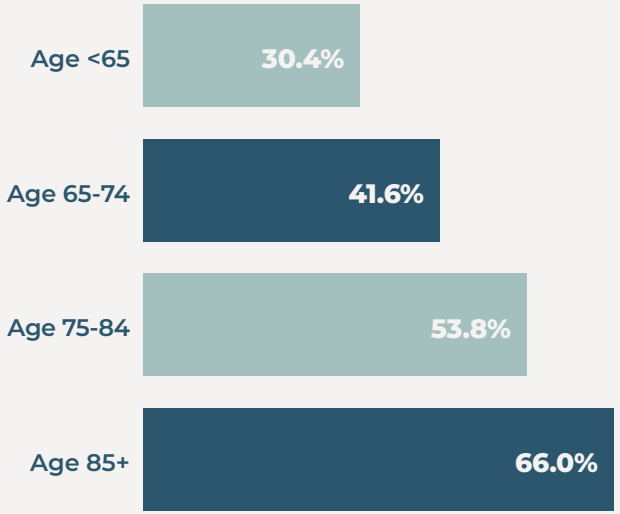
47.9%
used hospice (2024)

Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Beneficiary Age

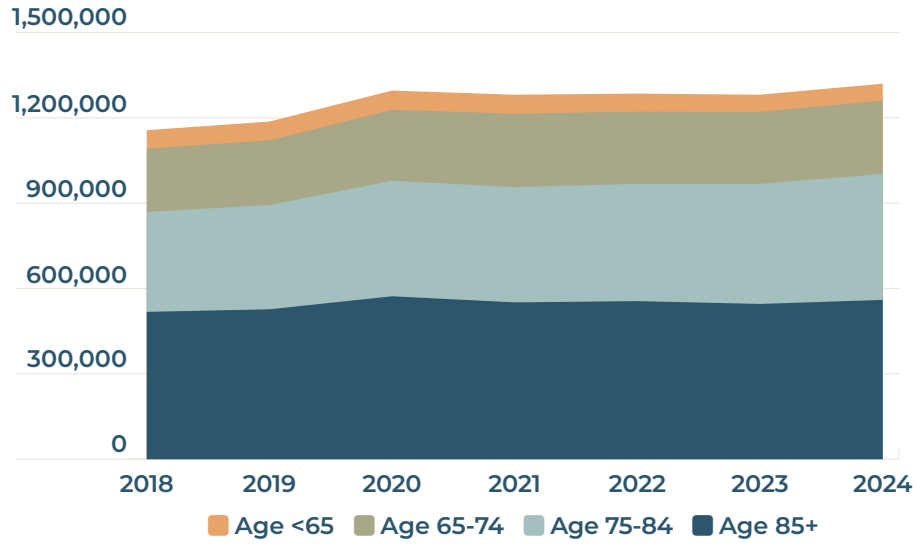
In CY 2024, as shown in Figure 8, two-thirds (66.0%) of Medicare decedents age 85 years and older utilized the Medicare Hospice Benefit, while progressively smaller percentages of decedents in younger age groups received hospice care. Figure 8 highlights the overall changes for all age groups CY 2018-2024, noting increases in total hospice population are driven by 75-84 year-olds (26% increase from 2018-2024), decedents aged 65-74 years old (16% increase), and the 85 and older (8% increase) whereas use in persons under age 65 declined (-9% change).

Figure 8: Share of Medicare decedents who used hospice, by age 2024 (percentage)



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Figure 9: Medicare decedents who used hospice, by age 2018-2024 (total)



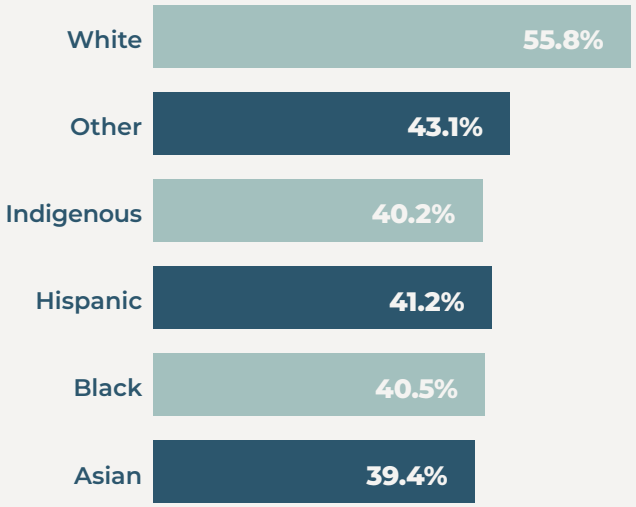
Source: *Source: KNG Health analysis of Medicare Standard Analytic Files, 2018- 2024.*

Who Receives Hospice Care? (continued)

Beneficiary Race/Ethnicity

In CY 2024, 55.8% of White Medicare decedents used the Hospice Benefit. 39.4% of Asian American Medicare decedents and 40.5% of Black Medicare decedents enrolled in hospice. 41.2% of Hispanic and 40.2% of North American Native Medicare decedents used hospice in 2024.

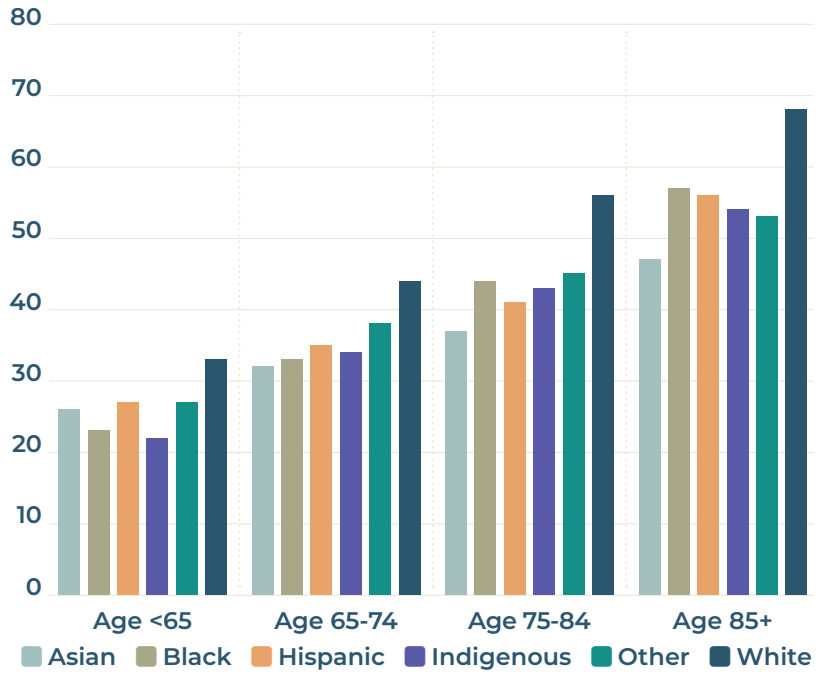
Figure 10: Share of Medicare decedents who used hospice, by race/ethnicity, 2024



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

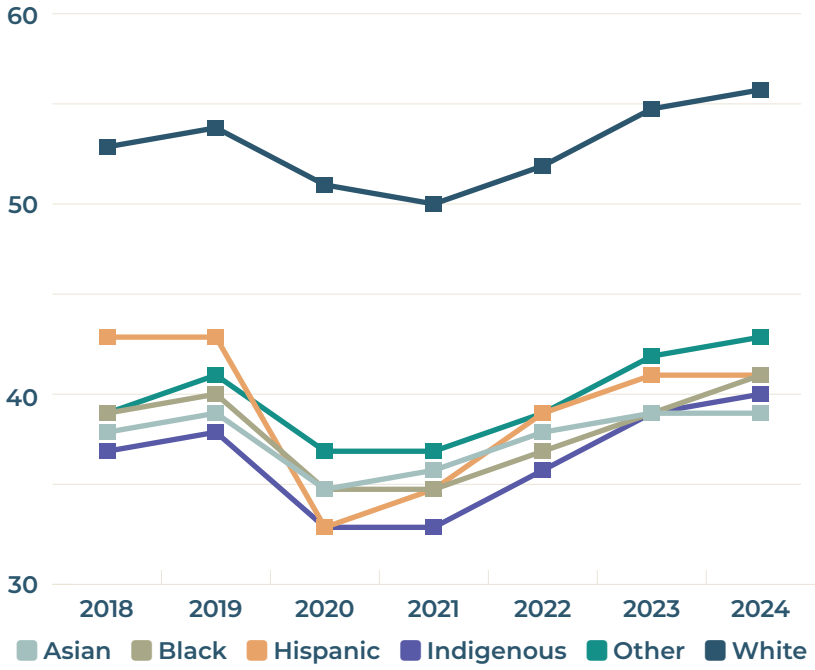
Figure 11 shows that differences in race/ethnic group decedent use of hospice are persistent across age groups. Figure 12 shows the change over time in use rate of hospice among decedents age 85+ by race/ethnicity. At its lowest, use of hospice among White decedents age 85+ dipped to 50% in 2020. In contrast, no other race/ethnicity has exceeded 45% in an observed year, and are typically 15% points lower than White decedents. Potential causes of this pattern of disparities in access warrant further investigation and may include issues with referral sources and cultural differences among patient/caregiver groups.

Figure 11: Share of Medicare decedents who use hospice, by race/ethnicity and age, 2024



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Figure 12: Share of Medicare decedents who use hospice age 85+, by race/ethnicity, 2018-2024



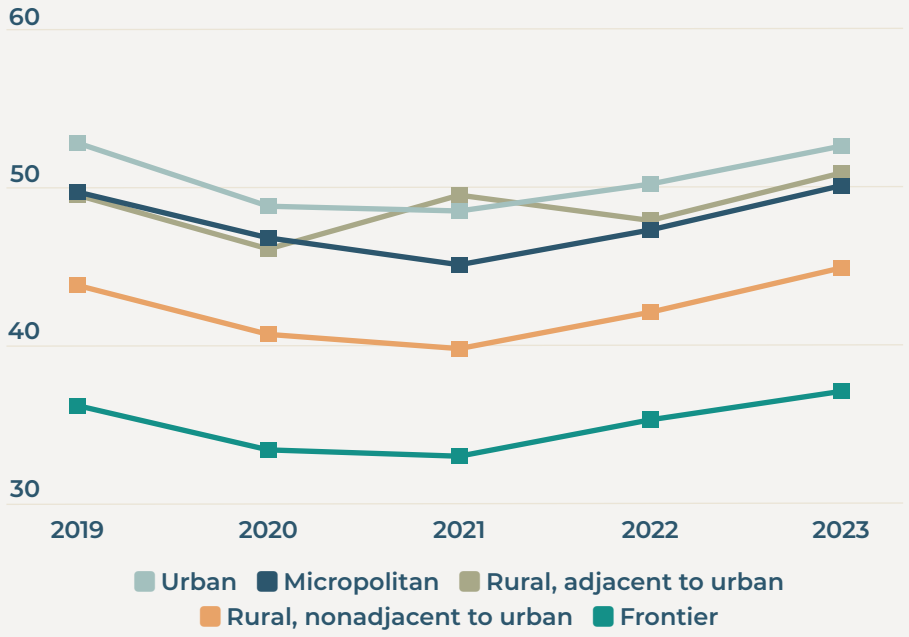
Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Who Receives Hospice Care? (continued)

Beneficiary Location

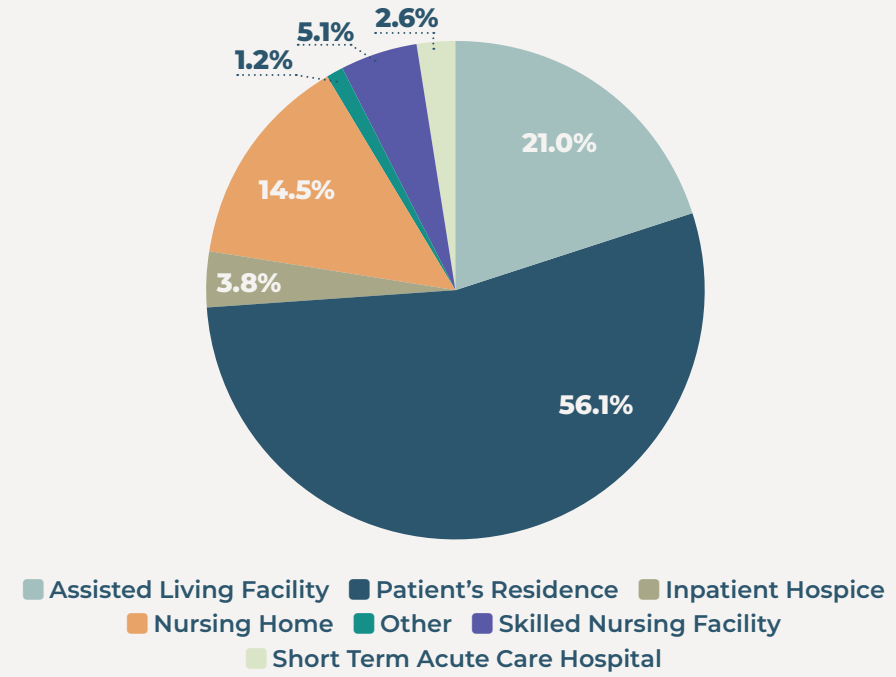
In CY 2023, over half of decedent beneficiaries utilized hospice in urban areas (52.6%), micropolitan (50.1%), and urban-adjacent rural (50.9%). Rural and frontier counties have recovered from the pandemic lows (44.9% and 37.1%, respectively). Geographic density appears to be a major driver hospice access. Despite multiple rural classifications, rural decedents near an urban community tend to have more similar access to services as urban decedents, whereas rural decedents not near an urban community have a utilization rate more similar to frontier decedents. However, all groups saw a similar at least a 3.3% point recovery from 2020-2023.

Figure 13: Share of Medicare decedents who use hospice, by location (2023)



Source: *MedPac March 2023 Report to Congress, Table 10-3; MedPAC 2025 Databook chart 11-11*

Figure 14: Hospice cases by site of care (percentage), 2024



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

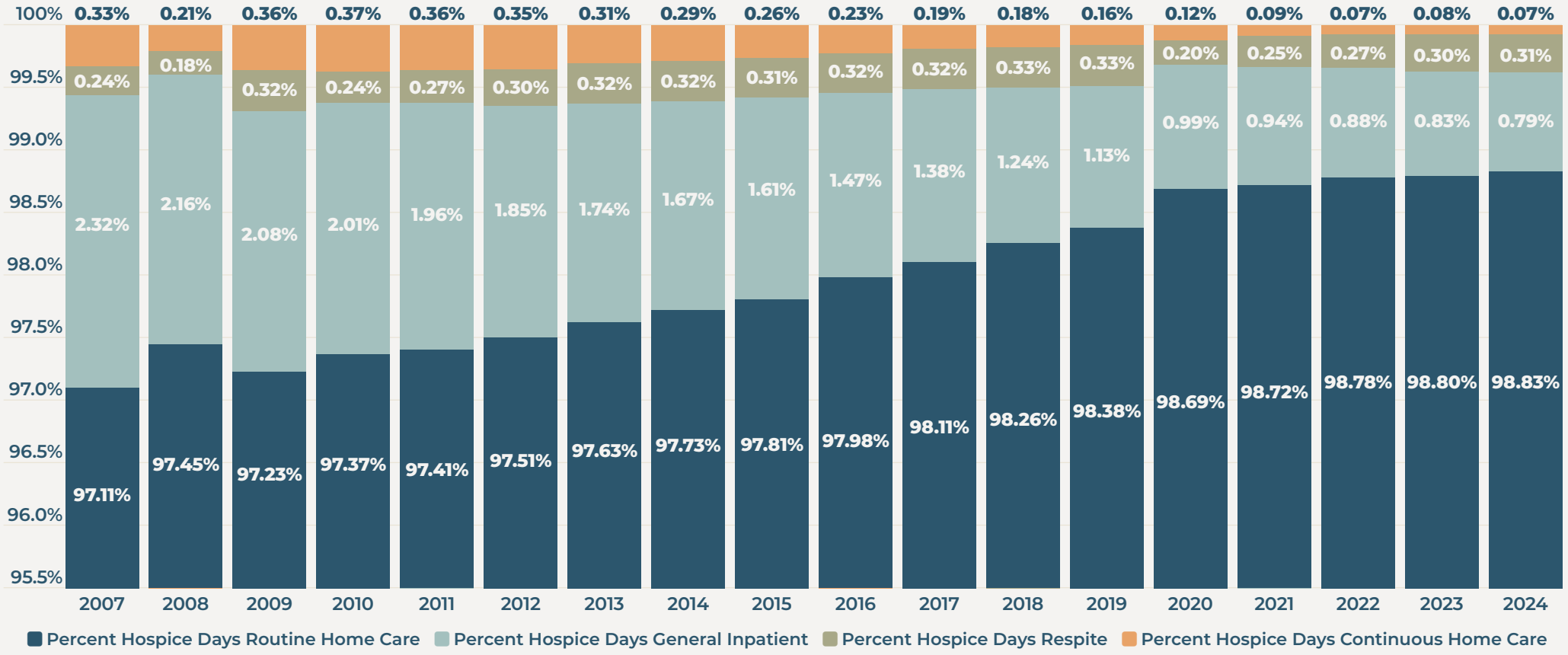
Who Receives Hospice Care? (continued)

Level of Care

In CY 2024, the vast majority of Medicare days of care were at the routine home care (RHC) level of care for both payments made and days of care provided. RHC has represented over 97% of hospice days from at least 2007 while there has been a notable decline in the proportion of inpatient days.

Figure 15: Percent of days, by level of care

Source: *Hospice Analytics*

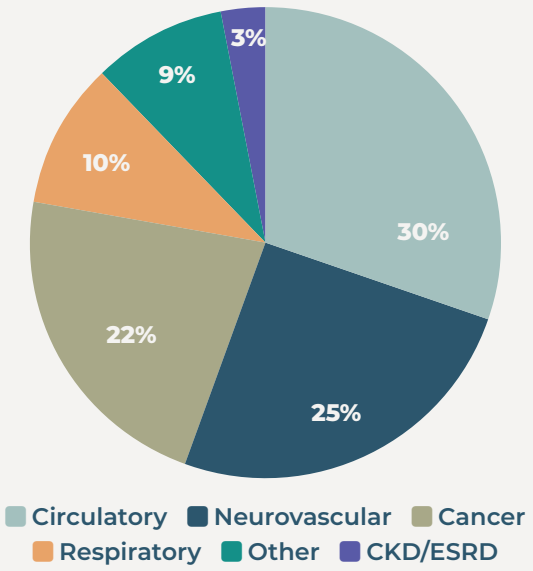


Who Receives Hospice Care? (continued)

Principal Diagnosis

The principal hospice diagnosis is the diagnosis (based on ICD-10 codes) determined to be the most contributory to the patient's terminal prognosis. In CY2024, the most common reason for hospice use was a circulatory system condition, such as stroke and heart failure. 25% of hospice stays had a principal diagnosis of a neurovascular condition.

Figure 16: Hospice cases by primary diagnosis (percentage), 2024



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Table 2: Top 20 Principal Hospice Diagnoses, by ICD-10 code, 2024

Source: *Hospice Analytics*

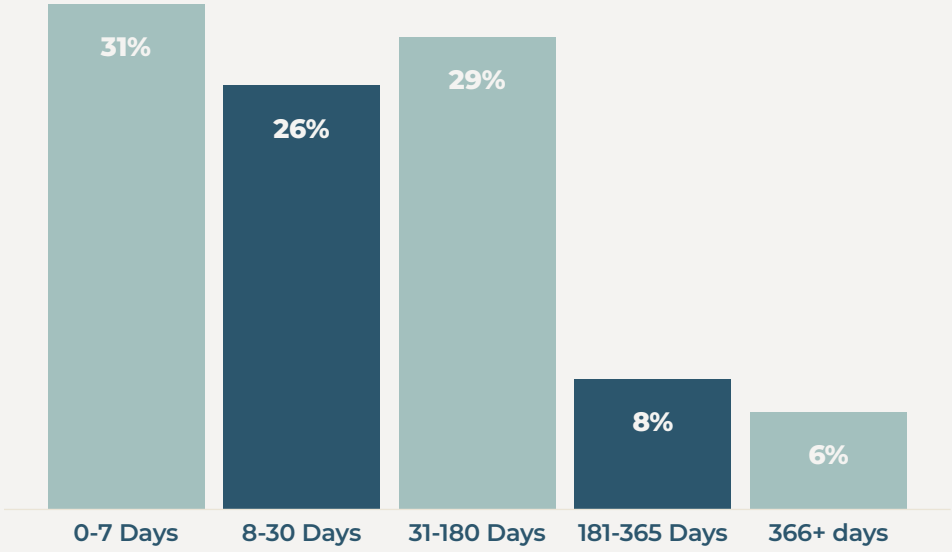
2024 Rank	ICD-10 Code	Description	Frequency	Percent
1	G311	Senile degeneration of brain- not elsewhere classified	164,996	9.0%
2	G309	Alzheimer's disease- unspecified	109,223	6.0%
3	J449	Chronic obstructive pulmonary disease- unspecified	77,109	4.2%
4	G301	Alzheimer's disease with late onset	62,843	3.4%
5	I672	Cerebral atherosclerosis	52,780	2.9%
6	I2510	Atherosclerotic heart disease of native coronary artery without angina pectoris	47,221	2.6%
7	I679	Cerebrovascular disease- unspecified	44,346	2.4%
8	I110	Hypertensive heart disease with heart failure	43,977	2.4%
9	I509	Heart failure- unspecified	41,182	2.3%
10	E43	Unspecified severe protein-calorie malnutrition	39,135	2.1%
11	C3490	Malignant neoplasm of unspecified part of unspecified bronchus or lung	39,023	2.1%
12	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease- or unspecified chronic kidney disease	36,857	2.0%
13	C61	Malignant neoplasm of prostate	28,206	1.5%
14	G20A1	Parkinson's disease without dyskinesia- without mention of fluctuations	26,142	1.4%
15	N186	End stage renal disease	24,336	1.3%
16	I639	Cerebral infarction- unspecified	23,793	1.3%
17	J9601	Acute respiratory failure with hypoxia	23,694	1.3%
18	C259	Malignant neoplasm of pancreas- unspecified	23,040	1.3%
19	I5022	Chronic systolic (congestive) heart failure	19,118	1.0%
20	J441	Chronic obstructive pulmonary disease with (acute) exacerbation	18,830	1.0%

Section 3: How Much Care was Received?

Length of Stay

Average length of stay for a Medicare decedent enrolled in hospice in 2024 was 88.6 days with a median length of stay of just 21.0 days. We note a change in the measurement approach taken here – prior versions of this report used the MedPAC lifetime length of stay measure. This measurement approach has been replaced with length of stay taken among completed (discharged or disease) stays.

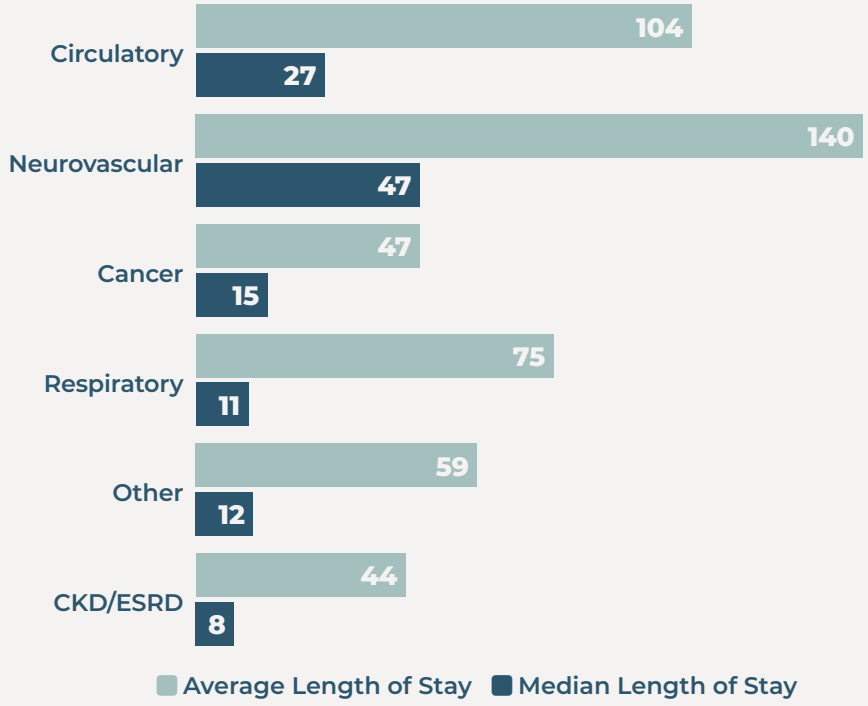
Figure 17: Length of Stay Distribution, 2024



Source: *MedPac March 2023 Report to Congress, Table 10-3; MedPAC 2025 Databook chart 11-11*

As seen in Figure 18, patients with a neurovascular primary diagnosis have the longest lengths of stay (140 days average, 47 days median) followed by circulatory system issues (104 days average, 27 days median).

Figure 18: Average and median length of stay, in days, by diagnosis, 2024



Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

How Much Care Is Received? (continued)

Discharges

In CY 2023, 18.3% of all Medicare hospice discharges were live, a slight increase from prior years. Increases in the reasons for revocations and moving out of services saw an increase from 2022.

Table 3: Rates of hospice live discharge and reported reason for discharge, CY 2020–2023 (percentage)

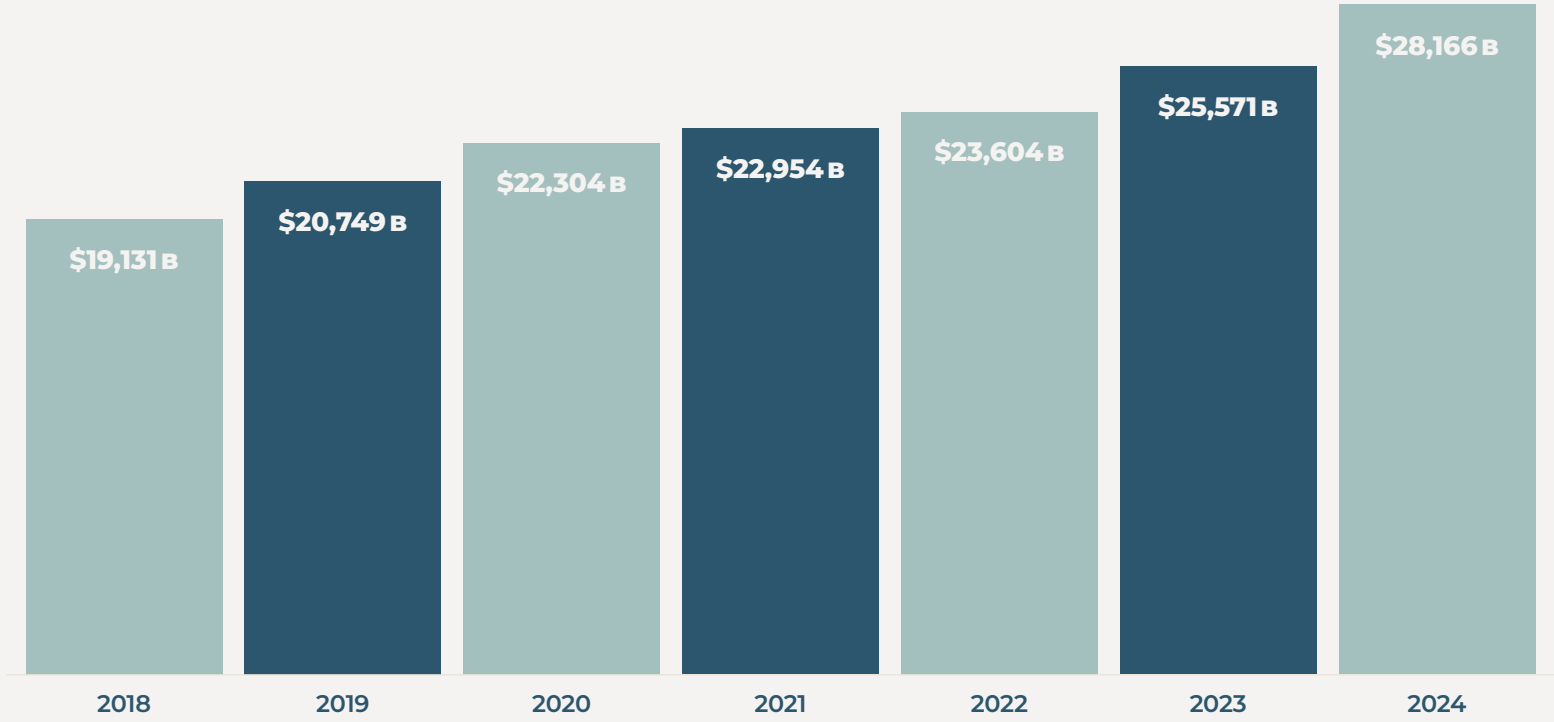
Reason for Discharge	2019	2020	2021	2022	2023
All live discharges	17.4%	15.4%	17.2%	17.3%	18.5%
Patient-Initiated Live Discharges					
Revocation	6.5	5.7	6.3	6.1	6.7
Transferred hospice providers	2.3	2.2	2.4	2.4	2.6
Hospice-Initiated Live Discharges					
No longer terminally ill	6.5	5.6	6.3	6.1	6.2
Moved out of service area	1.7	1.6	2	2.3	2.7
Discharged for cause	0.3	0.3	0.3	0.3	0.4

Source: *MedPac March 2023 Report to Congress, Table 10-3; MedPAC 2025 Databook chart 11-11*

Section 4: How Much Does Medicare Pay for Hospice?

Medicare paid hospice providers a total of $28.2 billion dollars for care provided in CY 2024, representing an increase of 10% over the previous year. This is a typical annual growth rate for hospice, noting growth was slower during the COVID-19 pandemic and several years following.

Figure 19: Medicare spending (billions of US dollars)



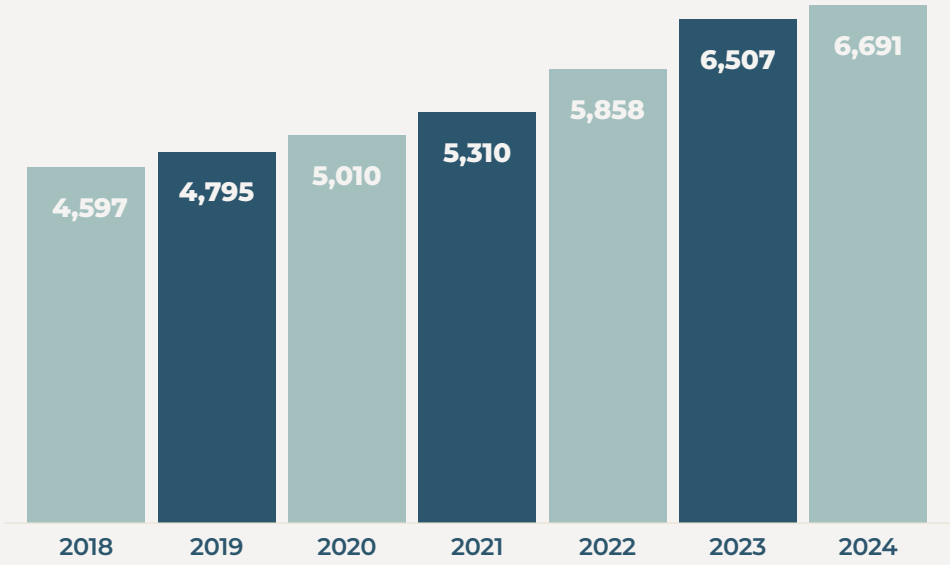
Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

Section 5: Who Provides Care?

How many hospices were in operation in 2024?

In CY 2024, there were 6,691 Medicare-certified hospices in operation that billed at least one claim to CMS. This is a modest 3% increase from CY 2023.

Figure 20: Number of operating Medicare certified hospices



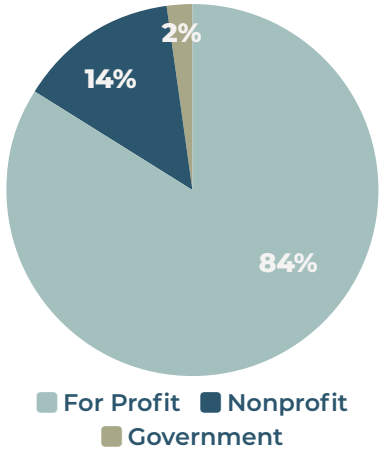
Source: *KNG Health analysis of Medicare Standard Analytic Files, 2018-2024*

What are the characteristics of Medicare certified hospices?

CMS reporting of hospice characteristics has degraded in recent years with 10% of hospices not having a displayed tax status, structure or location as of 2024. Among hospices with available public reporting, a large majority (84%) are for-profit, 88.9% are freestanding, and 88.5% are located in urban areas.

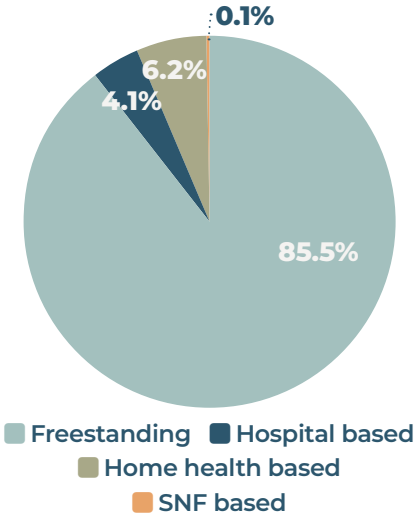
Tax Status

Figure 21: Tax status



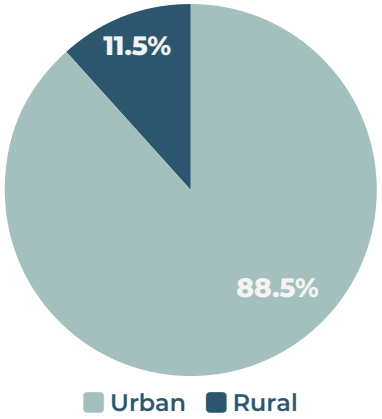
Hospice Care Setting

Figure 22: Hospice structure



Location of Hospice

Figure 23: Hospice location



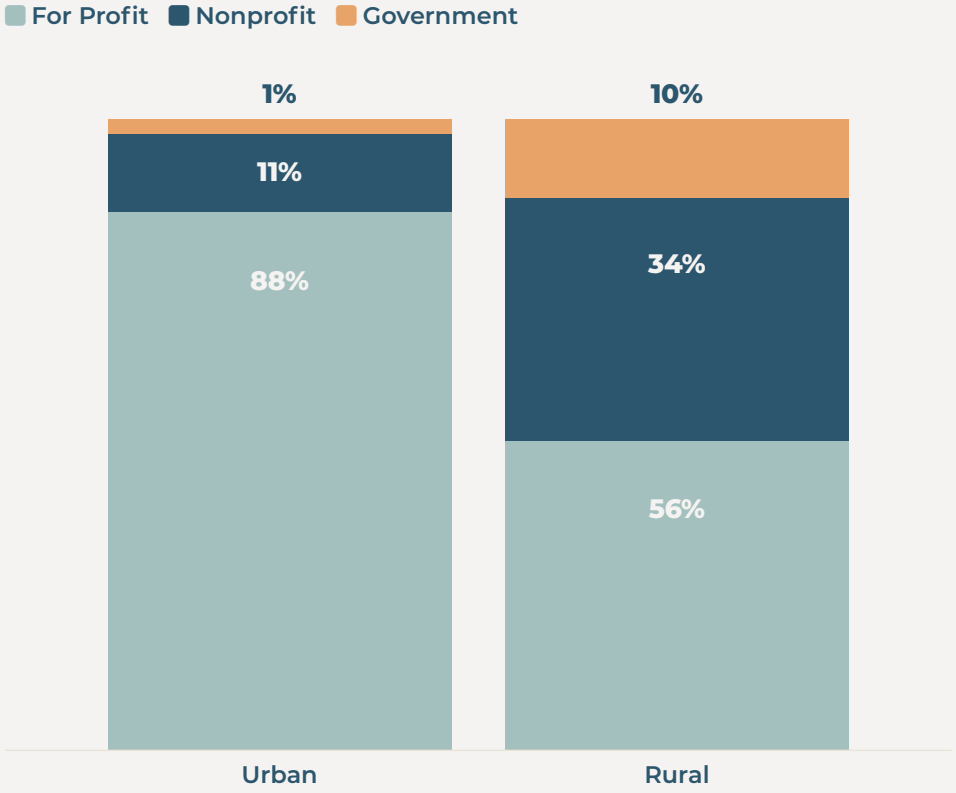
Source: *Alliance analysis of IQIES data*

Who Provides Care? (continued)

Further examining the intersection of hospice structure, urbanicity and location, 61% of hospices are urban, for-profit and freestanding providers. The following chart shows that both nonprofits are more common in rural areas as are housing of hospice within other provider types (e.g., home health agency or inpatient hospital).

Hospice Care Setting

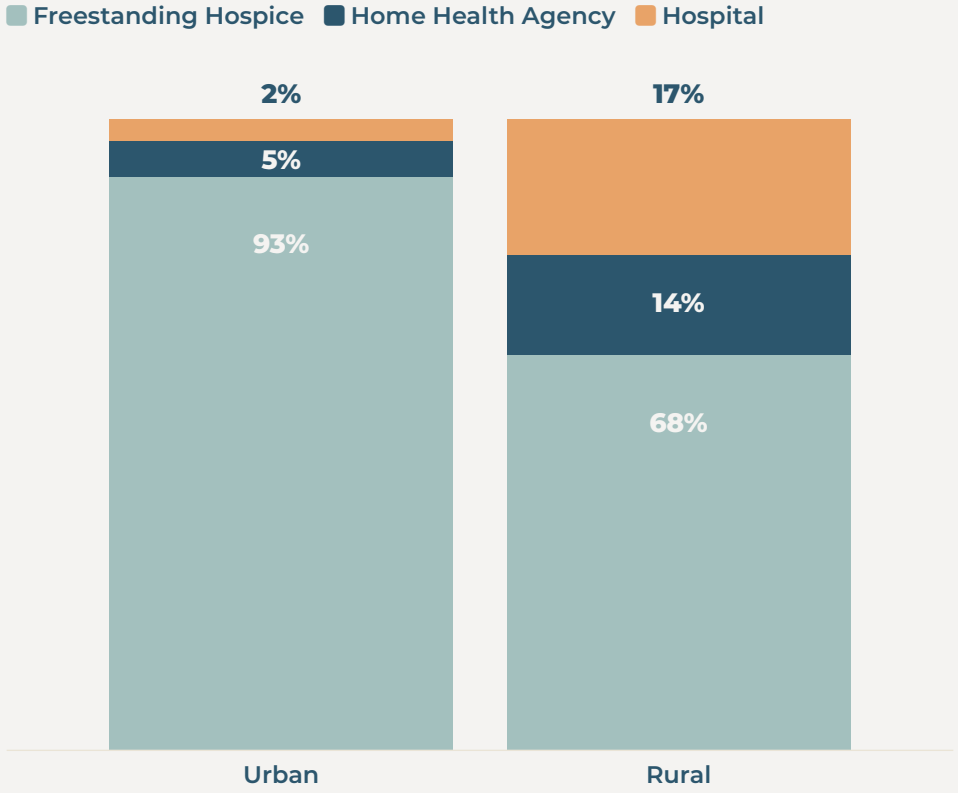
Figure 24: Hospice structure & urbanicity



Source: *Alliance analysis of IQIES data*

Location of Hospice and urbanicity

Figure 25: Hospice location & urbanicity



Source: *Alliance analysis of IQIES data*

Section 6: What is the Quality of Hospice Care?

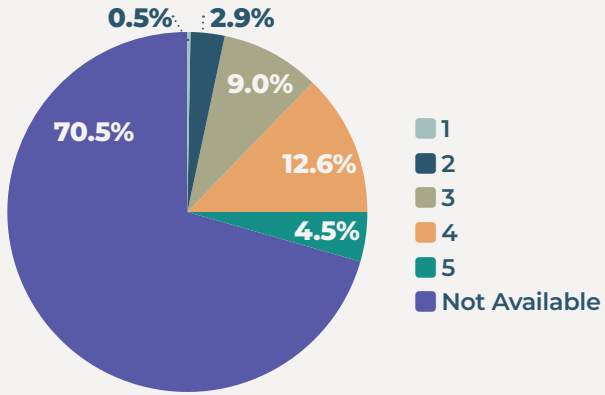
Quality and process measurement is critical to support providers to continuously improve the care they give, and public reporting can help patients and their families to choose the provider that is best for them. Scores on publicly reported quality measures attempt to describe and enumerate many domains of hospice care process, outcomes, and family/caregiver experience.

Publicly reported data represents only a fraction of providers who submit data to those systems due to data limitations and conceptual issues with the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Hospice Outcomes and Patient Evaluation (Hope) Tool, and Hospice Care Index (HCI) measurement systems. While over 90% of Medicare hospice providers submit data, only 29.5% have a CAHPS Summary Star Rating, 64.2% of hospices have a Hospice Visits in the Last Days of Life rating, and 80.0% have a composite Hospice Care Index rating.

The CAHPS® survey assesses the experiences of patients who died while receiving hospice care and their primary informal caregivers. The CAHPS Hospice Survey provides Hospice Survey Star Ratings for hospices with at least 75 survey responses in a reporting period. The typical reason for being excluded from a rating system is due to low sample.

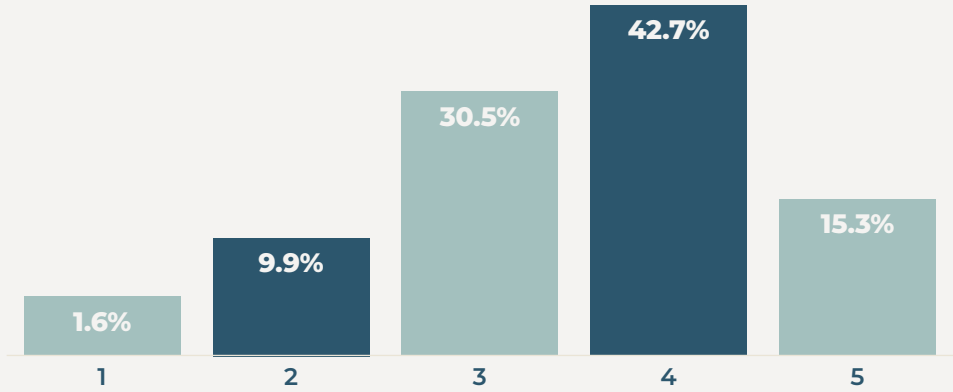
Submission of hospice quality data

Figure 26: Hospice Quality Star Ratings including Unavailable



Scoring of hospice quality data for providers with sufficient sample

Figure 27: Hospice Quality Star Ratings excluding Unavailable

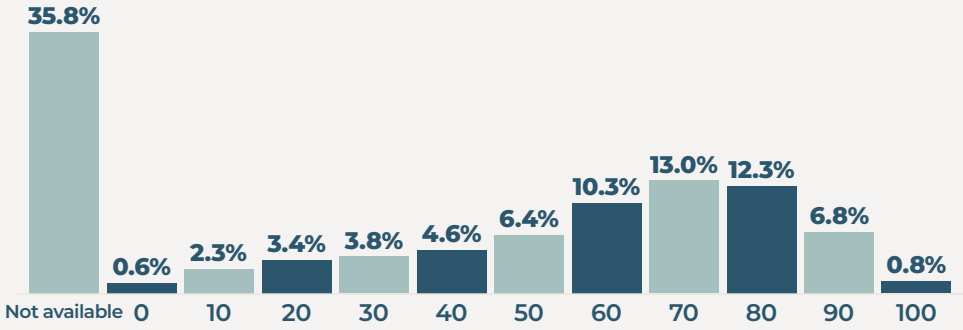


Source: *Alliance analysis of Hospice CAHPS data*

What is the Quality of Hospice Care? (continued)

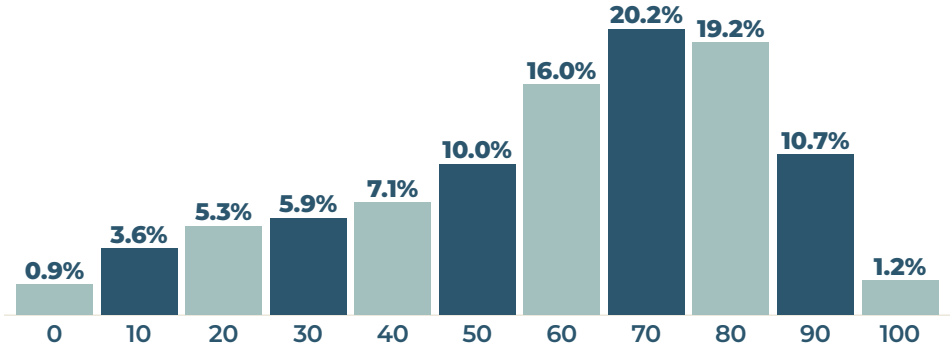
Hospice Visits in Last Days of Life

Figure 28: Proportion of hospices by HVLDL case percentage, including Unavailable



Hospice Visits in Last Days of Life scoring

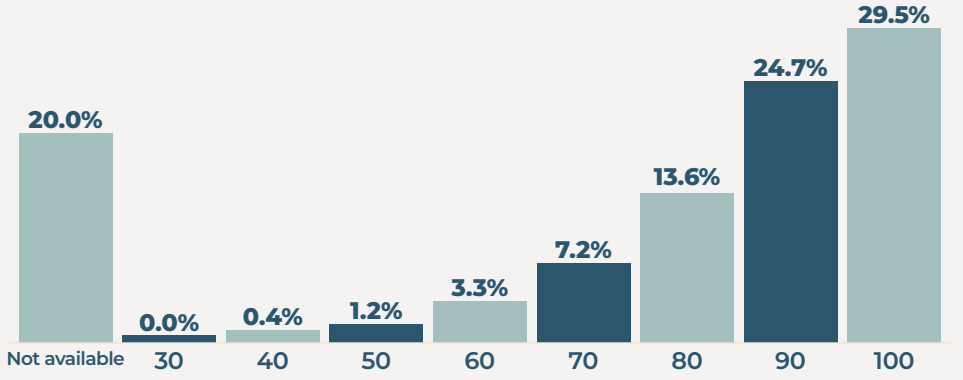
Figure 29: Proportion of hospices by HVLDL case percentage, excluding Unavailable



Source: *Alliance analysis of Hospice CAHPS data*

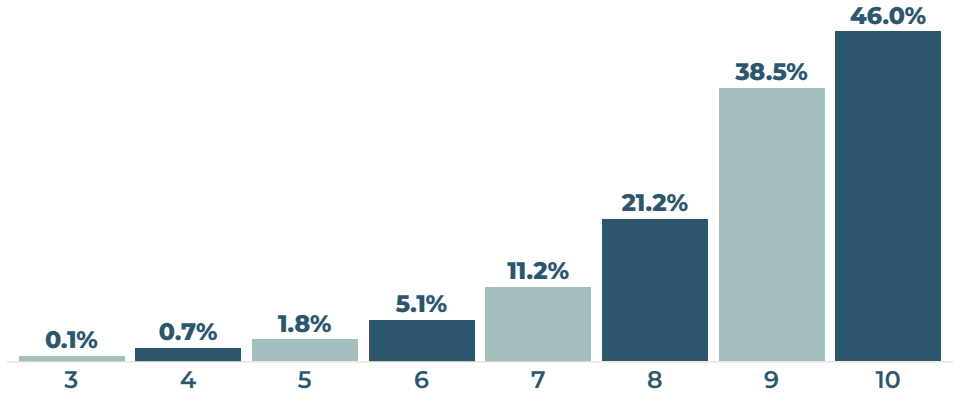
Hospice Care Index Composite ratings

Figure 30: Proportion of hospices by HCI rating, including Unavailable



Hospice Care Index Composite scoring

Figure 31: Proportion of hospices by HCI rating, excluding Unavailable



Source: *Alliance analysis of Hospice CAHPS data*

Appendix

Citations

CMS Program Statistics – Medicare Deaths

Congressional Budget Office. The Veterans Community Care Program: Background and Early Effects. October 2021. Washington, D.C.

Hospice Analytics

MedPAC March 2024 Report to Congress, Chapter 9: Hospice services

MedPAC July 2025 Data Book, Section 11: Other services

Limitations

For this report, only sources with comprehensive national level claims data were utilized. More detailed information may be available but did not include all Medicare hospice claims for the time period of this report's review.

In addition, data reported may be in calendar year (January through December) or fiscal year (October through September).

Finally, the data utilized is limited by the format of data collected by the Centers for Medicare and Medicaid Services; specifically, the limited language describing gender and race/ethnicity.

Questions May Be Directed To:

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Email: communications@allianceforcareathome.org

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AllianceForCareAtHome.org